BOARD OF DIRECTORS PUBLIC MEETING
Thursday 5th March 2026, commencing at 10:55
Lecture Theatre 1, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**25/26/350**	**10:55 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/351**	**10:56 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/352**	**10:57 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **5th February 2026.**	**D**	Read enclosure
4.	**25/26/353**	**10:59 (1 min)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**25/26/354**	**11:00 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**25/26/355**	**11:10 (30 mins)**	**Vision 2030 Update; including:** • **Transformation Board update.**	D. Jones/ J. Grinnell	To receive an update on progress.	**A**	Presentation
7.	**25/26/356**	**11:40 (10 mins)**	**Advanced Foundation Trust Update; including:** • **Results of provider capability assessment.**	J. Grinnell/ E. Saunders	To receive an update.	**N**	Read enclosure
8.	**25/26/357**	**11:50 (10 mins)**	**NMPP (Tripartite) Memorandum of Understanding.**	D. Jones	For approval.	**D**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**25/26/358**	**12:00 (15 mins)**	**Cheshire and Merseyside System Wide Update; including:** • **C&M financial position update.**	D. Jones R. Lea	To receive an update on the current position. To receive an update on the current position.	**A** **A**	Presentation Presentation
Unrivalled Experience							
10.	**25/26/359**	**12:15 (10 mins)**	**Infection, Prevention and Control Report, Q3.**	B. Larru	To receive the Infection, Prevention and Control Report for Q3.	**A**	Read report
Lunch (12:25-12:55)							
Performance Against Annual Plan							
11.	**25/26/360**	**12:55 (35 mins)**	**Evidence of Our Performance:** • **Flash Report, M11.** • **Integrated Performance Report for M10, 2025/26:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman A. Bateman N. Askew A. Bateman J. Chester M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read report
Unrivalled Experience							
12.	**25/26/361**	**13:30 (5 mins)**	**PALS and Complaints Report, Q3.**	N. Askew	To receive the PALS and Complaints Report for Q3.	**A**	Read report
13.	**25/26/362**	**13:35 (5 mins)**	**Safeguarding Children and Adults at Risk Annual Report, 2024/25.**	L. Cooper	To receive the Safeguarding Children and Adults at Risk Annual Report, 2024/25	**R**	Read report
14.	**25/26/363**	**13:40 (5 mins)**	**Children in Care Annual Report, 2024/25**	L. Cooper	To receive the Children in Care Annual Report for 2024/25.	**R**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
15.	**25/26/364**	**13:45 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 25.2.26.** - **Approved minutes from the meeting held on the 21.1.26.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 21.1.26.	**A**	Read enclosures
Pioneering Breakthroughs							
16.	**25/26/365**	**13:50 (5 mins)**	**Growth and Opportunities Committee:** - **Chair's verbal update from the meeting held on the 26.2.26.** - **Approved minutes from the meeting held on the 16.12.25.**	M. Jennings	To escalate any key risks, receive updates and note the approved minutes from the 16.12.25.	**A**	Read enclosure
Supporting our People							
17.	**25/26/366**	**13:55 (10 mins)**	**Strategic People Update; including:** • **EDI Action Plan.**	M. Swindell	To receive an update on the current position.	**A**	Read report
18.	**25/26/367**	**14:05 (5 mins)**	**Gender Pay Gap Report.**	M. Swindell	To receive the Gender Pay Gap Report.	**N**	Read report
Strong Foundations (Board Assurance)							
19.	**25/26/368**	**14:10 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 12.2.26.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 10.12.25.	**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 10.12.25**				
20.	**25/26/369**	**14:15 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's Highlight Report from the meeting held on the 23.2.26.** - **Approved minutes from the meeting held on the 21.1.26.** - **2025/26 top key risks (M10)**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 21.1.26.	**A**	Read enclosures
21.	**25/26/370**	**14:20 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read reports
22.	**25/26/371**	**14:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
23.	**25/26/372**	**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, 2nd April 2026, LT1, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in February 2026: 432: Medivet Limited Car Park – Hill Dickinson

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M10, 2025/26	R. Lea
Digital, Data and Artificial Intelligence Update	K. Warriner

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 5th February 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)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Chief Scientific Officer	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. C. Lee	ACOO, Division of Surgery	(CL)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Mr. D. Powell	Director of Development	(DP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
Item 25/26/326	Ms. K. Turner	Freedom To Speak Up Guardian	(KT)
Observing	Ms. J. Jones	NHSE AFT Assessment Team	(JJ)
	Mr. C. Laidlaw	NHSE AFT Assessment Team	(CL)
	Mr. L. McDonald	NHSE AFT Assessment Team	(LMc)
	Ms. J. Preece	Governance Manager	(JP)
Apologies	Ms. S. Almond	Consultant Paediatric Surgeon	(SA)
	Ms. B. Pettorini	Director of Surgery	(BP)

Patient Story

The Chair welcomed Sam's dad and Jen Yates (*Sefton Mental Health Practitioner*) who had been invited to February's Board to share Sam's story.

The Board was provided with an overview of Sam's journey through CAMHS. It was reported that Sam was under various teams at Alder Hey for neurodevelopmental issues, hypersensitivity, sleep and urological care as an infant and toddler, and was diagnosed with ASD when moving to secondary school. Sam had a mental health crisis due to health anxiety in 2021 and after attempts to access CAMHS via a GP referral were unsuccessful, eventually he was accepted through a parent referral. Sam's mental health stabilised and he was under a few different clinicians with some highs and lows. Attention was drawn to the success, which is the key focus of the story, after Sam came under Jen's care as his CAMHS coordinator.

A key theme was the value of personalised, goal-based therapeutic intervention, including graded exposure and shared decision-making. Jen described how care was tailored to Sam's individual sensory needs, goals and motivations, with active involvement of the family. Attention was drawn to the positive outcomes achieved through this approach, including improved confidence, social participation, and engagement with education.

Sam's dad shared some reflections with the Board, including the importance of early recognition of neurodiversity, clarity of referral and escalation routes, and consistency in clinical approaches.

The Chair expressed gratitude to Sam for allowing his story to be shared and wished him all the very best for the future. The Chair informed Sam's dad that the Trust will review his feedback to inform service development and quality improvement discussions.

25/26/314 Welcome and Apologies

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

25/26/315 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.

25/26/316 Minutes of the previous meeting held on 8th January 2026.
Resolved:
The minutes from the meeting held on the 8.1.26 were agreed as an accurate record of the meeting.

25/26/317 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

ACTION 25/26/301.1: *Strategic People Update (Obtain data from the Trust's occupational health provider to determine whether stress-related absence can be differentiated between workplace and personal causes)* – Not all employees absent due to stress require an Occupational Health referral. Data indicates that 58% of respondents attributed their stress-related absence to work-related factors. Additionally, some staff members are on sick leave due to complex long-term or mental health conditions. Support mechanisms, such as Staff Advice Liaison Service (SALS), remain in place for affected employees. **ACTION CLOSED**

25/26/318 Chair's and CEO's Update

The Chair drew attention to the Strategy Board session held on the morning of 5.2.26 which focused on strategic issues, including topics such as advancing Vision 2030, the Paediatric Chain, Artificial Intelligence (AI), and tackling health inequalities. The session was considered highly productive and inspiring.

During the last month the Chair has met with the Chairs of other provider organisations, as well as Sir David Henshaw, Chair of the Integrated Care Board (ICB), who provided updates on the new Executive Team being assembled to address finance and governance matters at the ICB.

The Board was informed that Alder Hey won a Gold Award in the hospital category of the 'Jolly Josh Inclusive Greenspace Award' at the Northwest in Bloom competition. The Lord Mayor or Liverpool and the Mayor of Rochdale visited Alder Hey to present both the North West in Bloom Award and the Jolly Josh Award. The Chair noted that it is encouraging to see how the space on the Campus is providing enjoyment for children and young people (CYP) and staff.

It was reported that the Trust has signed a Memorandum of Understanding with Edge Hill University. This partnership extends beyond training staff; it involves the University's department of education collaborating with the Trust to educate people about the challenges faced by CYP today. The Chair acknowledged the contributions of the Trust's Academy Director, Katherine Birch, during recent years.

John Grinnell provided an update from a national, regional and local perspective, including financial and performance expectations, workforce pressures, and emerging policy direction. Reference was made to the complexity of delivering year-end financial targets while simultaneously planning for the next three years. It was reported that Resident Doctors have voted for the ability to strike in the future. The timeline is unclear but currently discussions are positive.

Over the past week, a number of sessions have taken place with the Centre, including one with the CEO of NHS England (NHSE) Jim Mackey. It was reported that the Centre is pleased with progress in 2025/26 and there is a real possibility of the Trust meeting its financial targets by the year end. While waiting times have improved, they remain critical, so maintaining low waits and strong performance is a priority for Alder Hey. The Board was advised that the Centre is sponsoring a sprint for Q4.

'*How We Work in the Future (Vision 2030)*' - During a recent senior leadership session, the Trust's new programme of work was introduced, focusing on how Alder Hey will work in the future to organise itself to address ambitions, opportunities, and challenges in the coming year. Alder Hey is now moving into the implementation stage of Vision 2030, which requires the Trust to adjust its structure to consistently and sustainably meet strategic goals. Staff will be engaged in transparent but compassionate discussions, with careful attention paid to their feedback.

The Board was informed that the People Committee is being asked to provide assurance regarding potential cultural changes. It was pointed out that it is important to keep sight of the cultural work that the Trust has already undertaken.

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

25/26/319 Vision 2030 Update

It was reported that the Medium Term Plan is aligned with Vision 2030. A number of iterations of the plan have been reviewed by the Finance, Transformation and Performance Committee (FTPC) and the Board, with feedback still being collected prior to submission. Emphasis was placed on the necessity for the Board to reach agreement on the Board Assurance Statements before the plan is submitted.

Medium Term Plan

The Trust has outlined specific ambitions for the next three years. The first objective is to establish a single system for CYP that focusses on population health, integrates the provision of paediatric services across C&M, and to hold the health budget. The second goal is to reduce inequities in health outcomes and improve life chances. Third, Alder Hey aims to revolutionise CYP experience and access to services. Fourth, the Trust would like to secure Advanced Foundation Trust (AFT) status as this will provide a platform for delivering the CYP system and offer the flexibility to focus on their needs and also to become an exemplar site where best practice can be delivered and shared. Finally, to ensure that the Trust's workforce is thriving. While the plan includes radical changes, maintaining the integrity and culture of the Alder Hey team is essential throughout this process.

The Board received a comprehensive overview of the five enablers identified to deliver the Trust's ambitions, including details on the proposed delivery method, financial and performance considerations, workforce implications, risks, as well as the strategic direction and integrated collaborative approach underpinning the plan, as detailed in the report.

John Grinnell referred to the shape of the Medium Term Plan over the next three years and acknowledged that further work is required in terms of scoping and identifying system opportunities. The plan highlights the anticipated challenges in year one, which are expected to ease slightly in years two and three. Currently, as a result of the deconstruction of funding, the Trust is being underpaid by £8m annually therefore it is imperative to approach year one with precision. Entering April with a significant portion of the programme established is crucial, making the next six weeks vital. The scale of deliverables remains concerning, particularly the need to reduce headcount by 8% while increasing productivity. Although the plan is in place, substantial risks persist. Accelerating the implementation of the *How We Will Work in the Future* programme and exploring avenues to enhance resources will be essential.

The Chair highlighted the team's collective work on the plan, which outlines key step changes, challenges, and risks. It was felt that the enormity of the changes that have got to be made are very stark. Board members were invited to share feedback.

A suggestion was made about including narrative within the risk section of the plan, specifically addressing quality in line with the new National Quality Strategy and patient experience. Reference was also made to the risks relating to access and clinical capacity and the need for honest evaluation of productivity gains to identify investment needed for teams to address any gaps.

It was pointed out that the deliverability of the Trust's financial plan remains crucial, yet it faces challenges due to the evolving financial demands of the system. These factors could impact the Trust's projected small surplus for 2025/26 and alter the forecast for the coming year.

The Board was advised that the Trust has outlined its capacity in detail, and ongoing discussions with Spec Comm and the ICB are currently underway; however, a resolution has not yet been reached. At present, there is no national investment allocated for growth, prompting further dialogue to better understand the rationale and explore potential solutions to address this gap. From a national standpoint, the Trust is projected to achieve a breakeven position for 2025/26, and it was suggested that the Trust provide an update to the region regarding this status.

The Chair of the Audit and Risk Committee, Kerry Byrne advised that the Trust has commissioned MIAA to undertake an audit on the governance of the Finance Improvement Programme with findings expected by April 2026.

Board Assurance Statements

The Board undertook a detailed review of the Board Assurance Statements, focusing on whether the stated maturity ratings accurately reflect the evidence presented, the progress already made, and the risks associated with future delivery. As a result of this discussion, a number of amendments were agreed to ensure the statements provided a balanced, credible, and transparent assessment, as follows:

Governance and Leadership (The Board can confirm that plans reflect the consideration of population needs, underserved communities and inequalities when developing plans) – BO suggested evaluating how the Trust's level of maturity aligns with the strong evidence presented in the organisation's self-assessment. Outline the Beyond programme and highlight that the Trust has a Public Health Consultant providing innovative, world-class services, such as Ketamine Clinics and a lung health programme initiative, which align with the Centre's Core20Plus5plus approach.

For noting
Following discussion, it was agreed to amend the governance and leadership assurance statement.

Governance and leadership (Robust Quality and Equality Impact Assessments have been undertaken and reviewed by the Board to inform the sign off of the organisation's plan) – AB advised that the Trust has used EIAs a lot to assess how the organisation will work in the future.

For noting
Following discussion, it was agreed to retain the statement as level 1: embedded; however, the next step is to evaluate it.

Plan Development – JG advised that both statements are interlinked and may change in the next few weeks due to uncertainties with commissioners.

NHS Standard Contract Commissioning (The Board can confirm that that the organisation has engaged with its ICB to ensure contract values used in planning submissions are agreed across commissioner and provider activity and financial plans) – It was noted that this process is currently ongoing and remains in progress.

Workforce – KW recommended revising the statement to reflect the Trust's current digital progress.

For noting
It was agreed to include narrative on the Trust's current digital progress.

Moving into Community Neighbourhoods – It was felt that this area of work is in progress, but the depth of alignment is embedded.

JK pointed out that the Trust is currently performing well in its ongoing activities but acknowledged that future initiatives are still evolving. While some aspects can be described as embedded, the newer developments have not reached that stage yet.

The Chair thanked everyone for their contributions and noted that if any additional changes are necessary, they must be submitted by 11.2.26.

C&M Financial Position

An update was provided on the financial position across the Cheshire and Merseyside (C&M) system. It was reported that the system remains under significant financial pressure, with a strong focus from the region on organisations delivering against agreed plans for the current financial year.

The Board was advised that some organisations within C&M are forecasting delivery in line with plan whilst others continue to experience challenges. As a result, the system-level position remains fragile, and confirmation of full system financial delivery has not yet been secured.

It was reported that the deficit support funding for the system has been withheld, pending confirmation that the C&M system will achieve its planned financial position.

Resolved:
The Board:

- Approved the Medium Term Plan.
- Approved the Board Assurance Statements pending the amendments agreed during the meeting.
- Noted the C&M financial position update.

25/26/320 Evidence of Our Performance

Flash Report, M10

The Board received the Flash Report for M10. The following points were highlighted:

- Key operation challenges include diagnostics and issues in Gastroenterology. Actions are being undertaken to ensure progress resumes by March 2026.

- Was Not Brought (WNB) did not achieve target. In response, the Trust has transitioned to a high street model for WNB, launched the patient portal, and enhanced the booking process to try and address this area of concern.
- The Transcription Team is currently facing challenges with clinical letters due to capacity constraints resulting from staff illness and the ongoing transition to Lyre Bird. A recovery plan has been implemented to address and reduce the backlog. Additionally, a review of the Transcription Team is scheduled for the 6.2.26. It was noted that 30% to 40% of letters are now processed through Lyre Bird.
- There has been a reduction in the waiting list from 25k to 17k due to interventions.
- The number of patients being treated within 18 weeks has increased from 61.9% to 62.5%.
- The Trust plans to schedule an additional 2,000 outpatient appointments after receiving funding for this purpose.

Outstanding Care and Experience – Safe and Caring

- There has been a reduction in the number of restrictive interventions required.
- There has been an increase in medication errors, with no clear trends identified. To address this risk, the Trust is actively promoting adherence to the five rights of medication administration.

Workforce

- While long term sickness absence has slightly reduced, short-term sickness has increased again in month. It was reported that the Trust is not an outlier as similar trends were observed across C&M during December.

A question was raised about whether there is a plan in place to improve PDR targets. It was reported that the Trust has introduced a new app to improve PDR targets, with communications planned to increase awareness. Training is also being provided to managers to support effective PDRs.

Financial Sustainability - Well Led

It was reported that the Trust is slightly behind plan and exploring opportunities to accelerate activity. The Trust has been asked to finalise its forecast for the year, which remains aligned with the best-case scenario at the present time, given the ongoing income discussions with the ICB. Additionally, there are technical matters to address, including presenting the Accounting Policy to the Audit and Risk Committee on the 12.2.26.

The Trust is required to confirm its forecast to NHSE and confirm its commitment to meeting its plan, while addressing any issues with the ICB. The Board was advised of the importance of managing this matter with the ICB to ensure that the Trust doesn't carry over figures into 2026/27.

A concern was raised about the way in which the ICB are making decisions in relation to unresolved income, and a question was raised and responded to about the risk relating to financial support for industrial action.

Community and Mental Health Division

- *Board Assurance Framework (BAF)* - The risk relating to medication shortages has been closed.

- *Informal CQC visit to Sunflower House (Tier 4 Unit for under 13s)* – In October, the Trust experienced staff shortages, recruitment challenges, estate concerns, and a demanding group of CYP who required care in the Tier 4 Unit. Alder Hey worked with NHSE to consider suspending inpatient admissions during this period. A comprehensive action plan was compiled and approved by the Safety and Quality Assurance Committee (SQAC). All training identified in the plan has been completed, and capital funding has been secured, with some allocated to repair the unit's automatic doors, which are currently out of order.

  NHSE and CQC conducted an informal visit to Sunflower House on the 3.2.26. The feedback received was positive, accompanied by a number of recommendations relating to the environment. The Board was advised that the Tier 4 Unit is currently unable to admit patients; consequently, the Trust is mobilising its Outreach Team who will begin to see patients via the Outpatient department. Regular updates are being provided to SQAC, and Estates will continue to offer ongoing support to Sunflower House. It was also confirmed that CQC will conduct an unannounced inspection in due course.

Division of Medicine

- *Emergency Department (ED)* – Tactical Command was initiated to ensure ED had effective staffing levels during industrial action.
- There has been an intense focus on improvements to safety and quality metrics and clinical audit.
- The Division's mandatory training target is over 90%.
- Inpatient discharges per working day has declined each month during Q3 due to the high acuity of patients. Work is taking place with the Discharge Team and IT to improve the visibility of data relating to patient flow and bed management.

It was queried as to whether the patient portal will reduce WNB figures. It was reported that once parents are able to use the functionality to reschedule appointments it will have an impact. Additionally, proactive engagement with families and use of AI audio to contact them will contribute to the reduction of figures.

Division of Surgery

- The Division is maintaining a strong position in the majority of specialities in respect to RTT compliance improvement though challenges remain in Dentistry.
- A meeting has been arranged with clinical leads to review theatre schedules, with the objective of achieving full operational capacity in Q4.
- Attention was drawn to overdue follow up waits in three key specialities.

Resolved:
The Board:

- Noted the Flash Report for M10.
- Noted the content of the IPR for Month 9.

25/26/321 Deteriorating Patients Quality Improvement Report

The Board received an update on the quality improvement work that has taken place around deteriorating patients. The update emphasised that this was a whole-hospital approach to patient safety, designed to strengthen the identification, escalation, and response to patient deterioration across a complex, high-acuity clinical environment.

A key element of the improvement programme was the implementation of the National Paediatric Early Warning Score (PEWS), supported by the integration of observation devices. The Board noted that observations are now captured electronically in real time, with automated calculation of PEWS scores and escalation alerts sent directly to the Response Team.

The update included progress on Martha's Rule, which provides an escalation route for families and carers via WhatsApp to the Response team. Early experience indicated that most escalations related to communication concerns rather than acute deterioration, reinforcing the importance of patient and family-centred safety approaches.

Significant workforce enhancements were also highlighted, including strengthened consultant presence, expanded middle-grade cover, and revised on-call arrangements to support timely senior decision-making on a 24/7 basis.

Education, training, and culture formed a central component of the improvement programme. A review of training packages was undertaken along with assurance of compliance, and a Deteriorating Patient Learning Review Forum was established to support reflective, learning-focused discussions on cases to determine what went well and areas for improvement.

The Board was advised that the quality improvement work is having a positive impact on the rate of deteriorations throughout the hospital.

A number of questions were raised and responded to about whether the significant data digital capability now in place could be used to not only respond to deterioration but also to predict and prevent deterioration earlier, and how escalation alerts were received and acted upon by the Response Team.

The Chair offered thanks to all those involved in the quality improvement work and acknowledged the progress that has been made.

Resolved:
The Board noted the update on deteriorating patients and the quality improvement work that has taken place.

25/26/322 Learning from Patient Safety Incidents, Q3

The Board was provided with an update on activity for Q3, 2025/26 following the transition to the Patient Safety Incident Investigation Framework (PSIRF) on the 1.1.24. The report highlighted areas of system-wide learning and improvement and next steps. The following points were highlighted:

- *PSII Wrong Route Medication Administration (InPhase ID: 29369)* – It was confirmed that the Terms of Reference for the investigation are now in their final draft form.
- *PSII Retained Swab Spinal Surgery (InPhase ID: 27662)* – The final draft report is in the process of being reviewed and will be ready w/c 9.2.26 for approval.
- The Board was advised of the ongoing work with theatres to develop deeper understanding and drive an effective improvement plan following two Never Events. It was reported that the Chief Executive joined the team during their away day, contributing to these efforts.

Resolved:
The Board noted the activity undertaken during Q3 2025/26

25/26/323 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 17.12.25 were submitted to the Board for information and assurance purposes.

During January's meeting the Committee received a detailed update on improvements in the Neurodevelopmental Single Pathway and Sunflower House. A deep dive was also undertaken on BAF risk 1.4.

Resolved:
The Board noted the Chair's Highlight Report from the meeting held on the 21.1.26 and the approved minutes from the meeting held on the 17.12.25.

25/26/324 Strategic People Update
Resolved:
The Board received and noted the Strategic People Update.

25/26/325 People Committee

The approved minutes from the meeting held on the 19.11.25 were submitted to the Board for information and assurance purposes.

During December's meeting the Committee was advised of the notable success in the strategic partnership between Alder Hey and Edge Hill, especially in terms of the innovative PGCE mental health specialist partnership. It was reported that a strong and credible Communication Strategy has been approved and a Comms Plan has been developed at pace for the overall organisation, aligned to Vision 2030. The Committee received the first findings from the Staff Survey, and a discussion took place on some of the indicators that have dropped and the possible reasons for this. It was confirmed that work will be undertaken to assess the challenges facing vulnerable teams to triangulate and understand the issues.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 19.11.25.

25/26/326 Freedom To Speak Up Update

The Board was provided with a summary of the activities of the Freedom To Speak Up service for Q3 and an outline of the actions planned for the coming period. The following points were highlighted:

- It was reported that Joe Fitzpatrick (JF) Internal Communications Manager, has been appointed as the Deputy Freedom to Speak Up Guardian (DFTSUG). The Board welcomed this appointment and noted that JF will work with the FTSU Champions to build a network that represents the Trust's diverse workforce.
- There is a requirement for further development of the FTSU App as it is not anonymous enough. If further development is not possible the Trust will transition to the InPhase system as it allows staff to report anonymously, which was the primary driver for the app development.

A number of questions were raised and responded to about whether the Trust has been able to recruit Champions from clinical teams, and if there is any intelligence in respect to the large percentage of concerns raised by the Division of Medicine versus the 0% raised by Corporate services.

It was felt that it is important to capture the full scope of the FTSU Champions' work and that consideration should be given in terms of how the organisation monitors the timeliness of closing cases. Time management and effectiveness of cases should also be reflected accurately in the data. It was reported that the Trust's Speak Up Policy is under review to clarify processes and determine suitable timeframes.

The Chair advised Board members that undertaking a walkaround with the FTSUG is invaluable.

Resolved:
The Board received and noted the FTSU update for Q3.

25/26/327 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 11.12.25 were submitted to the Board for information and assurance purposes.

During January's meeting the Committee received the Medium Term Plan and focussed on risks, taking into account the changes that have taken place over the last couple of weeks.

Resolved:
The Board noted the update, the approved minutes from the meeting held on the 11.12.25, and the Committee's top key risks in M9.

25/26/328 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:

- It was reported that each Committee has scrutinised the BAF during meetings.
- The risk scoring profile is evolving, showing a notable increase in the number of red-rated scores.
- Deep dives continue, with work being undertaken to refine this approach adding sophistication to processes.
- There is now an interrelation between the strategic risks in the BAF but additional work is required before April to reset the profile.
- The organisation has started to use some aspects of the Risk Management Forum (RMF) to discuss the impact of risks.
- It was confirmed that further refinement of the BAF will be undertaken following approval of the Medium Term Plan, and risk appetite and tolerance will be revisited.

Non-Executive Director, Kerry Byrne (KB) felt that the BAF has undergone significant changes over the past six months. It was reported that ARC is going to undertake a technical review of BAF risk 4.1 and KB advised of her attendance to a recent RMF to evaluate the effectiveness of its operations.

Resolved:
The Board received and noted the contents of the Board Assurance Framework Report for December 2025.

25/26/329 Any Other Business

There was none to discuss.

25/26/330 Review of the Meeting

Non-Executive Director Bola Owolabi (BO) was invited to review the meeting. BO commented that the meeting was chaired excellently. In terms of the Strategy Board BO appreciated the update on the Liverpool Institute of Child Health and noted the significant progress achieved. To summarise the Strategy Board, BO chose four words; impact (*seeing tangible results across all presentations*); coherence *(recognising that there is a lot of good work taking place and team coordination*); intersectionality (*acknowledging the overlapping areas of work*); and finally, integration (*embedding initiatives into Alder Hey's core operations*).

BO highlighted the exceptional performance of the Emergency Department during winter pressures and periods of industrial action, acknowledging the significant efforts made by staff to achieve this outcome. In relation to the discussion on Board Assurance Statements, it was noted that a mature conversation was conducted, with rating changes supported by clear justifications. BO emphasized that this serves as evidence of a high performing Board.

The Chair thanked Board members for their contribution during the meeting and brought the public element of the meeting to a close.

Date and Time of Next Meeting: Thursday 5.3.26, 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 March 2026							
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	5.3.26	**On track Mar-26**	
Actions for April 2026							
7.11.24	24/25/214.2	Integrated Performance Report	Invite the family of a patient who were supported by the Wellbeing Hub, to a future Board meeting to share their story.	D. Jones/ K. McKeown	Feb-24	**Apr-26**	
1.5.25	25/26/45.1	People Plan Strategic Update	Landmark Supreme Court Judgment - Provide an update on the implications of this case for the Trust once further guidance has been published.	M. Swindell	Jul-25	**Apr-26**	
6.11.25	25/26/223.1	Alder Hey in the Park Campus Development Update	Strategic planning session to be scheduled in the new financial year to explore future development opportunities for the Campus.	D. Powell	Apr-26	**On track Apr-26**	
Actions for May 2026							
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
8.1.26	25/26/301.1	Strategic People Update	Obtain data from the Trust's occupational health provider to determine whether stress-related absence could be distinguished between workplace and personal causes.	M. Swindell	5.3.26	**Closed**	**5.2.26** - Not all employees absent due to stress require an Occupational Health referral. Data indicates that 58% of respondents attributed their stress-related absence to work-related factors. Additionally, some staff members are on sick leave due to complex long-term or mental health conditions. Support mechanisms, such as Staff Advice Liaison Service (SALS), remain in place for affected employees. **ACTION CLOSED**
Status							
Overdue							
On Track							
Closed							

To: John Grinnell
Chief Executive Officer

Dame Jo Williams
Chair

Alder Hey Children's Hospital NHS
Foundation Trust
E Prescot Road
Liverpool
L14 5AB

By email

Louise Shepherd
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

louise.shepherd17@nhs.net

6 February 2026

Dear John and Jo,

Alder Hey Children's Hospital NHS Foundation Trust: 2025/26 Capability Rating

You will be aware that the NHS Oversight Framework 2025/26[1] (NOF), published on the 26 June 2025 and updated 24 October 2025, outlines a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts. This seeks to ensure public accountability for performance and provides a foundation for how NHS England works with systems and providers to support improvement.

As part of the NOF, NHS England is required to assess NHS trust boards' capability, alongside their NOF segments, to determine what actions and/or support may be needed. As a key element of this, NHS trust boards were asked to self-assess their organisation's capability against a range of expectations across six areas derived from *The Insightful Provider Board*, namely:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

[1] NHS England » NHS Oversight Framework 2025/26

We wrote to you in August 2025, confirming the commencement of the first Provider Capability self-assessment process[2] and requested that you complete and submit the national self-assessment template for NHS England regional assessment.

During November 2025, the regional team reviewed your submission statements and evidence. We triangulated this information with our own views, your historical track record of delivery, any recent regulatory history, and relevant third-party information to support us in reaching a holistic view across the six domains and to assign a single overall capability rating from one of four categories, using national indicative criteria, which is summarised in the table below:

Rating	Indicative Criteria
Green *High confidence in management*	• No evident concerns evident from the self-assessment or subsequent performance. • No concerns arising from third party information. • High confidence in the trust's ability to deliver on its priorities based on track record over past 12-24 months.
Amber-Green *Some concerns or areas needing addressing*	• After discussion with the trust, some concerns emerging across more than one domain but not as yet affecting quality of care, delivery of core services, finance or the wider reputation of the NHS. • Trust has prepared plan(s) to address any problems and associated timeframe for delivery. • Historic issues/track record means that NHSE does not (yet) have full confidence in the board.
Amber-Red *Material issue needs addressing, or failure to address issues over time*	• Issues with self-assessment or subsequent issues across multiple domains. • Failure to deliver on agreed plans to address a material issue. • Potentially in breach of licence.
Red *Significant concerns arising from poor delivery and other issues*	• Material and or long-running concerns at the organisation that management have been unable to achieve grip for. • Trust in actual or likely breach of licence.

Each provider capability rating has been signed off through the region's governance and a national moderation process resulting in Alder Hey Children's Hospital NHS Foundation Trust overall capability rating being assessed as '**Green**' for 2025/26.

As part of our oversight responsibilities, we will continue to monitor trust performance, which may lead to in year changes in the overall assessment rating if concerns arise across any of the assessment areas or, alternatively, there is evidence of improvement.

We will not be publishing capability ratings at this time. However, we plan to publish provider capability ratings in Quarter 1 2026/27, taking account of the implications of Quarter 4 2025/26 segmentation and planning outcomes in an updated view of organisations' capability.

[2] NHS England » Assessing provider capability: guidance for NHS trust boards

If you wish to discuss the rating in more detail, please contact Nicola Allen, Director of System Coordination, in the first instance, via email: nicola.allen7@nhs.net

Finally, I would like to take this opportunity to thank you and your teams for your continued hard work towards delivering improvements to ensure the population of the North West has timely access to high quality care.

Yours sincerely,

Louise Shepherd CBE
Regional Director (North West)

cc Liz Bishop, Chief Executive Officer, Cheshire and Merseyside Integrated Care Board.

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**The North Mersey Provider Partnership MOU**
Report of:	**Dani Jones, Chief Strategy & Partnerships Officer**
Paper Prepared by:	Abby Prendergast, Associate Director of Strategy & Partnerships

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	Trust Board are asked to review and approve the MOU between partners of the North Mersey Provider Partnership.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	N/a

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

Risk number	Risk description	Score

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

1. Executive Summary

The 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 sets out shared purpose, principles, governance, and ways of working, while maintaining organisational sovereignty.

For 2025–2027, 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.

Trust Boards are asked to approve the Memorandum of Understanding and associated Terms of Reference.

2. Introduction

This paper and MOU is to be presented at the following Trust Boards:

University Hospitals of Liverpool Group	15 January 2026 (Approved)
Mersey Care NHS Foundation Trust	22 January 2026 (Approved)
Alder Hey Children's Foundation Trust	5 March 2026

The North Mersey Provider Partnership (NMPP) is a collaboration between five major NHS Foundation Trusts in North Mersey, collectively serving nearly one million people. The Anchor Institutions are working together to improve population health, address health inequalities, and deliver more integrated, preventative, and person-centred care.

The NMPP was established in response to local and national policy drivers, including the Liverpool Clinical Services Review (2023), the Darzi Review (2024), and the Fit for the Future 10-year Health Plan (2025).

This partnership offers a unique opportunity for our system and should be viewed as an asset in connecting and delivering on our shared priorities across the region. By working together, we can align our efforts to deliver integrated, high quality care, utilising collective resources and expertise to accelerate transformation. This collective approach strengthens resilience, improves efficiency, and ensures that services are aligned to meet the needs of local communities.

3. Memorandum of Understanding (MOU)

The MoU formalises the relationship between Alder Hey Children's NHS Foundation Trust, Mersey Care NHS Foundation Trust, Liverpool University Hospitals NHS Foundation Trust (LUHFT), Liverpool Women's NHS Foundation Trust (LWH), and Liverpool Heart & Chest Hospital NHS Foundation Trust (LHCH). Together, these organisations are committing to coordinated strategic planning, aligned delivery priorities, and utilising their collective expertise for communities across Liverpool, Sefton, and Knowsley.

While this MoU is non-binding, it lays out the shared purpose, principles, scope, governance, and working arrangements that guide the Partnership's activities.

Principles of Partnership Working

The Partnership is guided by a commitment to act in good faith and prioritise the population's best interests. While maintaining organisational sovereignty, partners will support shared accountability, share information and best practices transparently, collectively manage risks and benefits, and remain attuned to local differences and needs.

Partners agree to participate in intentional collaboration, with a specific commitment to working together rather than in competition, e.g. in response to bids or tenders. In doing so, each Partner will routinely and proactively consider, across all relevant activity, whether matters under discussion or development would benefit from engagement across the three partners.
Where tripartite working is identified as likely to add value, Partners will seek to agree proportionate mechanisms for joint involvement, aligned decision-making and shared accountability, while respecting each Partners statutory duties and governance arrangements.

Scope of Collaboration

The Partnership seeks to create a more connected, equitable, and sustainable health system. Partners will work together to develop an integrated community health offer tailored to population needs, address fragmented pathways, avoid duplication, improve efficiency, and prioritise prevention and health equity.

For 2025–2027, priorities include:

- Fulfil NHS Neighbourhood Health Guidelines 2025-26 and guidance on multidisciplinary teams for children and young people (CYP).
  - Support adults and CYP with complex health and social needs, focusing on lung health.
  - Jointly create a population health strategy that targets specific groups and prioritises patient-centred care.
  - Develop a single care record to empower patients and improve communication and safety.
  - Leverage collaboration to enhance research, innovation, and commercial opportunities.

Governance

The NMPP Executive Group, composed of senior executives from each organisation, oversees delivery. Decisions are reached by consensus, escalating to Chief Executives if necessary. LUHFT, LWH, and LHCH operate a single collective vote as the University Hospitals of Liverpool Group. The group meets monthly, and quoracy requires at least one representative from each partner group.

Term, Review, and Termination

The MoU comes into effect upon signing by all Partners and will be reviewed after 12 months. The agreement will last for a minimum of 12 months, with any Partner able to terminate the MoU by providing six months' notice.

4. Recommendations & Proposed Next Steps

Trust Board is asked to review the MOU and Terms of Reference included, and approve the MOU for signing.

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**Infection Prevention & Control CQRM Report Q3**
Report of:	Director of Infection Prevention & Control (October – December 25)
Paper Prepared by:	Dr Beatriz Larru (DIPC)

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

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score
2749	Lack of advanced data skills within the IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data. Funding secured for ICNet. Action closed. New action for the implementation of ICNet go live date in progress. Data Scientist in post in March 2025. Risk score static until user testing and implementation complete.	3

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

1. Executive Summary

The purpose of this report is to provide oversight of Infection Prevention Control (IPC) activity and reporting for the Q3 period (1st October – 31st December 2025) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

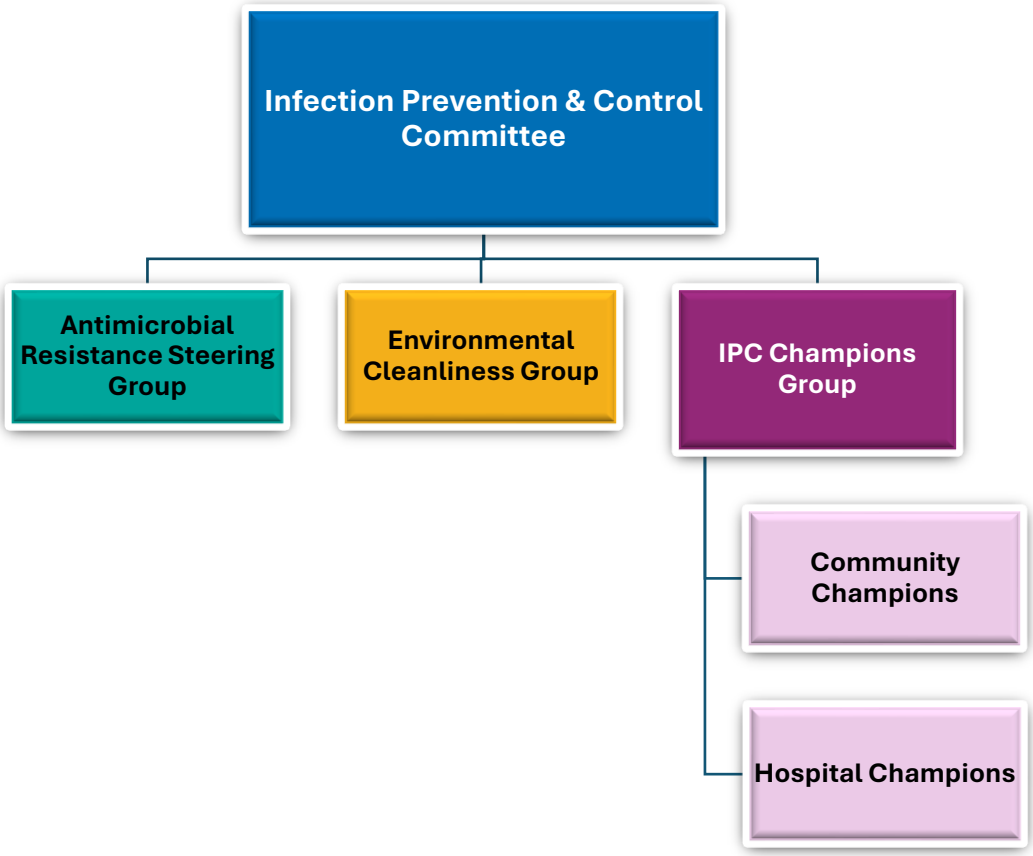
The Trust recognises that the effective prevention and control of healthcare-associated infections (HAIs) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently by everyone working directly with patients to ensure their safety. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

2. Background and current state

The IPC committee meets bimonthly and reports to both the Safety Quality and Assurance Committee (SQAC) and Trust Board. Its workplan, based on the National IPC board assurance framework, was recently approved.

Governance has been strengthened through oversight of IPC policies and workplans, guiding operational groups and supporting assurance. The DIPC actively participates in monthly subdivision IPC committees that provide further updates.

During Q3, the IPC committee received reports from the following subgroups:



IPC TEAM

INFECTION PREVENTION & CONTROL COMMITTEE	
Antimicrobial Resistance Steering Group	**The ongoing workstreams focus on:** 1) De-labelling penicillin allergies 2) Promote IV to PO administration of antimicrobial 3) Promote nursing role in AMS 4) Understand health inequities and antimicrobial resistance 5) Promote diagnostic stewardship by limiting unnecessary blood cultures in ICU 6) Understand behavioural change science in antibiotic prescribing 7) Surgical prophylaxis
Environmental Cleanliness Group	During Q3 the group met on 21.10.25, 18.11.25 and 16.12.26 **Work continues on the below actions:** • How to best implement the Hospital Cleaning policy RM49 across the Trust • New electronic auditing system being procured • SharePoint page developed with instructions for cleaning and decontamination of items, in accordance with the National Standards of Healthcare Cleanliness 2021 • Reviewing terminal cleaning processes
IPC Champions Group	The groups continue to meet monthly - attendance has improved across all divisions, reflecting better engagement with the sessions. Educational sessions continue to be fully aligned with the NHSE IPC Educational Framework, ensuring consistency with national standards and best practice. These sessions not only provide structured learning opportunities but also serve as a dynamic platform through which all relevant updates, guidance, and policy changes can be communicated to staff. By maintaining this alignment, the programme supports staff in staying informed, confident, and competent in applying IPC principles, ultimately strengthening patient safety and quality of care across the organisation. **The groups are currently exploring:** • A new Hand Disinfection Audit tool • New hand hygiene audit strategies that will include families and visitors

3. Main body of report – Infection Prevention & Control Metrics

3.1 Bacteraemia Surveillance

Preventing healthcare-associated Gram-negative blood stream infections (GNBI) is a priority for NHS England, as these infections are associated with severe clinical outcomes, prolonged hospital stays and antimicrobial resistance.

While children and young people have different risk factors to developing GNBI and require focused preventive measures, surveillance of GNBI is a key component of the multifaceted approach proposed by NHSE to achieve GNBI reductions.

Hence, the IPC team reports all cases of healthcare-associated bloodstream infections to UK Health Surveillance Authority (UKHSA) monthly.

3.2 Healthcare-associated Gram-negative Bloodstream Infections

A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA (UK Health Security Agency) is shown below.

Note: Healthcare-associated infections include:

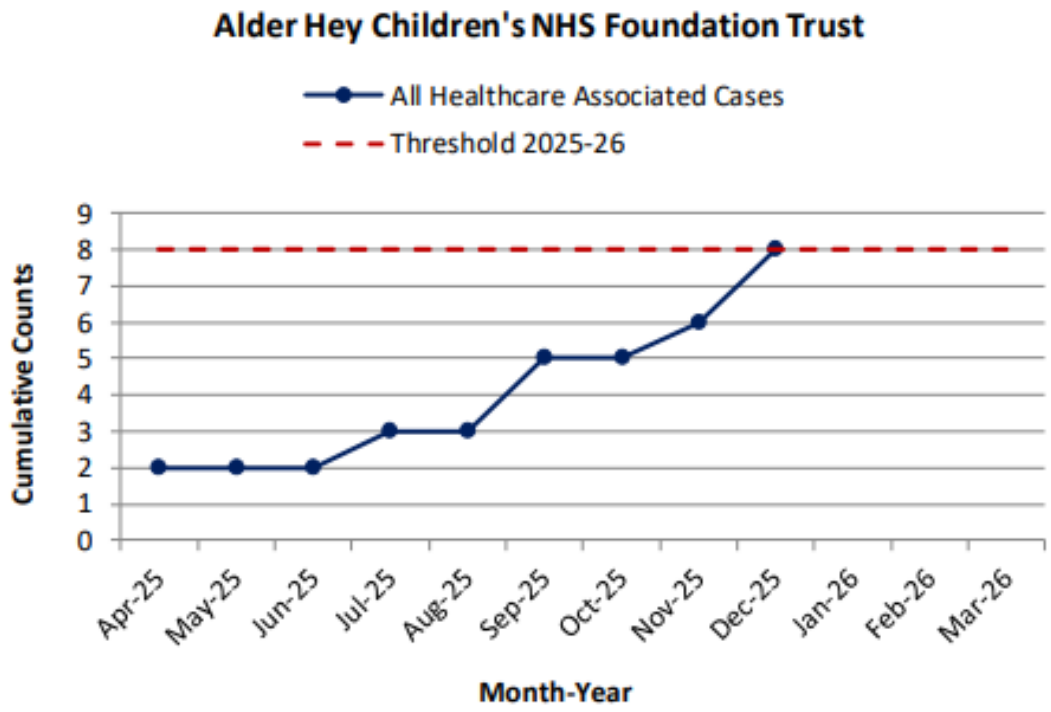
1) *Hospital Onset-Healthcare acquired (**HOHA**) (i.e., occurs in patients admitted >48Hr)*
2) *Community Onset-Healthcare acquired (**COHA**) (i.e., occurred in patients who have received healthcare in either the community or hospital in the previous 28 days).*

Healthcare-associated Gram-negative blood stream infections Quarter 3	
12 patients had healthcare-associated Gram-negative blood stream infections	
Critical Care	2
Oncology	6
Haematology	2
Surgical	2

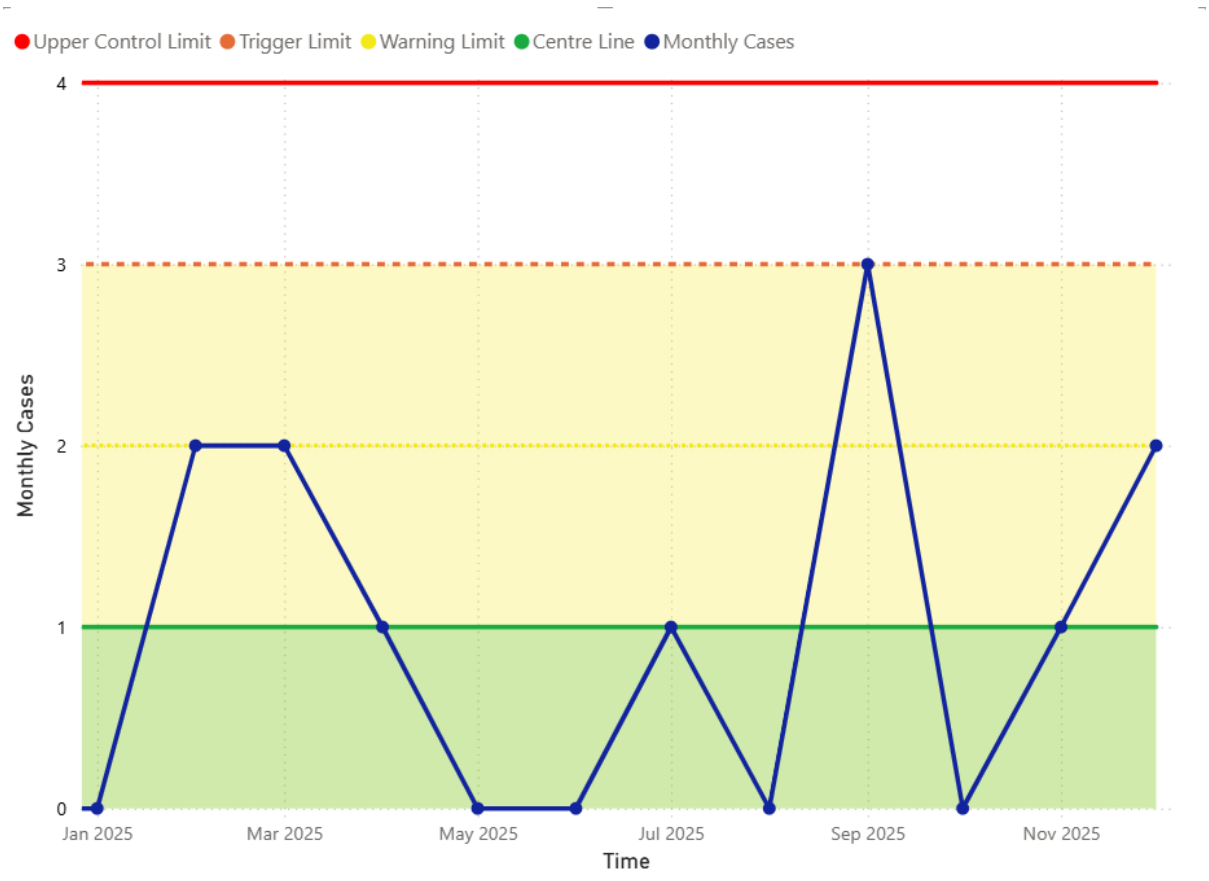
The post-infection reviews (PIRs) of these cases identified:

- Previous exposure to antibiotics
- Episodes of critical illness
- Extended hospital stays
- Areas for improvement in adherence to hand hygiene practices
- Areas for improvement in compliance with ANTT training
- The need for long-term vascular access due to difficult venous access & ongoing treatment requirements
- Significant patient comorbidities, all of which are recognised high-risk factors for gram-negative bloodstream infection

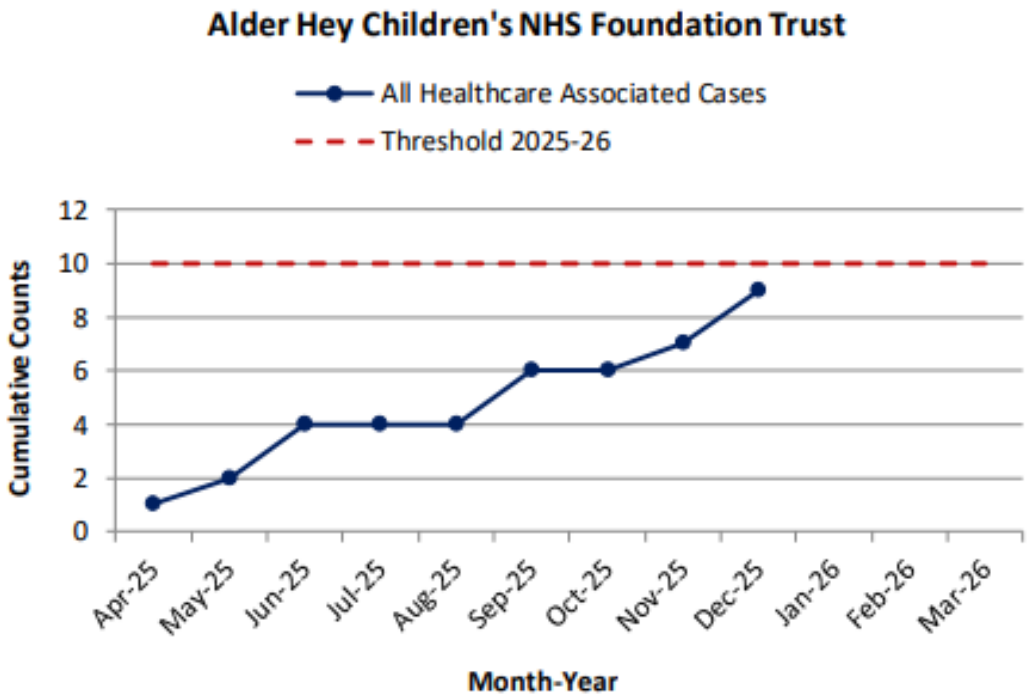
E. coli Bloodstream Infections



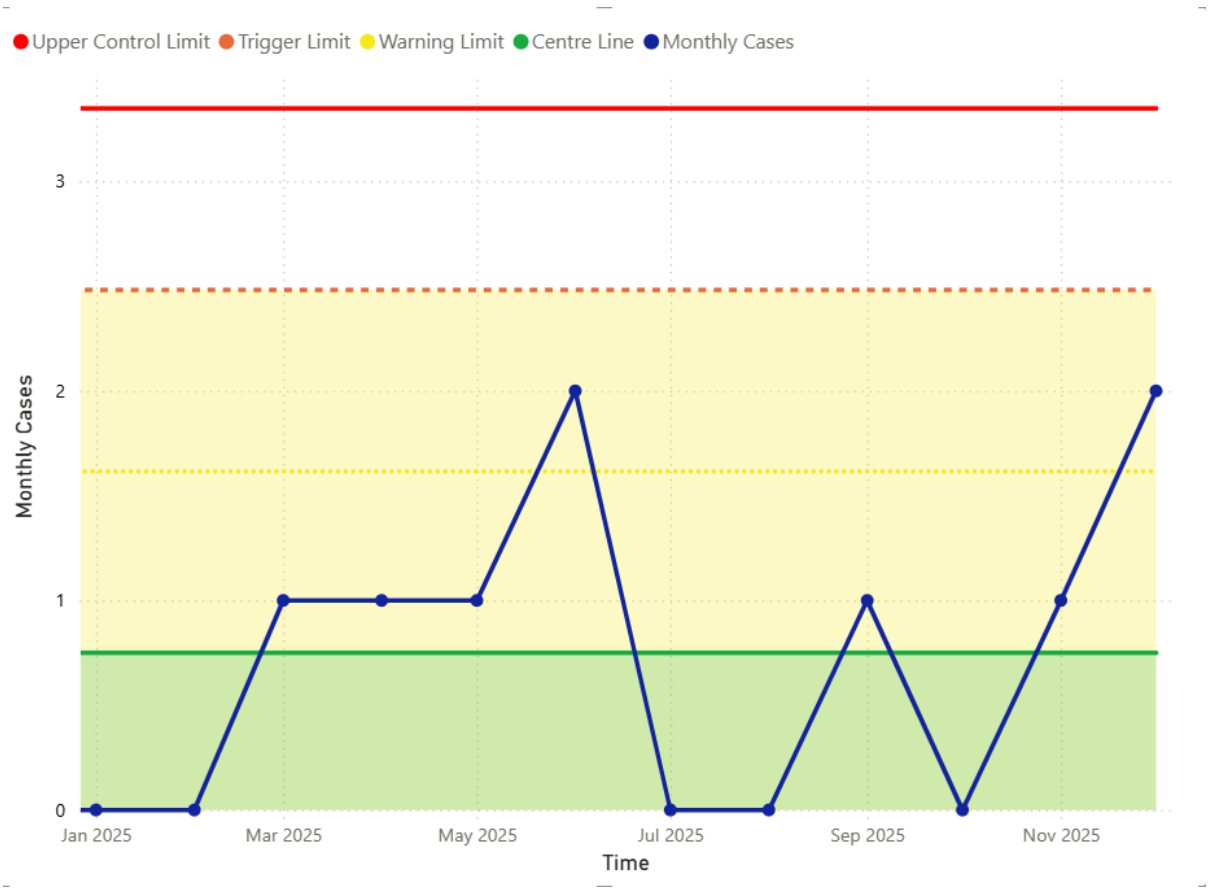
IPC *E. coli* SPC Charts



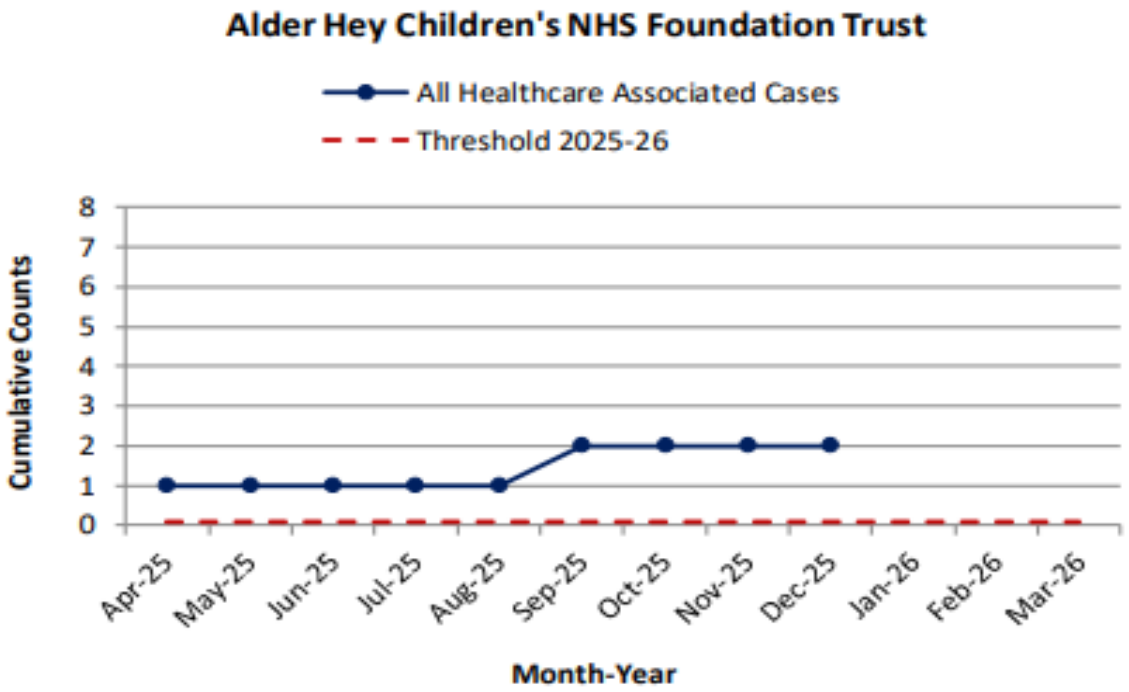
Klebsiella spp. bloodstream infections



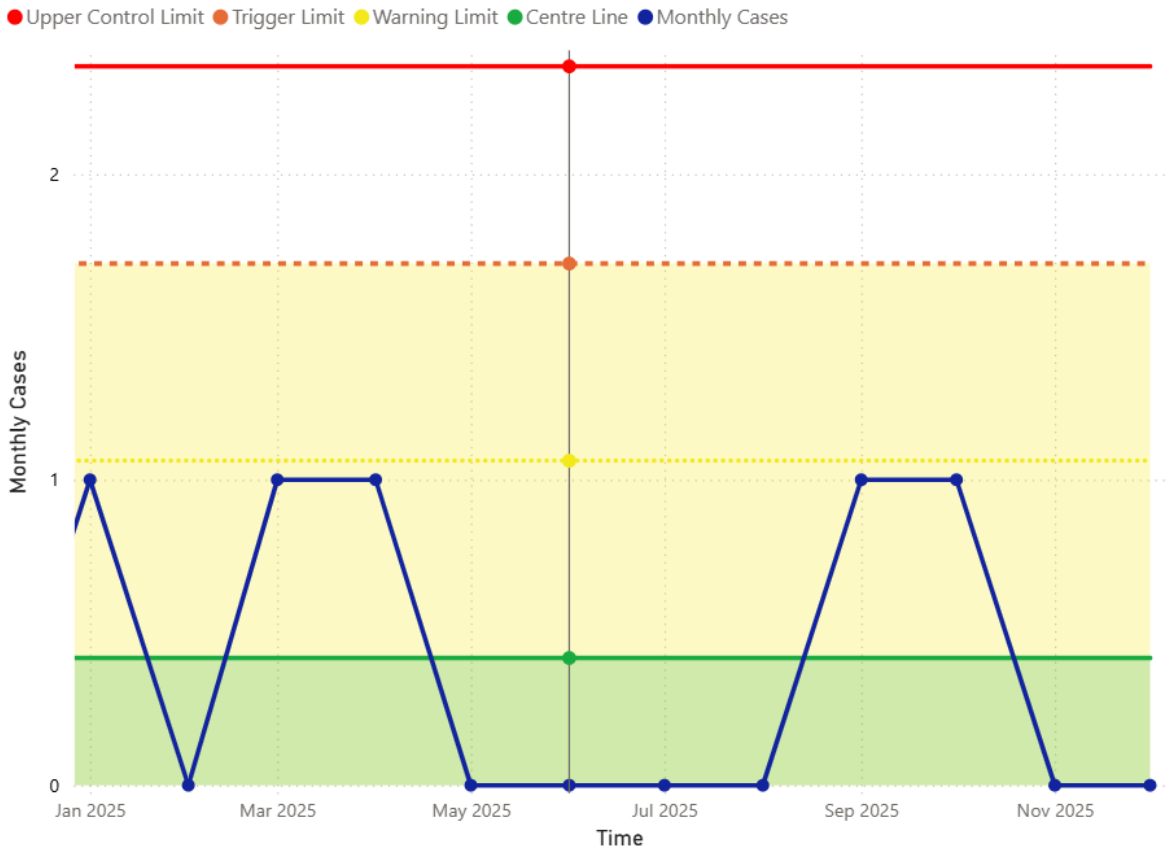
IPC Klebsiella SPC Charts



P. aeruginosa bloodstream infections



P. aeruginosa SPC Charts



3.3 Healthcare-associated *Staphylococcus aureus* bloodstream infections

Healthcare associated MSSA blood stream Infections Quarter 3	
3 patients had healthcare associated **MSSA** blood stream Infections	
Critical care	1
Cardiac	1
Neonatal	1

The post-infection review (PIR) learning:

- ANTT practice during dressing changes requires reinforcement to reduce contamination risk
- Patient behaviour (e.g., interfering with dressings, hygiene compliance) may have contributed
- Colonisation with Staphylococcus aureus increased infection susceptibility

Key actions:

- Strengthen staff ANTT training
- Improve patient education
- Monitor practice
- Manage colonised patients proactively

Healthcare associated methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections Quarter 3	
1 patient had healthcare associated methicillin-resistant *Staphylococcus aureus* (**MRSA**) bloodstream infections	
Oncology	1

Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)

The workplan to reduce Central Line Related Line Infections across the Trust has continued during Q3 with a closer collaboration between IPC and the Microbiology laboratory to include in PIRs *all significant blood stream infections and to engage with all stakeholders in the development of the CLABSI steering group.

(*not just those subject to mandatory UKHSA reporting such as E. coli, Pseudomonas aeruginosa or Klebsiella spp.)

4. Clostridioides difficile infections

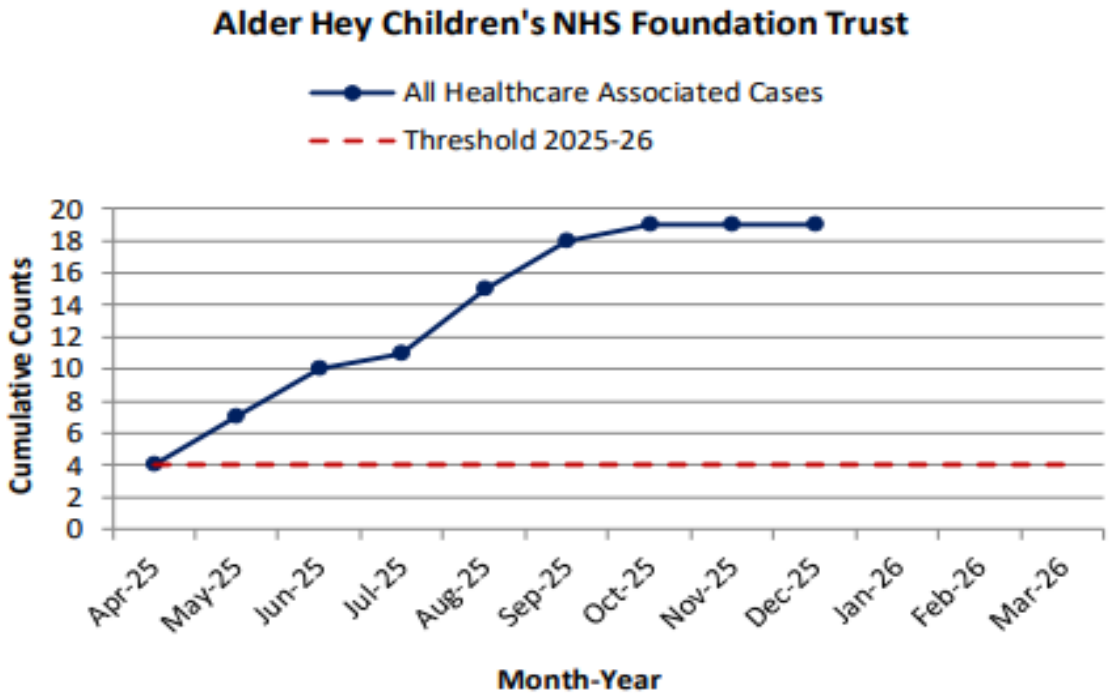
***Clostridioides difficile* infections** Quarter 3		
1 patient had healthcare associated *Clostridioides difficile* infections		
Oncology	1	**COHA**

Alder Hey invited UKHSA for a support visit to help identify opportunities for improvement. The purpose of their visit was to observe and review our current practices, tour the facilities, view different areas, and understand our current processes.
A summary report detailing their visit and recommendations below:

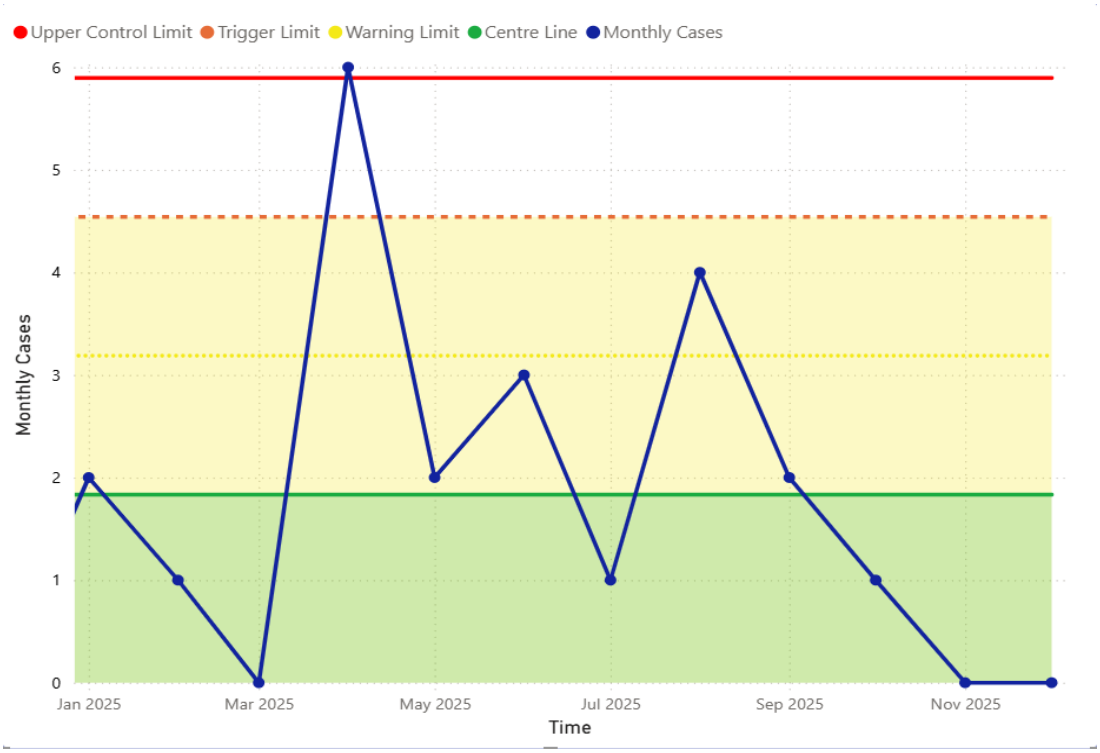
Summary of UKHSA visit to Alder Hey 19.

UKHSA reportable HCAIs are currently entered via a manual process, a UKHSA audit identified that a number of C. *difficile* cases had not been reported. When this was investigated, a significant number were related to postmortem findings and therefore excluded. The remaining unreported data were attributed to human entry errors by staff no longer in post but have been rectified. The implementation of ICNET will remove any chance of human error in the future as the system reports directly through to UKHSA.

C. difficile Infection



IPC C. difficile SPC Charts



5. Healthcare acquired viral infections

5.1 Respiratory viral infections

During Q3, a portion of positive respiratory viral tests analysed in the microbiology laboratory were from patients who had been admitted for more than three days, indicating healthcare-acquired viral infections. Additionally, the IPC team continue to report instances of inappropriate viral respiratory testing to the ED team to promote the effective use of diagnostic resources across the Trust.

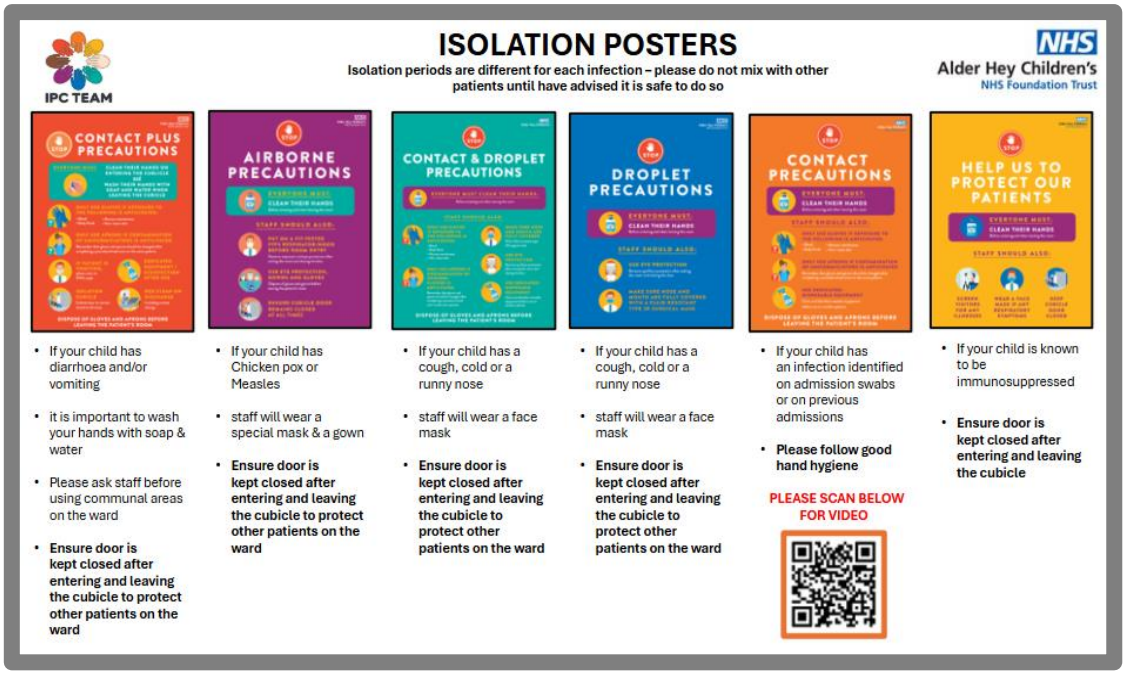
From May 2023, all nosocomial viral infections have been included in our PIR framework, which has identified the following common themes and learning points:

- Lack of staff awareness to use PPE accordingly to patient's symptoms, not just testing results
- Lack of staff awareness of the burden of nosocomial viral infections in hospitalised paediatric patients
- Previous visits from a friend or relative with symptoms
- Frequent contact outside the ward in families with long-term patients
- Patients being frequently exposed to multiple visitors
- Cubicle doors not being kept closed
- Lack of education for parents and visitors being given on admission
- Long hospital admission stays for patients with complex needs who have outside careers

IPC TEAM

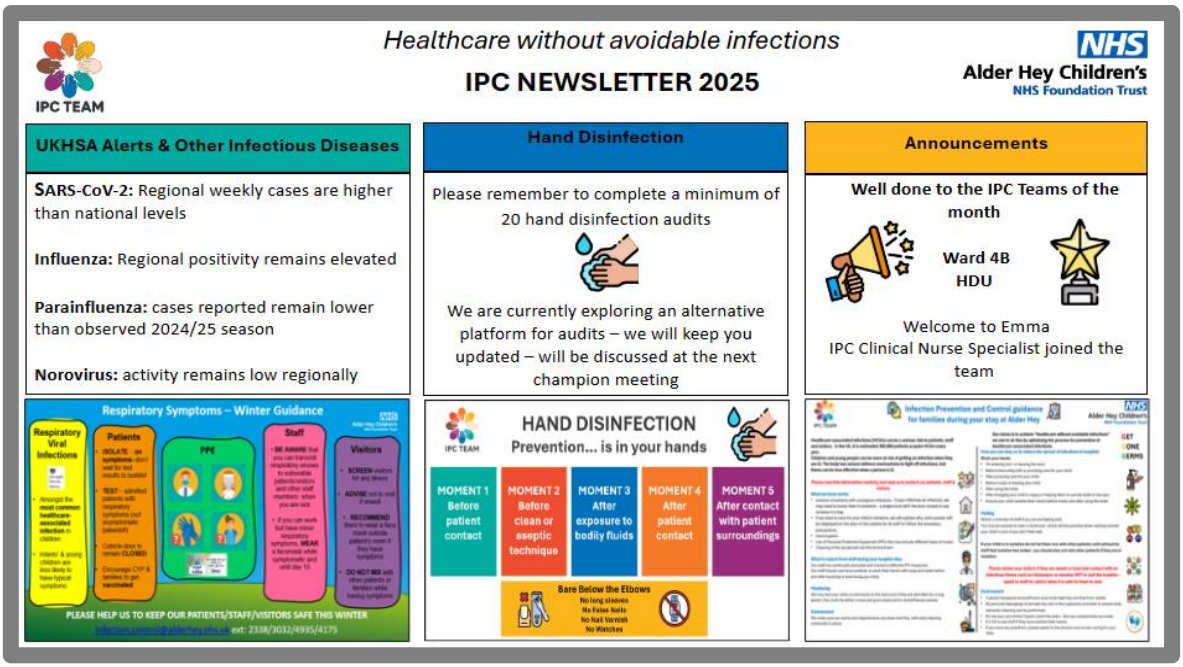
6. Daily isolation walks

The IPC team conducts daily “isolation walks” across all areas of the Trust to reinforce appropriate infection prevention and control (IPC) precautions with staff and to ensure appropriate patient placement and reduce exposure to infectious diseases.



6.1 Newsletter Example

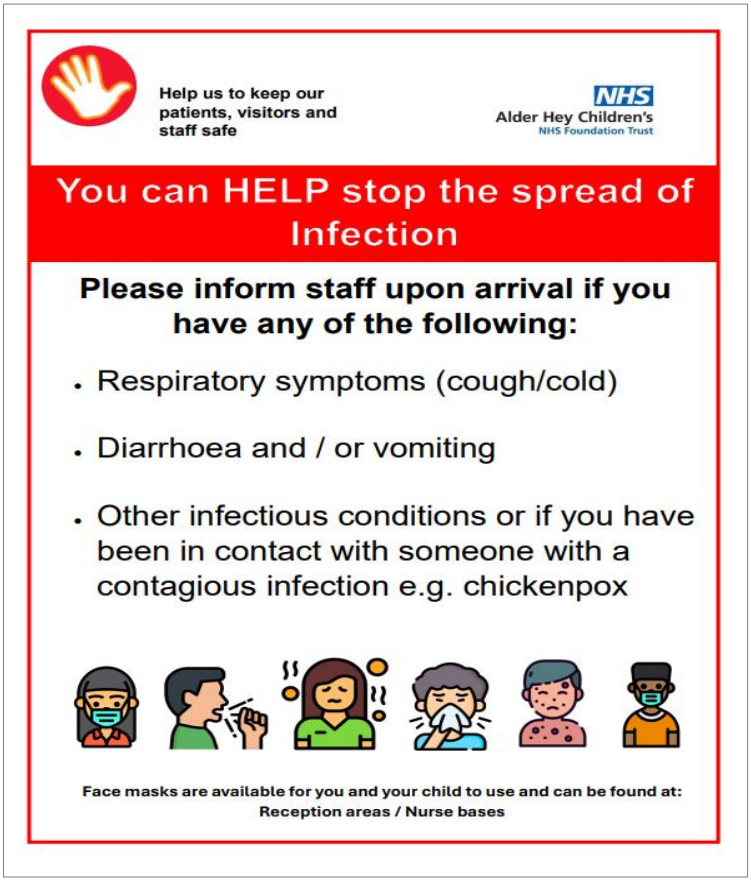
The IPC team distributes monthly newsletters featuring key messages and updates and delivers tailored education sessions to specific areas.



IPC TEAM

6.2 Guidance and key messages

The IPC team have developed an information leaflet for families and visitors with IPC guidance and a poster for visitors to alert staff if unwell when attending ED, OPD and day wards.



Help us to keep our patients, visitors and staff safe

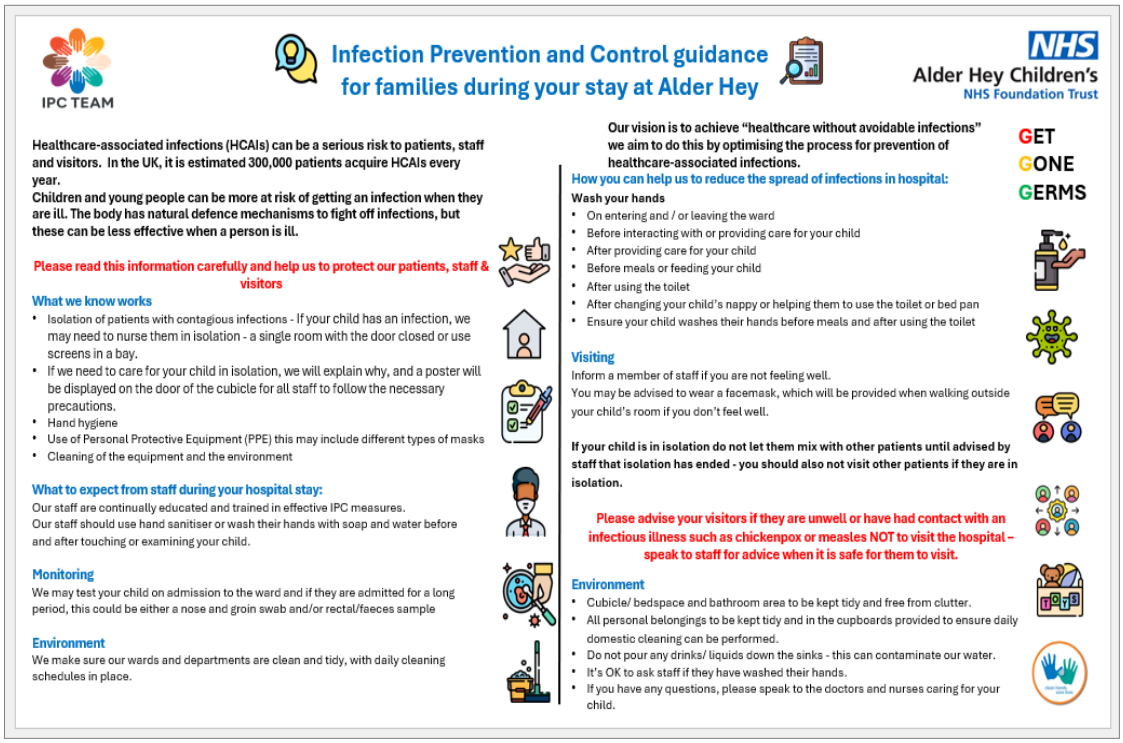
NHS Alder Hey Children's NHS Foundation Trust

You can HELP stop the spread of Infection

Please inform staff upon arrival if you have any of the following:

- Respiratory symptoms (cough/cold)
- Diarrhoea and / or vomiting
- Other infectious conditions or if you have been in contact with someone with a contagious infection e.g. chickenpox

Face masks are available for you and your child to use and can be found at: Reception areas / Nurse bases



IPC TEAM

Infection Prevention and Control guidance for families during your stay at Alder Hey

NHS Alder Hey Children's NHS Foundation Trust

Healthcare-associated infections (HCAIs) can be a serious risk to patients, staff and visitors. In the UK, it is estimated 300,000 patients acquire HCAIs every year.
Children and young people can be more at risk of getting an infection when they are ill. The body has natural defence mechanisms to fight off infections, but these can be less effective when a person is ill.

Please read this information carefully and help us to protect our patients, staff & visitors

What we know works

- Isolation of patients with contagious infections - If your child has an infection, we may need to nurse them in isolation - a single room with the door closed or use screens in a bay.
- If we need to care for your child in isolation, we will explain why, and a poster will be displayed on the door of the cubicle for all staff to follow the necessary precautions.
- Hand hygiene
- Use of Personal Protective Equipment (PPE) this may include different types of masks
- Cleaning of the equipment and the environment

What to expect from staff during your hospital stay:

Our staff are continually educated and trained in effective IPC measures.
Our staff should use hand sanitiser or wash their hands with soap and water before and after touching or examining your child.

Monitoring

We may test your child on admission to the ward and if they are admitted for a long period, this could be either a nose and groin swab and/or rectal/faeces sample

Environment

We make sure our wards and departments are clean and tidy, with daily cleaning schedules in place.

Our vision is to achieve "healthcare without avoidable infections" we aim to do this by optimising the process for prevention of healthcare-associated infections.

GET GONE GERMS

How you can help us to reduce the spread of infections in hospital:

Wash your hands

- On entering and / or leaving the ward
- Before interacting with or providing care for your child
- After providing care for your child
- Before meals or feeding your child
- After using the toilet
- After changing your child's nappy or helping them to use the toilet or bed pan
- Ensure your child washes their hands before meals and after using the toilet

Visiting

Inform a member of staff if you are not feeling well.
You may be advised to wear a facemask, which will be provided when walking outside your child's room if you don't feel well.

If your child is in isolation do not let them mix with other patients until advised by staff that isolation has ended - you should also not visit other patients if they are in isolation.

Please advise your visitors if they are unwell or have had contact with an infectious illness such as chickenpox or measles NOT to visit the hospital – speak to staff for advice when it is safe for them to visit.

Environment

- Cubicle/ bedspace and bathroom area to be kept tidy and free from clutter.
- All personal belongings to be kept tidy and in the cupboards provided to ensure daily domestic cleaning can be performed.
- Do not pour any drinks/ liquids down the sinks - this can contaminate our water.
- It's OK to ask staff if they have washed their hands.
- If you have any questions, please speak to the doctors and nurses caring for your child.

7. Gastrointestinal viral infections

Healthcare associated Norovirus Quarter 3	
4 patients had healthcare associated Norovirus	
Oncology	1
Surgical specialties	2
Medical specialties	1

Given its rapid transmission, infection prevention measures were promptly implemented to contain and minimise further spread. Staff were advised on best practices to prevent cross-contamination, and patient monitoring was intensified to identify any additional cases early.

Efforts included: enhanced infection control protocols, such as:

- Strict hand hygiene enforcement
- Thorough environmental cleaning
- Isolation precautions for affected individuals

Healthcare associated (HOHA) Group A *Streptococcus* Quarter 3	
0 patients had healthcare associated (HOHA) Group A *Streptococcus*	
N/A	0

8. Other Notable Infections

Positive measles cases reported during Q3		
Oct 2025	Nov 2025	Dec 2025
0	0	0

The IPC department and DIPC closely collaborate with multiple teams across the trust, and external agencies to develop a collaborative approach to:

- Reduce exposure rates
- Increase uptake of vaccinations
- Increase awareness of healthcare workers to promptly recognise symptoms of measles

Outbreak / Exposure cases Q3						
DATE	AREA	INFECTION	PATIENTS EXPOSED	Prophylaxis?	STAFF EXPOSED	Prophylaxis?
Oct-25	3C	Pertussis	0	0	15	1
	4C	Chickenpox	0	0	0	0
	ED/3C	Influenza A	0	0	4	0
	ED/HDU	Influenza A	12	0	0	0
	EDU	Sars Cov-2	3	0	3	0
	EDU	Influenza A	3	0	3	0
	EDU	Influenza A	3	0	4	0
	EDU	Influenza A	1	1	3	0
	EDU	Influenza A	2	0	3	0
	EDU	Influenza A	0	0	0	0
	EDU	Influenza A	2	0	3	0
Nov-25	MDU	Influenza A	0	0	0	0
	EDU	NOROVIRUS	0	0	0	0
	EDU	Influenza B	0	0	0	0
	EDU	Influenza A	3	0	0	0
	EDU	Influenza A	3	0	0	0
	EDU	Influenza A	3	1	0	0
	EDU	Influenza A	3	1	0	0
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	EDU	Influenza A	4	0	0	0
	EDU	Influenza A	1	0	0	0
	EDU	Influenza A	3	1	0	0
	EDU	Influenza A	3	0	0	0
	EDU	Influenza A	2	1	0	0
	EDU	Influenza A	3	0	0	0
	EDU	Influenza A	5	0	0	0
	EDU	Influenza A	5	0	0	0

	ED	Influenza A	20	0	0	0
	ED	Influenza A	21	0	0	0
	ED	Influenza A	0	0	0	0
	ED	Influenza A	0	0	0	0
Dec-25	3C	TB	174	**13**	81	**1 - EDU**
	EDU	Influenza A	4	0	0	0
	EDU	Influenza A	3	0	0	0
	EDU	Influenza A	16	2	0	0
	EDU	Influenza A	13	**1**	0	0
	EDU	Influenza A	9	0	0	0
	EDU	Influenza A	4	0	0	0
	EDU	Influenza A	5	0	0	0
	EDU	Influenza A	4	0	0	0
	EDU	Influenza A	4	**1**	0	0
	EDU	Influenza A	7	**2**	0	0
	EDU	Influenza A	4	**1**	0	0
	EDU	Influenza A	0	0	0	0
	EDU	Influenza A	0	0	0	0
	EDU	Influenza A	0	0	0	0
	EDU	Influenza A	0	0	0	0
	EDU	Influenza A	7	**1**	0	0
	EDU	Influenza A	3	**1**	0	0

9. Conclusion

Throughout Q3, the Infection Prevention and Control (IPC) department has consistently upheld a heightened level of visibility across the Trust.

This was achieved through the diligent execution of daily isolation ward rounds and the regular coordination of monthly steering group meetings.

9.1 Relaunch of the Alder Hey Clinical Water Safety Group

The Alder Hey Clinical Water Safety Group has been relaunched, providing a renewed opportunity for colleagues across the Trust to collaborate, share expertise, and strengthen our collective approach to water and wastewater safety.

This initiative reflects our commitment to maintaining the highest standards of safety and compliance in clinical environments. The first meeting of the group has been scheduled and following this initial meeting, the programme of work will include a series of walkarounds and debrief sessions designed to ensure practical, collaborative progress.

Walkarounds will be conducted two weeks after each Teams meeting, with details of the specific areas to be reviewed shared in advance. Findings and proposed actions from these walkarounds will then be discussed during subsequent Teams meetings,

ensuring a clear cycle of review, feedback, and improvement. This structured approach will enable the group to identify risks, implement effective actions, and continuously improve water safety management across the Trust.

9.2 IPC Team

Despite facing challenges associated with limited staffing and outbreaks, the IPC team demonstrated resilience and commitment by closely collaborating with the Director of Infection Prevention and Control (DIPC) and the Deputy Director of Allied Health Professionals (AHP). In addition to fulfilling their core responsibilities, the IPC team actively contributed to the Trust's response to outbreak incidents, showcasing their adaptability and dedication to safeguarding health standards.

Their ability to manage routine activities while responding to emerging challenges underlines their pivotal role within the organization. These efforts reflect the team's unwavering focus on maintaining infection control measures and supporting the Trust's overall objectives.

Governance within the IPC Committee has been enhanced through the oversight and approval of revised IPC policies and the associated IPC Assurance Framework workplans. These workplans guide the operational groups that report directly to the IPC Committee. Additionally, the DIPC actively participates in the monthly subdivision IPC committees, which provide further updates to the overarching IPC Committee. Funding for ICNet has been successfully secured, with implementation discussions in progress.

10. Recommendations & proposed next steps

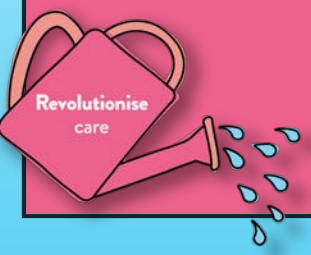
The Trust Board is asked to note the content of this report, the actions being taken to ensure the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice and note that the IPC service continues to struggle due to significant staffing challenges.

Flash Report February 2026

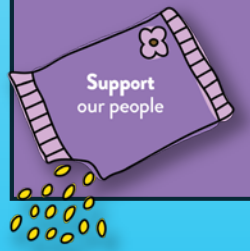
Performance is subject to change

Alder Hey Children's NHS Foundation Trust

1	1	92.3%	3	20
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed



80.3%	241	63.5%	1.76	93.7%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients waiting within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance



+53	11.6%	76.0%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed

Financial Sustainability

£0.9m	TBC	£-0.3m
I&E position (Actual in month)	I&E year end forecast to plan (Variance)	CIP (Forecast vs full year target)

HIGHLIGHTS

- Sustained performance for time to be seen and treated in ED - 11th consecutive month 80%+.
- Improved performance for % patients waiting under 18 weeks for treatment.
- Improved performance of diagnostic under six weeks.
- Good patient experience scores.

CHALLENGES

- Estimated Workforce above plan.
- x1 PSII (also an incident of fatal harm). Incident reported in Aug-25 and PSII commissioned Feb-26
- CIP (Forecast vs full year target) – £0.3m in year gap and £9.6m recurrent gap.
- I&E Forecast – to be finalised, however best case £7.2m subject to resolution of position with ICB.

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: February 2026

Performance: January 2026

Contents

VISION 2030

IPR – Executive Summary

NHS
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Outstanding Care and Experience

	Value	Target	Trend
Patients deteriorating from an inpatient bed admitted to PICU	9	n/a	↓
Number of Incidents per 1,000 bed days – No Harm	59	77.4	↓
Number of Incidents per 1,000 bed days – Low Harm and above	15	19.6	↓

Executive Summary

Performance remains strong in key quality and patient experience measures. All inpatients (100%) and most ED patients (92%) with suspected sepsis received antibiotics within 60 minutes, indicating strong compliance with urgent treatment standards. Patient and family feedback is also positive, with ED FFT results showing 91% of responding families rated their experience as good or very good, and a 93% positive response rate reported across the Trust overall. However, there are notable concerns requiring attention. Formal complaints increased significantly during the month, which has affected response timeliness, with compliance falling to 76%. In addition, a further case of C. difficile has been reported, with risks being managed through an existing action plan overseen by the Infection Control Committee. The immediate priority is to complete the review of the complaints policy and process and implement any agreed changes, with a stronger focus on local and timely resolution to improve responsiveness and reduce escalation..

Support Our People

	Value	Target	Trend
Workforce Plan	4,271	4,247	↔
Staff Turnover	12.2%	10%	↑
Sickness Absence (Total)	6.7%	4.5%	↑

Executive Summary

Workforce performance remains stable overall, with mandatory training compliance above 90% and further work underway to improve lower-performing modules. PDR completion continues to improve, with B7+ completion now at 86% and overall completion at 76%, supported by Learning & Development colleagues and the rollout of the new PDR App. Pressures remain in workforce capacity and attendance. Total workforce numbers have reduced again but remain above plan. A final small cohort of MARS leavers will leave before year-end, and plans are in place to deliver further reductions in 2026/27. Sickness absence is mixed: long-term sickness has reduced, but short-term sickness increased in-month. Trust-wide actions to reduce sickness absence remain in progress and continue to be monitored through People Committee. The forward focus is on sustaining PDR improvement, embedding the new PDR App, and supporting managers to complete outstanding reviews, while maintaining control of workforce reductions and sickness management to protect operational resilience.

Revolutionise Care

	Value	Target	Trend
ED % Treated Within 4 Hours	86.1%	78%	↑
% RTT Patients Waiting >52 Weeks*	1.43%	1.1%	↓
RTT Waiting List Within 18 Weeks*	62%	62.6%	↑

Executive Summary

Operational performance remains positive in several key areas. In January, urgent and emergency care performance was sustained, with 86.1% of patients treated within 4 hours. Theatre utilisation has also remained strong, exceeding 80% for a third consecutive month, and the WNB rate improved, reducing from 10% to 8%, indicating better attendance and pathway management. There are, however, some material pressures. CAMHS 52-week breaches have increased significantly to 30, all relating to Liverpool patients, with a risk of further deterioration in March due to staffing constraints. DM01 performance has also declined further to 90%, reflecting continued pressure on diagnostic timeliness. Planned actions are in place to address these issues. Additional CAMHS clinics are being established to reduce the number of children and young people waiting over 52 weeks. Additional theatre lists have been provided to support recovery in DM01 performance, particularly for gastroscopies.

Financial Sustainability

	Value	Target	Trend
I&E Year End Forecast	£7.1m	£7.1m	↔
Recurrent Efficiency Plans Delivered	£	£18.5m	↓
ERF Income (YTD)	£83.2m	£82.7m	↑

Executive Summary

The Trust reported a £1.1m surplus in month and £1.2m surplus year to date, £0.2m behind plan due to non-pay pressures. The external forecast is a £7.160m surplus, while the extrapolated forecast remains £5m, consistent with M9. CIP delivery is on plan year to date, with £19.7m transacted (£12m recurrent). Cash is below plan, driven by high non-cash CIP and capital spend ahead of plan. Capital expenditure is ahead of plan due to prioritised over-profiling and later funding approvals, with an additional £2m elective capital allocation and £2.1m SDEC capital funding now confirmed. Key risks remain around unresolved 2025/26 income assumptions with the ICB, recurrent CIP delivery, and cash performance. These issues could affect delivery of the overall financial plan and system stretch targets. Action is focused on continued cost control through FIP, strengthening divisional recovery (particularly vacancy factor and ERF performance), and supporting recurrent savings through Target Operating Models. A cash strategy is being developed to address forecast gaps, alongside a longer-term 5-year capital plan.

*RTT Targets based trajectory

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

• 100% of inpatients and 92% of patients in ED received antibiotics within 60 minutes for sepsis suspicion
• Increase in FFT satisfaction scores in ED with 91% of families who responded saying their experience was very good or good and 93% positive response Trust-wide

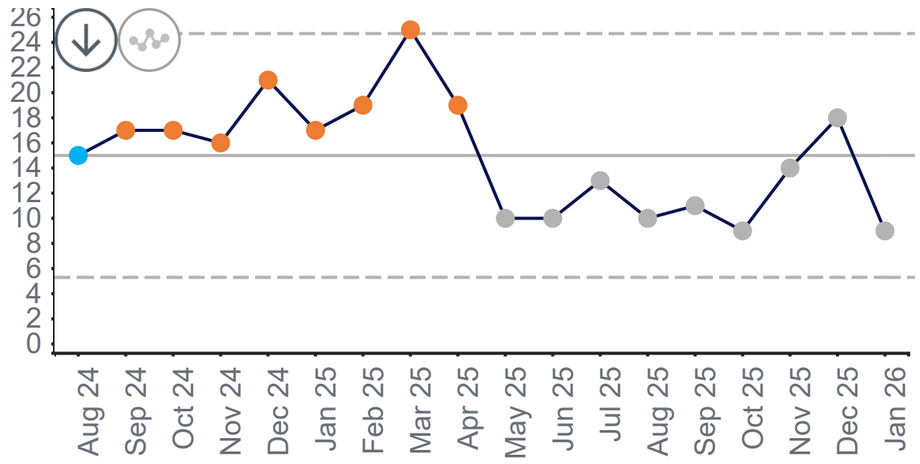
Areas of Concern:

• Significant increase in the number of formal complaints received which has impacted on response compliance (76% in month). Policy and process currently under review with emphasis on local and immediate resolution as much as possible.
• Further case of C-diff reported; C-diff action plan in place and monitored through Infection Control Committee

Forward Look (with actions)

• Review of complaints policy and process and implement any changes in process

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



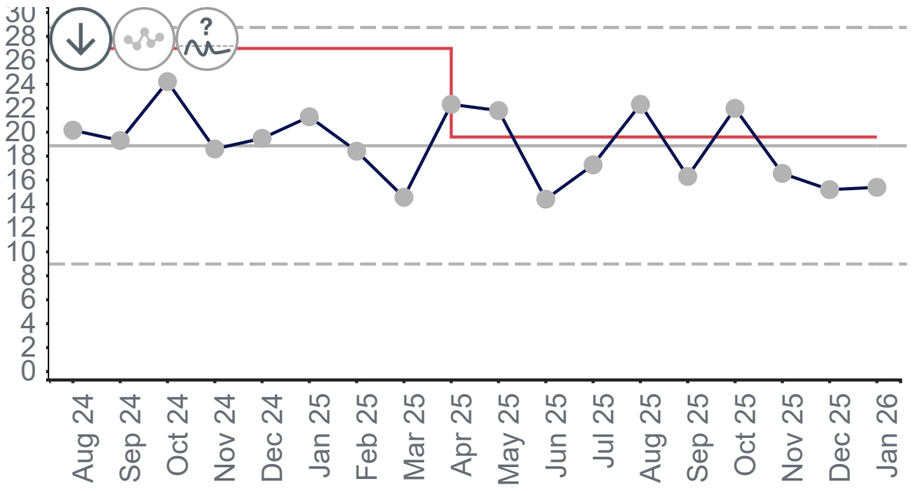
Technical Analysis:

Common cause variation observed with 9 patients deteriorating from an inpatient bed to PICU with an average of 15 a month during the last 18 months.

Actions:

Sustained decrease in the number of unplanned admissions to PICU / HDU from in-patient beds. Deteriorating Patient workstream progressing actions reporting into Patient Safety Board and through to SQAC

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



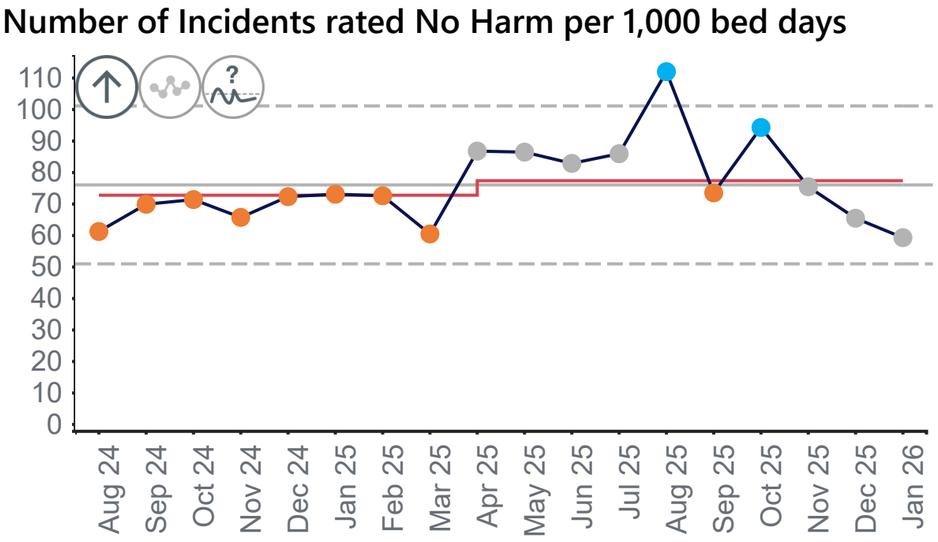
Technical Analysis:

Common cause variation with performance of 15 incidents of harm per 1,000 bed days, with a monthly average of 19 incidents during the period. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 24/25, with a monthly target of 19.6

Actions:

Decrease in the last 3 months; all incidents reviewed and opportunities for improvement and learning at local, regional and national level are optimised

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



Technical Analysis:

Common cause variation observed with 59 incidents of no harm per 1000 bed days, with a monthly average of 76. 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. 3rd consecutive month the below target however meeting target year-to-date.

Actions:

Downward trend in the last 3 months; all staff are encouraged to report any incident or near miss

Integrated Performance Report | February 2026

NHS
Alder Hey Children's
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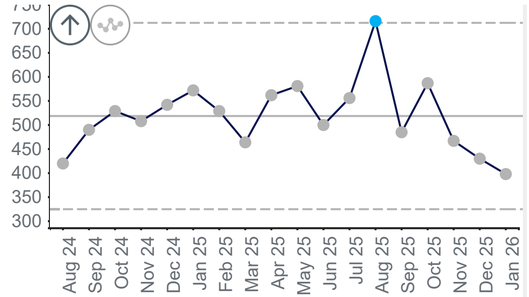
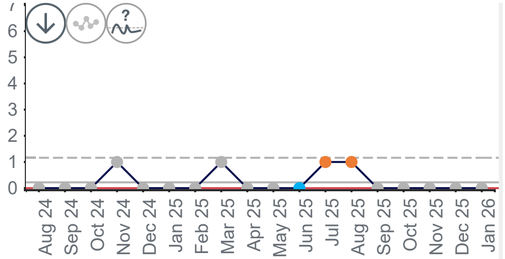
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



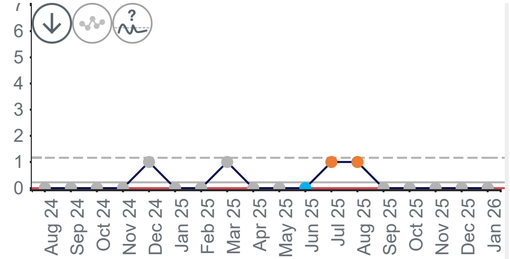
Severe or Fatal Incidents – Physical only

Target: Internal

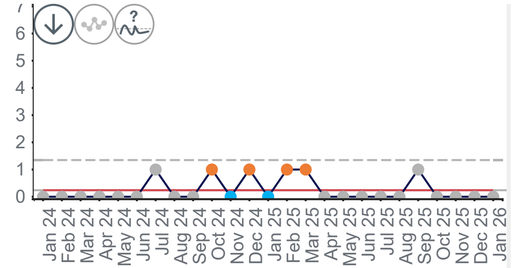


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

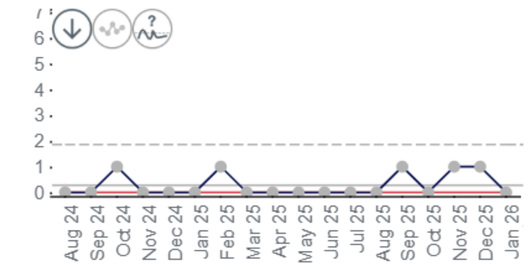


Number of PSIIs (Patient safety incident investigation) undertaken



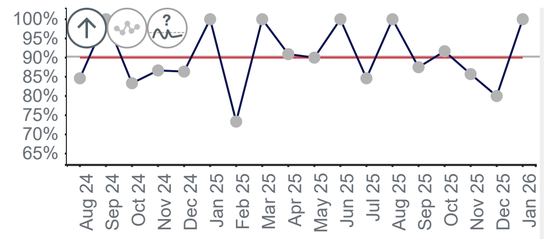
Number of Never Events

Target: Internal



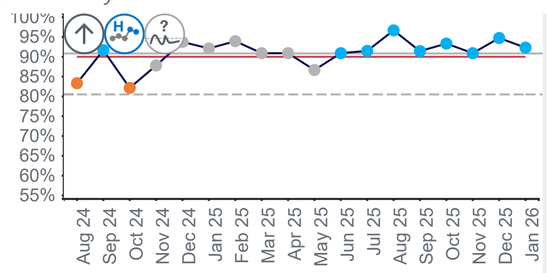
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

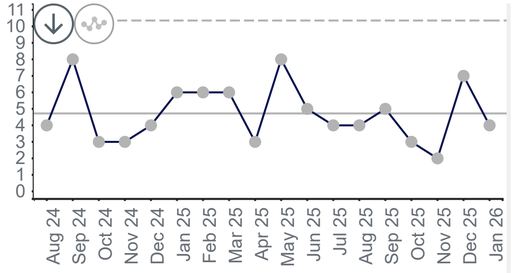


Sepsis % Patients receiving antibiotic within 60 mins for ED

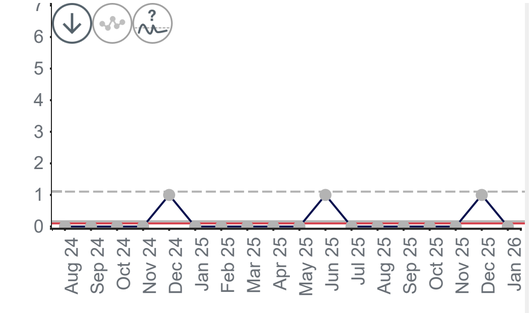
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

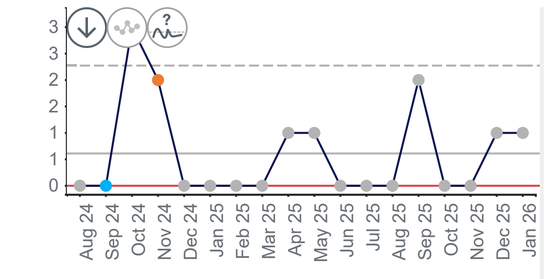


Pressure Ulcers Category 3 and 4

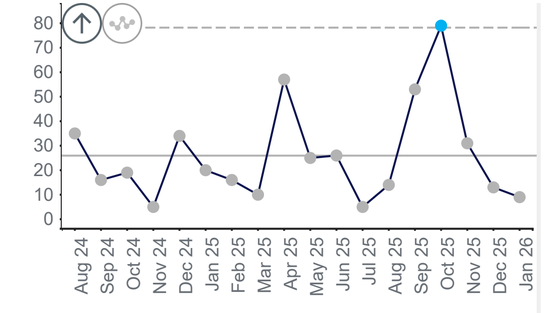


Pressure Ulcers Category 2

Target: Internal

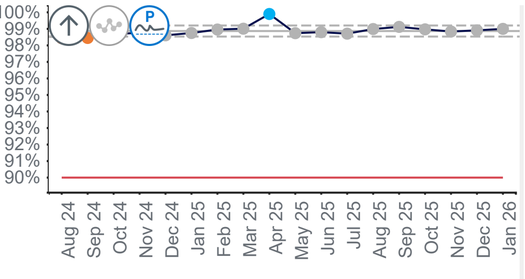


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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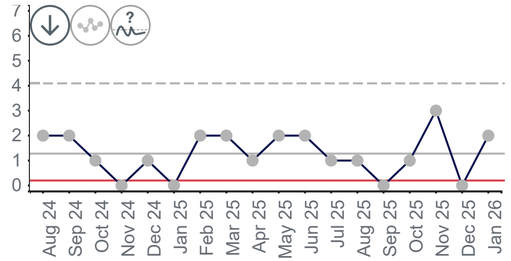
Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

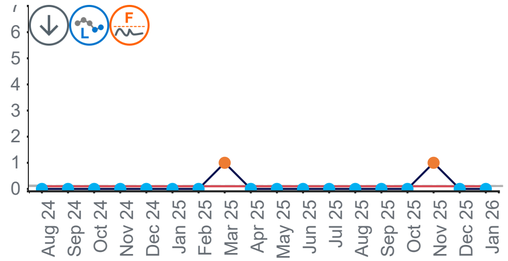
Hospital Acquired Organisms - MSSA

Target: Internal



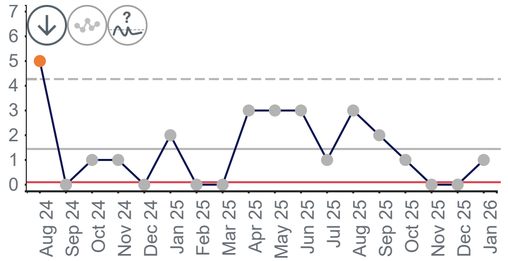
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



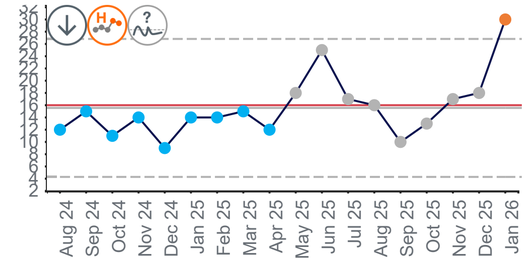
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



Number of formal complaints received

Target: Internal



% PALS Resolved within 5 Days

Target: Internal

Number of PALs contacts

Target: Internal

% Complaints Responded to within 25 working days

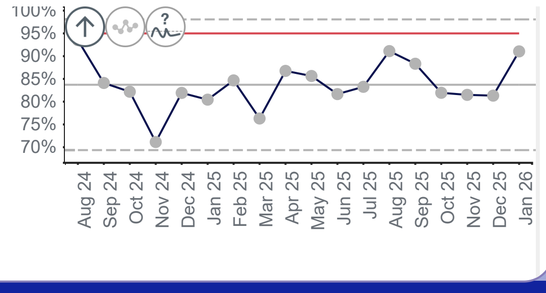
Target: Internal

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

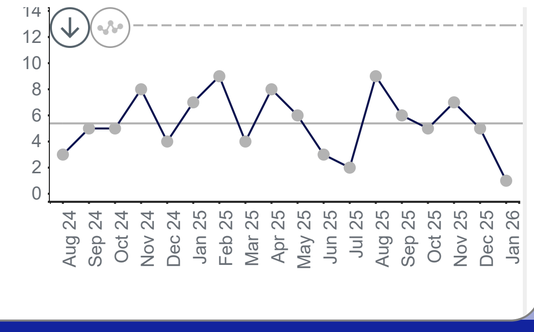
Target: Statutory

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

Target: Internal

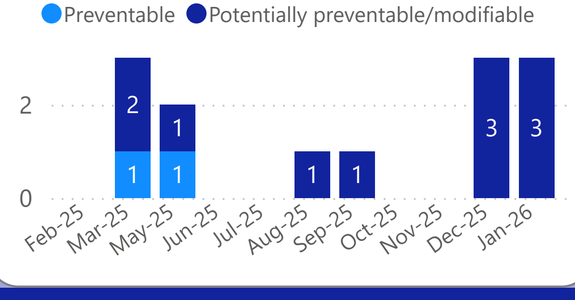


Number of patients deteriorating from HDU admitted to PICU

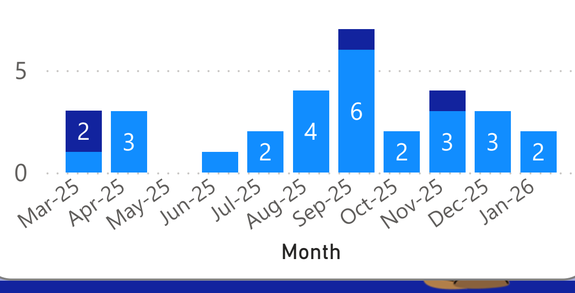


Predictable and preventable deteriorating patients

Not inclusive of all categories



Martha's Rule



Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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

Highlights:

- Consistent delivery of timely urgent and emergency care: January saw 86.1% of patients treated withing 4 hours
- Theatre utilisation has remained above 80% for a third consecutive month
- There was a reduction in the WNB rate, reducing from 10% to 8% in January.

Areas of Concern:

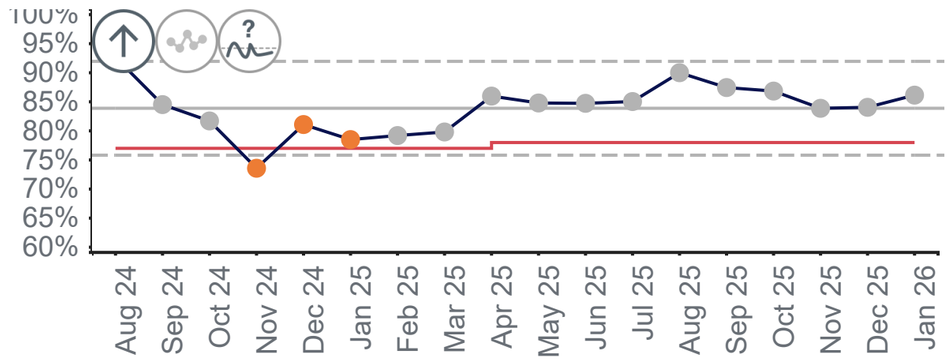
- There has significant increase in CAMHS 52-week breaches (30). These are all Liverpool patients with a risk of increasing further in March due to staffing levels.
- There has been a further reduction in DM01 performance, decreasing to 90%.

Forward Look (with actions)

- Additional clinics are being set up in CAMHS to reduce the number of CYP waiting over 52 weeks.
- Additional theatre lists have been provided to support DM01 position for gastroscopies.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

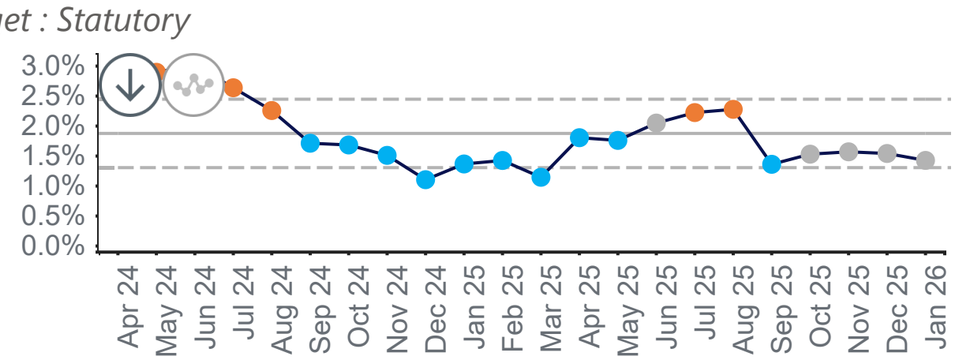
Achieved the national target in January-26 with the 14th consecutive month above target. Common cause variation observed with performance of 86.1% in January, +2% increase from Dec-25 (84.1%). Jan-26 represents performance +7.8% compared to Jan-25 (78.5%) whilst Jan-26 experienced an extra 215 attendances and +1.4% in Very Urgent/Red patient compared to Jan-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.

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

Target : Statutory



Technical Analysis:

1.43% of our open IP & OP RTT waiting list is waiting >52 weeks against a national target of less than 1% waiting lists waiting >52 weeks by March 2026. This is a decrease from December position of 1.54%. With the total volume now at 236 breaches. 80% of current waits >52 weeks within Dentistry service, followed by Plastic Surgery (9.3%).

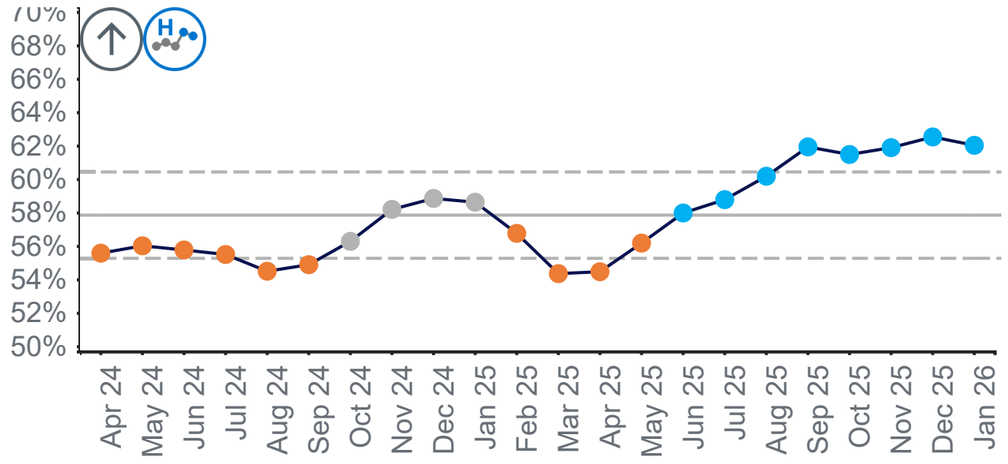
Actions:

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

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



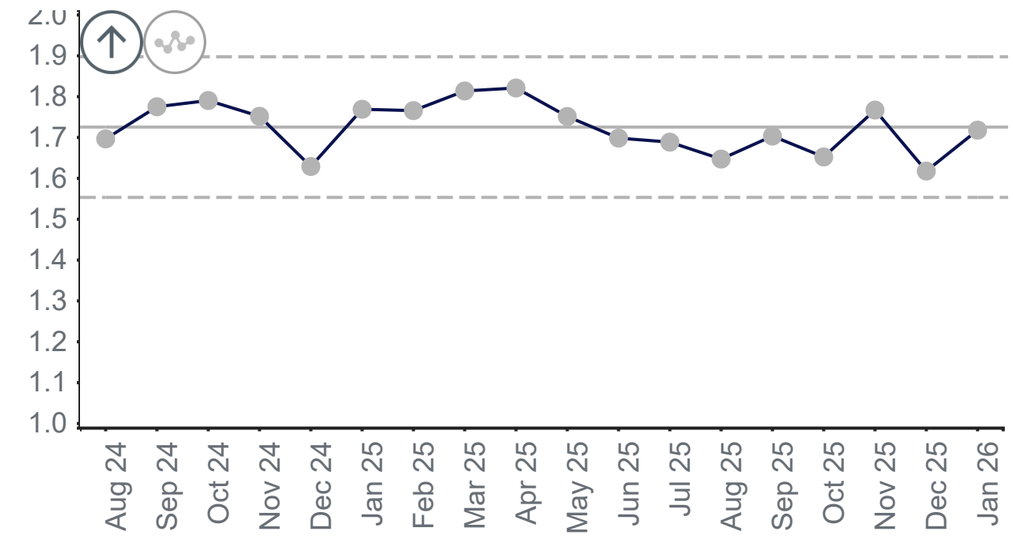
Technical Analysis:

Special cause variation with performance of 62% against a year end target of 63.1% by March 2026. This is slight decrease from December 2025 position of 62.5%. Dentistry, Oral Surgery, General Paediatrics and Plastic Surgery lowest performing of services with >100 waiters.

Actions:

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

Elective admissions (IP & DC) per clinical WTE



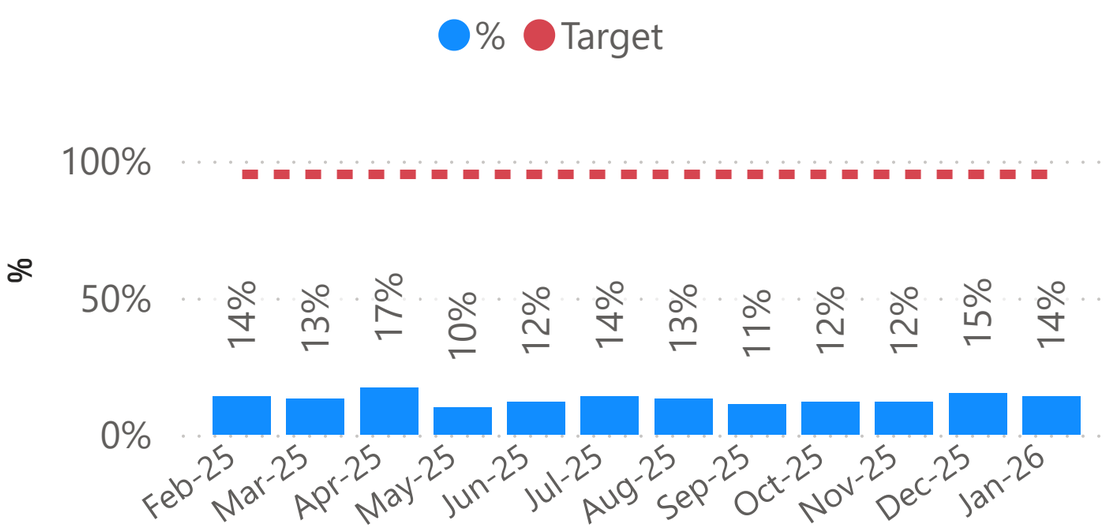
Technical Analysis:

Common cause variation has been observed with performance of 1.72 admissions per Clinical WTE (1600). Slight decrease from January 2025 rate at 1.77. Jan-26 experiencing -3 admissions per working day compared to Jan-25, with +7.8 clinical WTE.

Actions:

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

Neurodevelopmental Assessment waiting list: % within 65 weeks



Technical Analysis:

Performance at the end of January 2026 is 14% against a target of 95% which is slighly decreased performance from 15% last month.

Actions:

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

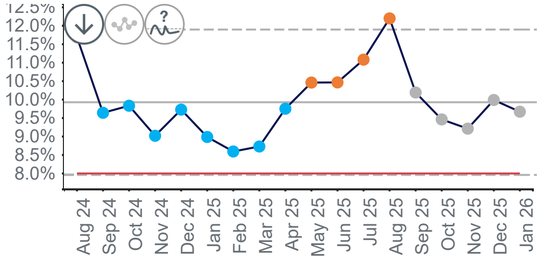
Integrated Performance Report | February 2026

NHS Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

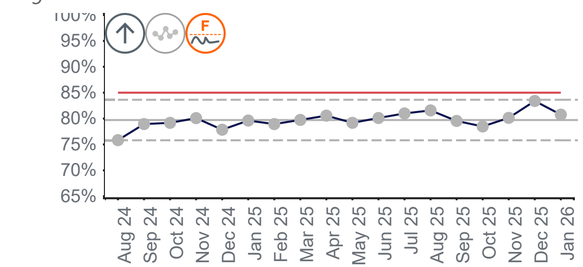
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

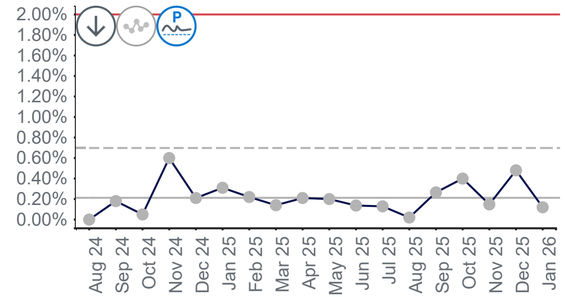


Theatre Utilisation (Capped Touch Time)

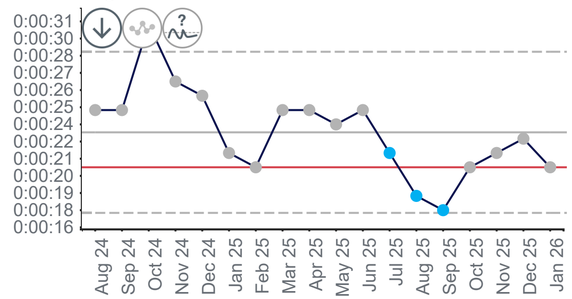
Target: Internal



% of ED attends over 12 hours



Average Ambulance Vehicle to Handover Time



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

SLAM Performance

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

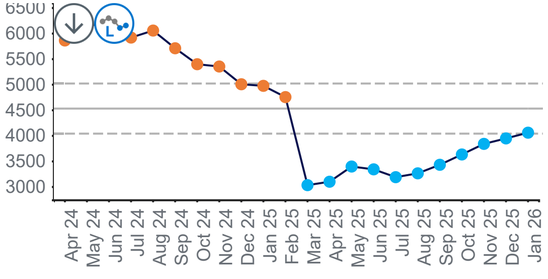
SLAM Performance

Activity per £1k Operating Expenditure

YTD Position

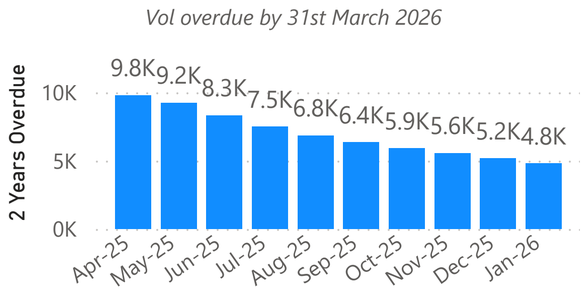
% follow up waiting list on PIFU

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

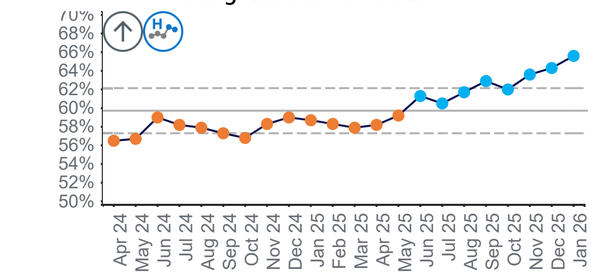


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

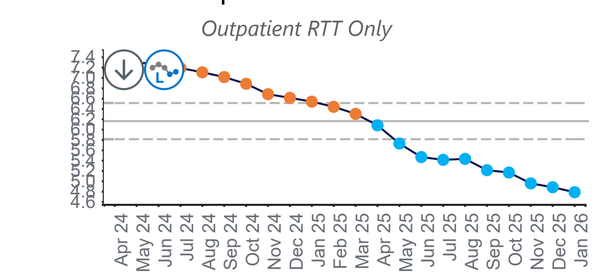


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



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

Outpatient RTT Only



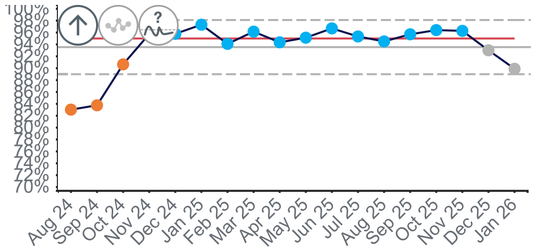
Integrated Performance Report | February 2026

Alder Hey Children's NHS Foundation Trust

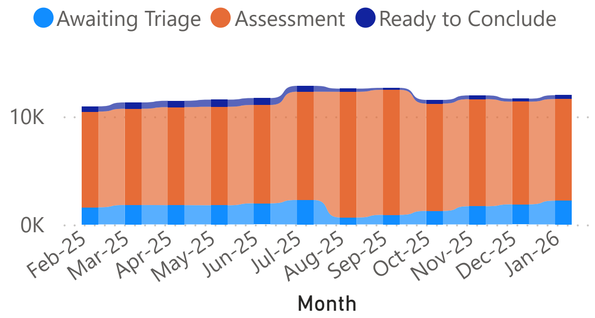
Revolutionise Care - Effective & Responsive - Watch Metrics

Diagnostics: % Completed Within 6 Weeks of referral

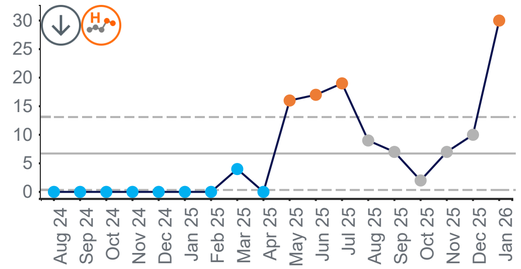
Target: Statutory



Neurodevelopmental Diagnosis Status

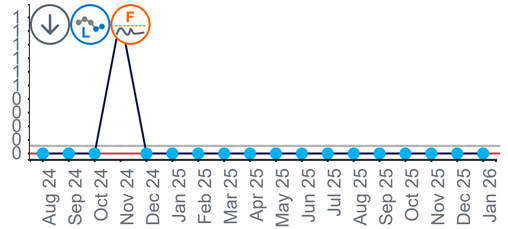


CAMHS: Number of children & young people waiting >52weeks



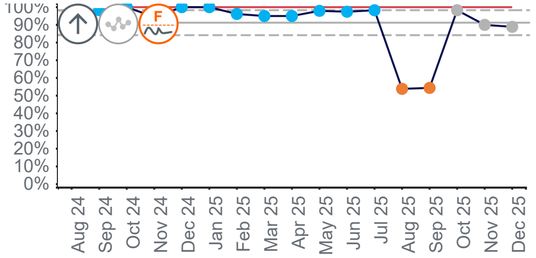
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



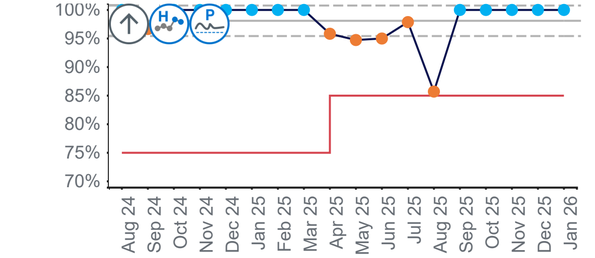
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



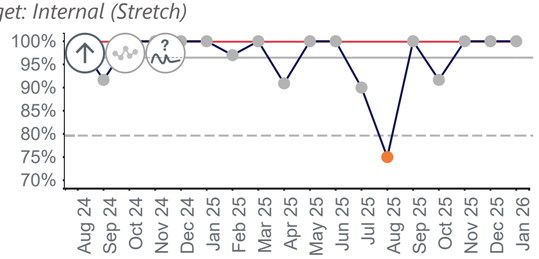
Cancer: Faster Diagnosis within 28 days

Target: Statutory



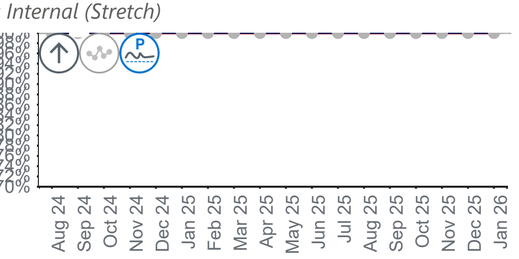
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

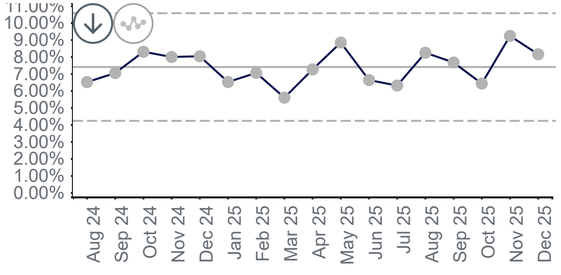


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

Target: Internal (Stretch)



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



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training completion remains over 90%. Work is underway reviewing modules with lower compliance levels

Areas of Concern:

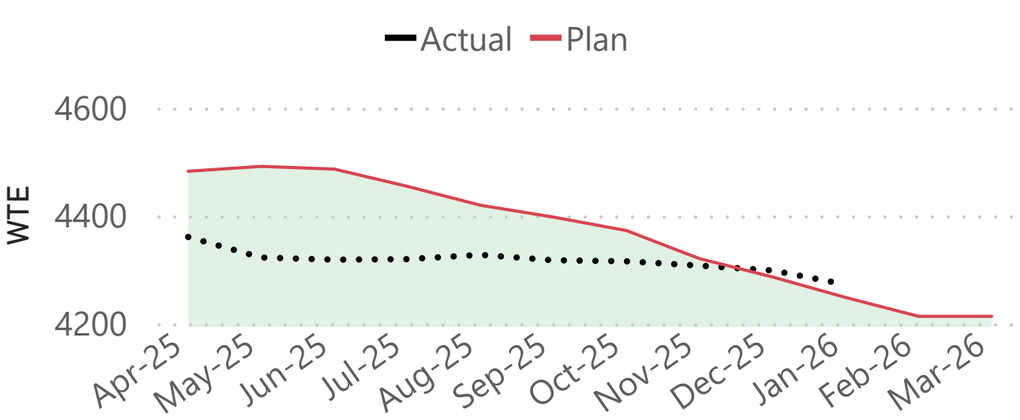
• Total workforce has reduced again, though still above plan. There is a final, further, small cohort of MARS leavers, leaving before the end of the year. Plans have been submitted to achieve further reductions in 2026/27 • While long term sickness absence has reduced, short-term sickness has jumped 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 86%, with completion of all PDRs at 76%. 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:

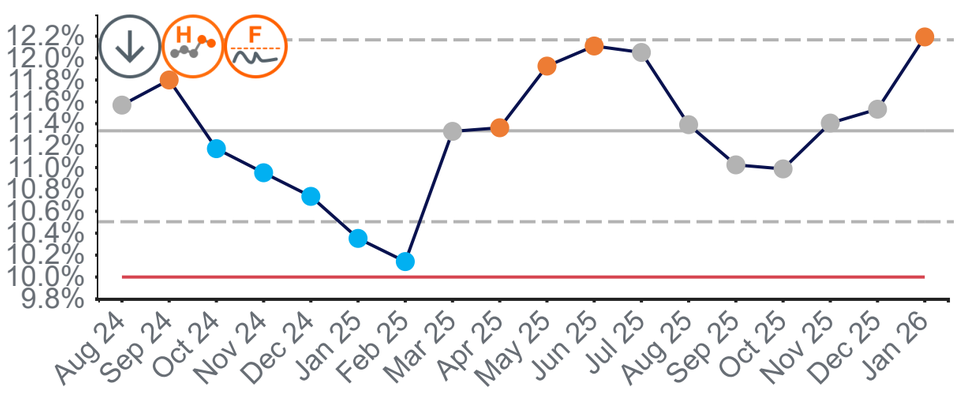
Total workforce for the end of January 2026 was 23.8 WTE above plan. M10 Total workforce was 4,271.5, against a plan of 4,247.7.

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 has decreased in January to the lowest level across the previous 12 months. There has been an increase in bank spend and WTE in the same period.

Staff Turnover

Target: Internal



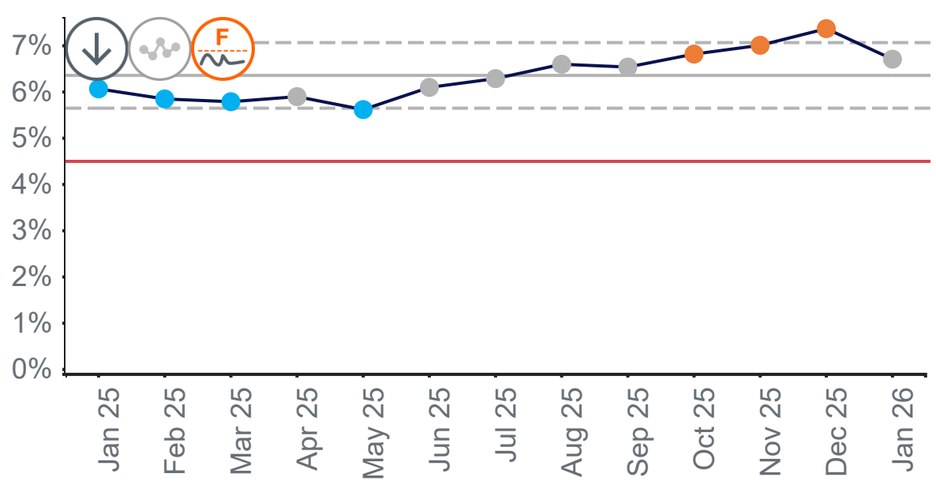
Technical Analysis:

Special cause variation of cause observed with performance of 12.2% in January 2026 against an internal target of 10%. Increase from Decembre-25 at 11.5%. Consistently failing metric.

Actions:

Turnover has increased in month due to the end of fixed term contracts, and further colleagues leaving as part of the MARS scheme. A full review of reasons for leaving has confirmed that there are no changing trends amongst voluntary reasons for leaving contributing to high turnover.

Sickness Absence Overall



Technical Analysis:

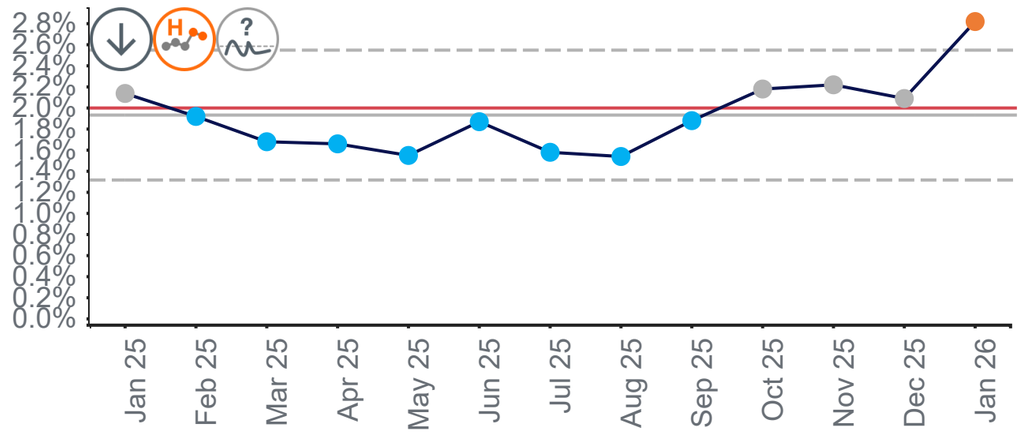
Special cause varation of concerning nature observed. Total sickness absence in January 2026 is 6.71% which is above the 5% target, a 0.66% decrease from December 2025 at 7.37%. January 2026 performance comprises STS at 2.782% and LTS at 3.90%. Lowest sickness rate in the last 4 months, with target being 4.5% in 2025/2026.

Actions:

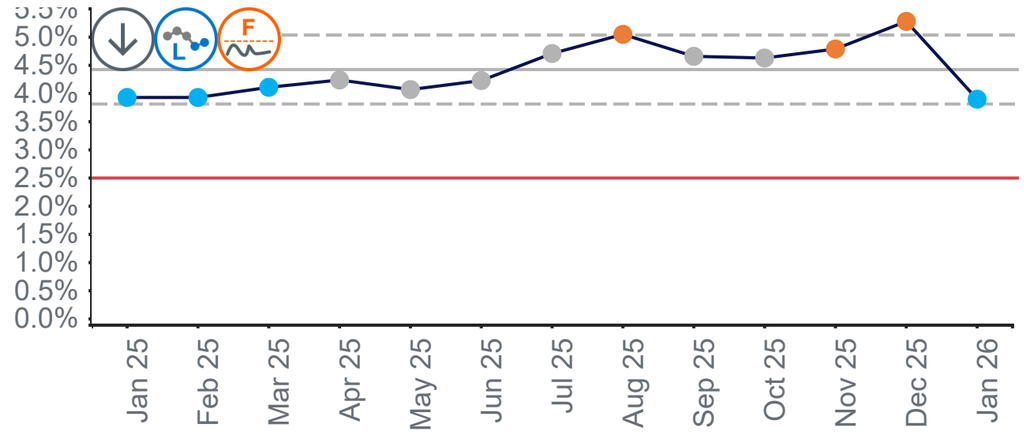
A detailed sickness absence update was presented to People Committee in January. Focus remains on prevention, working with SALS, OH and TU colleagues, with support for stress risk assessments, reasonable adjustments, enhanced wellbeing support from OH, management training, and targeted support for areas with higher absence.

Supporting Our People - Watch Metrics

Short Term Sickness

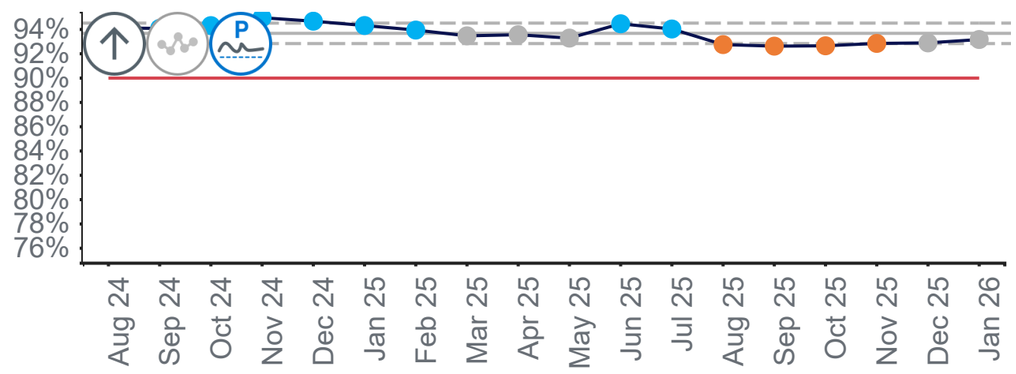


Long Term Sickness

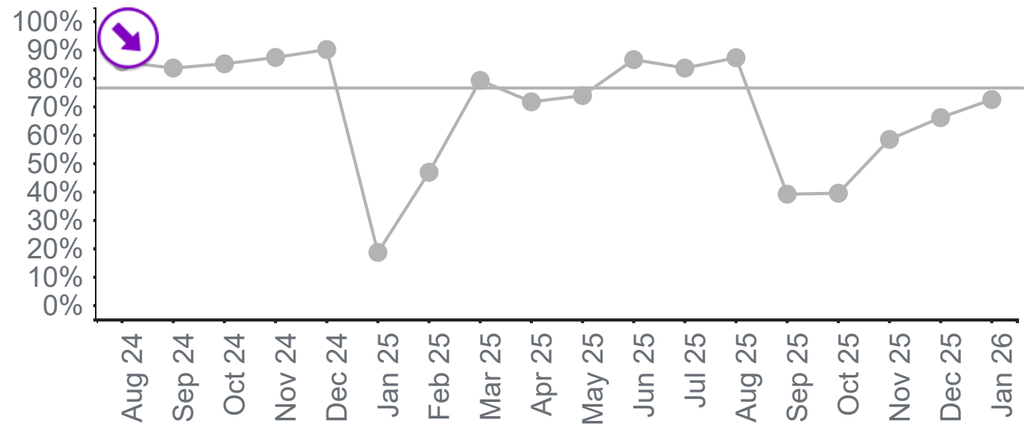


Mandatory Training

Target: Internal

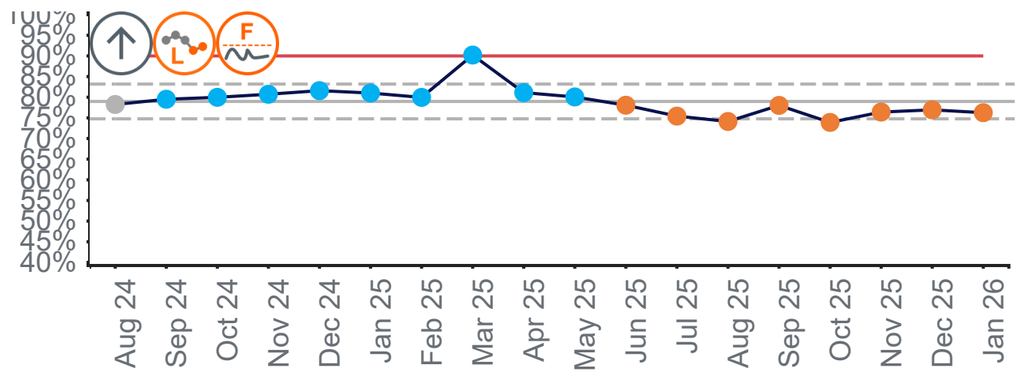


Medical Appraisal

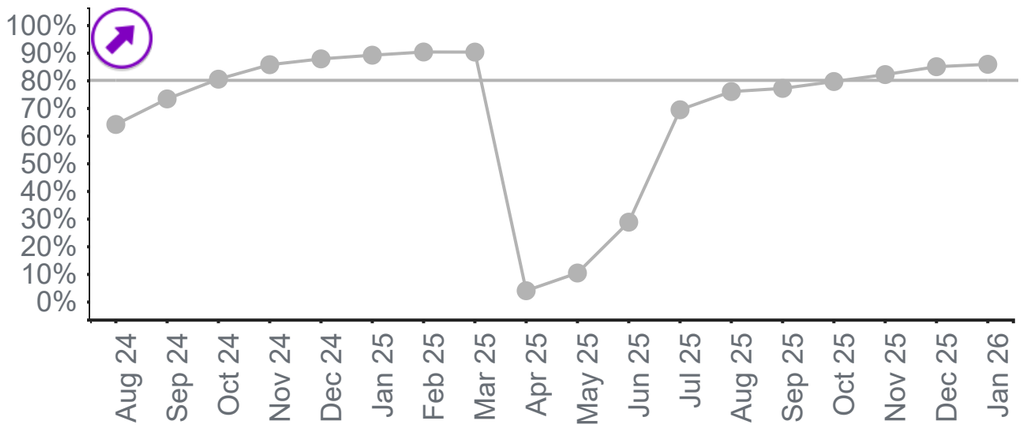


% PDRs Completed (Rolling 12 Months)

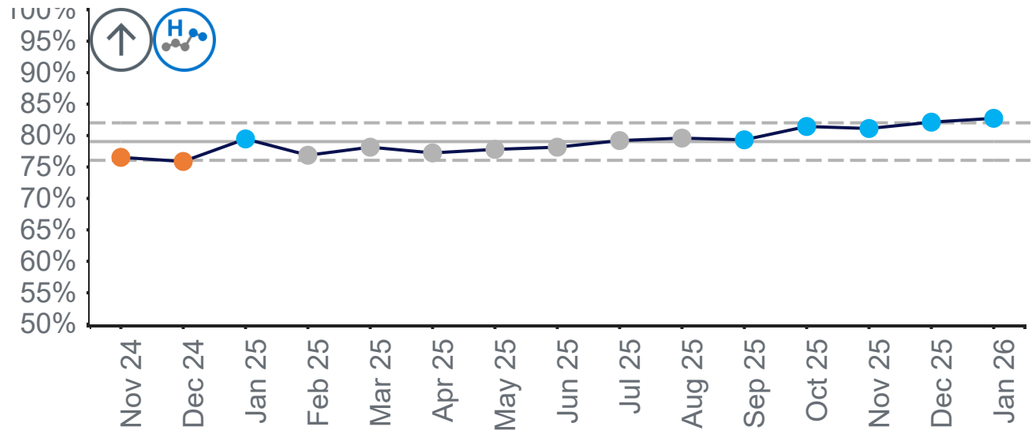
Target: Internal



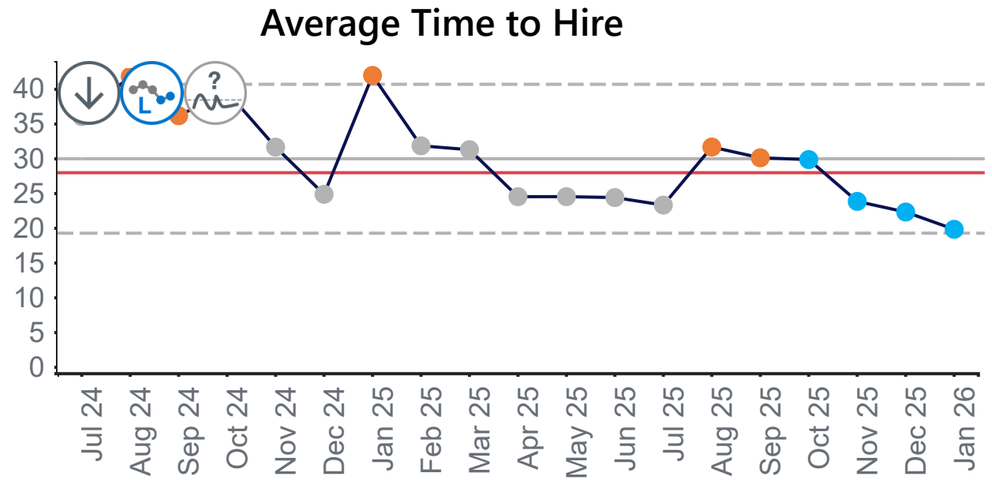
PDR B7+ Completed (Rolling 12 Months)



Workforce Stability



Average Time to Hire



Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

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

Highlights:

• EPIQ ependymoma and FIORE studies achieved major set-up and recruitment milestones, with the FIORE study being the first UK and European site to open and the only UK site to meet the NIHR set-up target • Paediatric Open Innovation Zone internal job creation on track, robust processes and SOPs implemented • Regional transformation award for Ambient Voice Technology (£3.02m across C&M) resulting in £119k benefit in year for AH • £101k award from DHSC Pharmacy Pump-priming scheme to improve set-up times for clinical trials • Kidney Research UK start up pharmacist award of £38,268 awarded to Dr Louise Bracken for 'using real time medical record data to identify rates of nephrotoxin prescribing and associated Acute Kidney Injury in hospitalised children' • Barclays bank leadership team visited through a Wavelength visit resulting in ongoing conversations with Barclays Eagle lab to explore potential collaboration • Alder Hey and Children's Health Ireland (CHI) formalised their long-standing collaboration through the signing of a joint Memorandum of Understanding (MOU) during visit on 5th February • Recruitment underway for Research PPI/E Officer post (0.6WTE) • Internal funding call launched to support existing and new researchers with a focus on health equity (aligned with the Liverpool Institute of Child Health and Wellbeing) • Surgical fixation versus non-surgical care for children with a displaced medial epicondyle fracture of the elbow (the SCIENCE study): a multicentre, randomised controlled, superiority trial and economic evaluation (https://pubmed.ncbi.nlm.nih.gov/41576983). Perry DC, Achten J, Zimmermann A, Kandiyali R, Appelbe D, Wright JG, Ferguson D, Wang K, Wilson N, Moscrop A, Mason J, Kounali D, Costa ML; SCIENCE Study Collaborators. Lancet. 2026 Feb 7;407(10528):577-586.

Areas of Concern:

MRI and RPA underachievement still driving adverse financial forecast position but being mitigated by overachievement in external income (including £119k benefit from AVT transformatioin funds) • Delays with plans for developing secure data environment funded through POIZ capital funding (collaboration between innovation and digital) posing risk to retaining funding from LCR Combined Authority.

Forward Look (with actions)

- Continued focus on closing the financial gap to ensure break even across the combined Futures budget • Sustainable financial model for research and innovation under review • Review of internal funding call focused on health equity to take place I early March so awards can commence in April 2026 • Development of platform study protocol for rapid evaluation of innovation technology – in discussion with MHRA prior to obtaining full research approvals • Combined research and innovation training to be delivered to thriving operational managers in Feb/Mar 2026 following positive feedback on innovation training from cohort 1 • Innovation celebration event planned for March 2026 including a formal launch of the Paediatric Open Innovation Zone (POIZ) by the Liverpool Metro Mayor and a keynote from the Children's Commissioner for England • Discussions continue to secure robust clinical leadership across research and innovation following the change in role for the or the current Research Director and the upcoming retirement of the Chief Scientific Officer

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

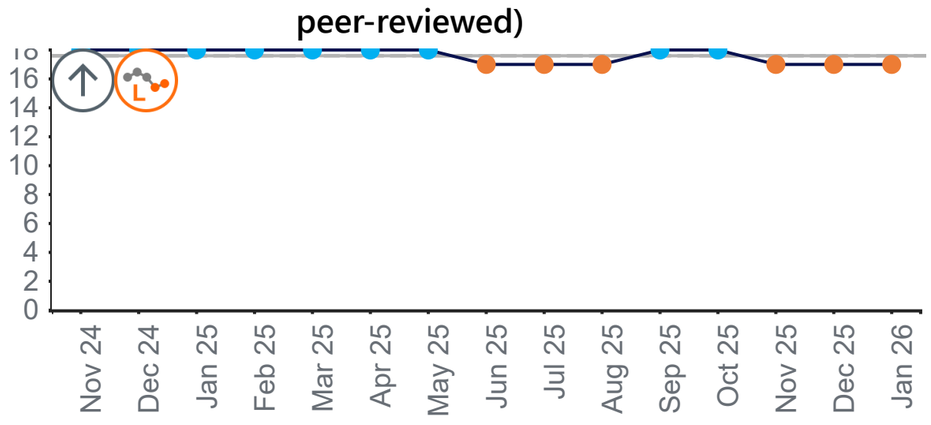
Technical Analysis:

Under Review

Actions:

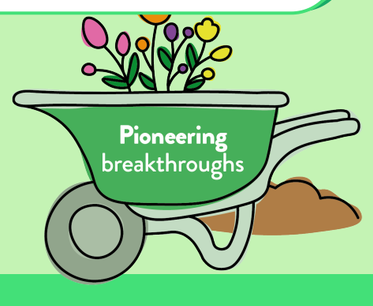
Under Review

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



Technical Analysis:

Actions:

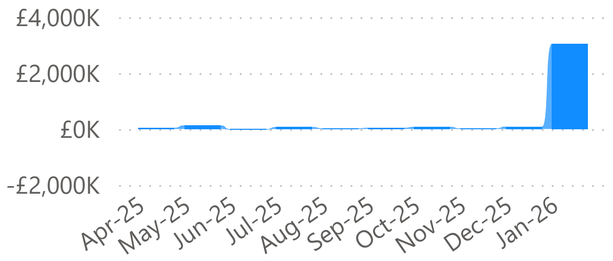


Integrated Performance Report | February 2026

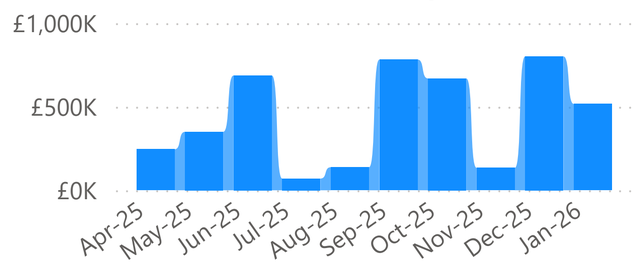
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

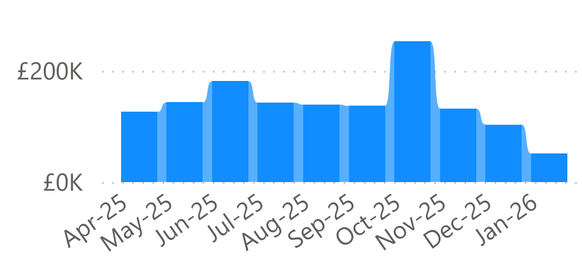
External innovation income received by month (commercial and non-commercial)



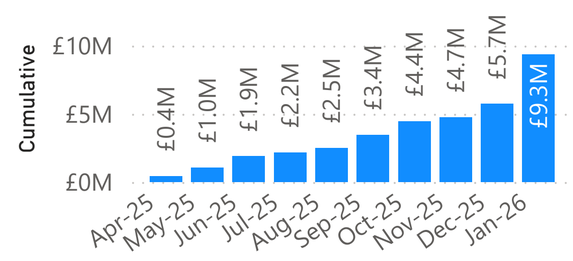
External research income received by month (commercial and non-commercial but excluding NIHR)



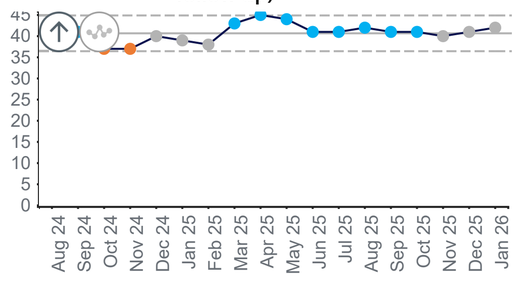
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



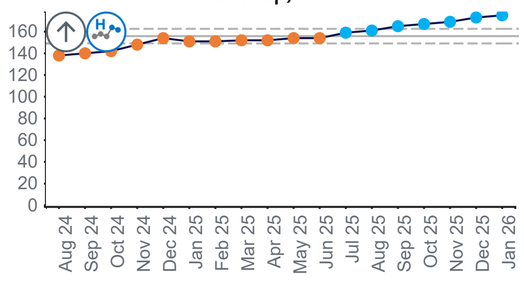
External income received by month across Research and Innovation (YTD Cumulative)



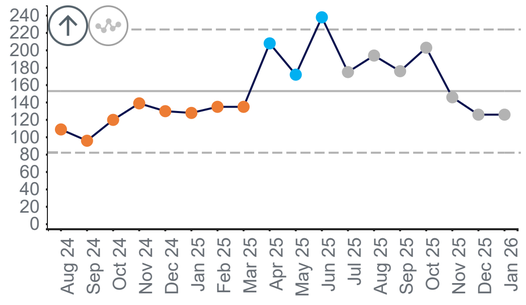
Number of open commercial studies (recruiting and in follow up)



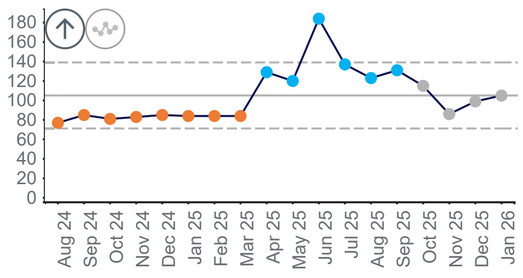
Number of open non-commercial studies (recruiting and in follow up)



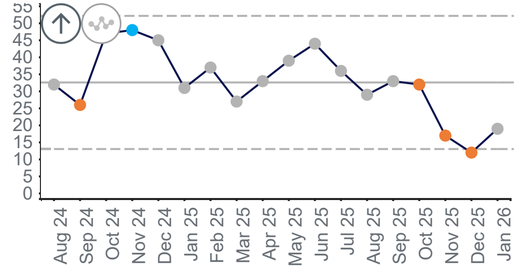
Number of participants recruited to all studies



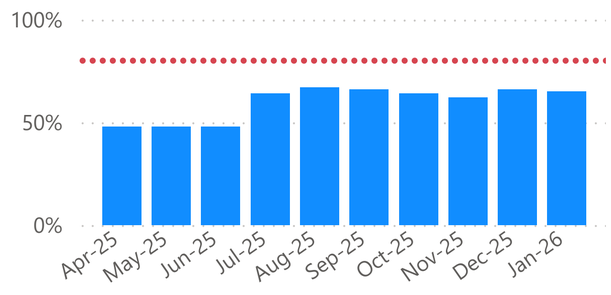
Number of participants recruited to all NIHR portfolio studies



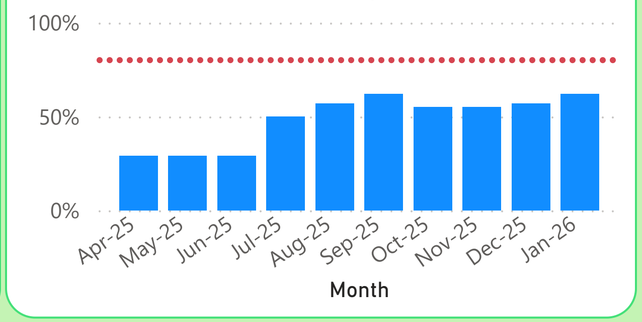
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



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



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



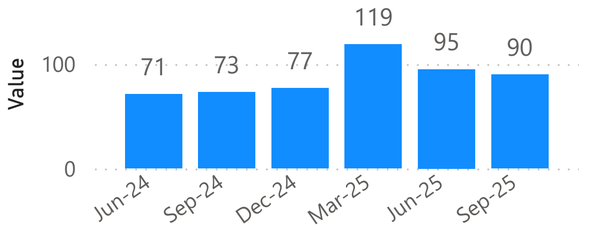
Integrated Performance Report | February 2026

NHS
Alder Hey Children's
NHS Foundation Trust

Pioneering Breakthroughs

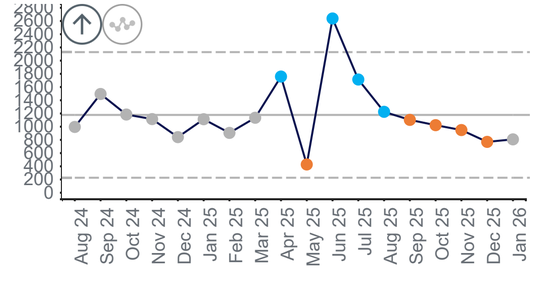
Number of publications with AH author by quarter including journal impact factor

Quarterly

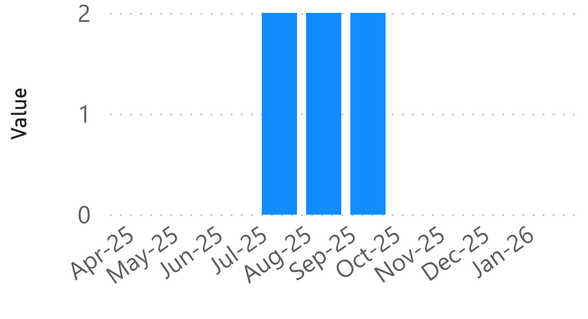


Number of businesses supported by POIZ

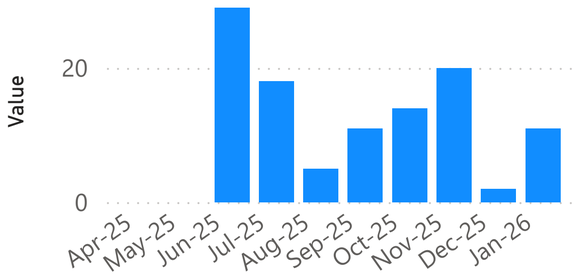
Manual hours released from automation/AI solutions - Monthly



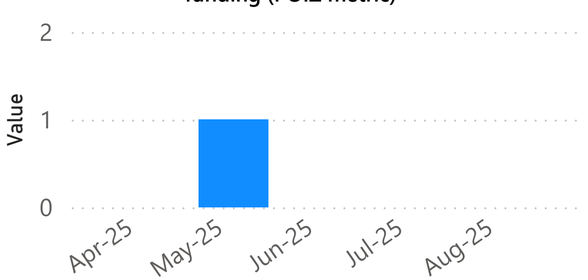
Number of staff trained in innovation methods



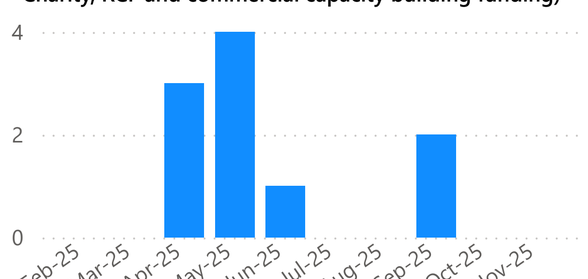
Number of staff trained in research methods



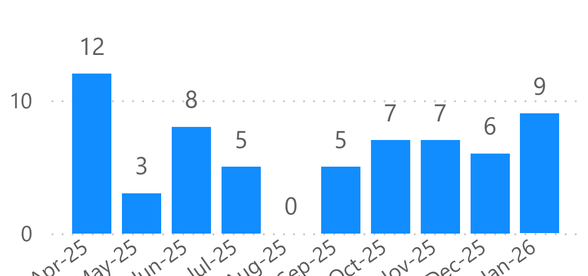
Number of AH-hosted jobs created through new external funding (POIZ metric)



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



Number of primary and secondary schools engaged with Futures activities



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

£1.1m surplus reported in month, £1.2m surplus YTD which is behind plan by £0.2m due to non-pay pressures. Externally forecasting £7.160m surplus. Extrapolated forecast remains at £5m surplus in line with M9. £19.7m CIP has been transacted in year (£12m 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:

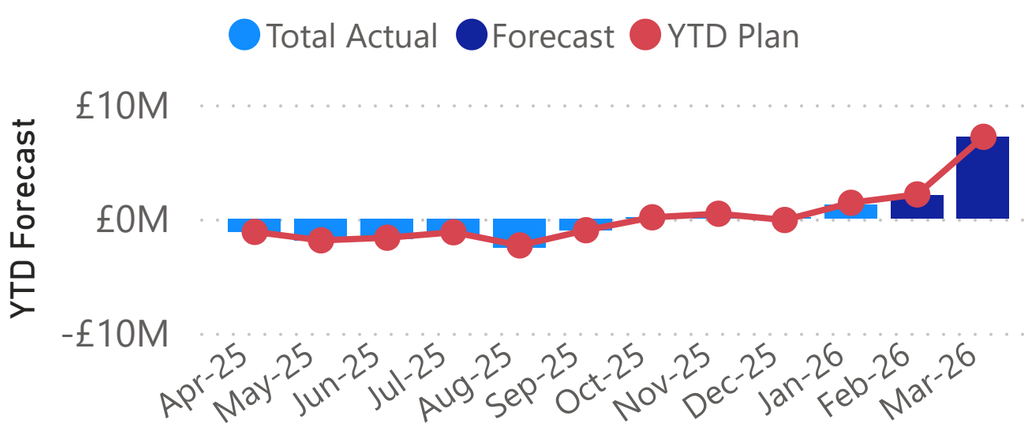
A number of income assumptions in the 25/26 forecast are currently in discussion with the ICB and present a risk to overall delivery of plan if not confirmed. Delivery of recurrent CIP programme continues to present a risk, which, alongside other mitigations, links to deliver of overall plan for the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

Forward Look (with actions)

Continued cost control measures are being implemented through FIP to support achievement of year end position and focus on transformation to aid longer term financial sustainability. Divisional forecasts have deteriorated in M10 largely due to unachieved vacancy factor and ERF underperformance. Cash strategy in development given the gap in forecast to ensure actions do not adversely impact on cash. Work is ongoing to support divisions in achieving recurrent savings, including development of Target Operating Models. 5-year capital plan in development.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

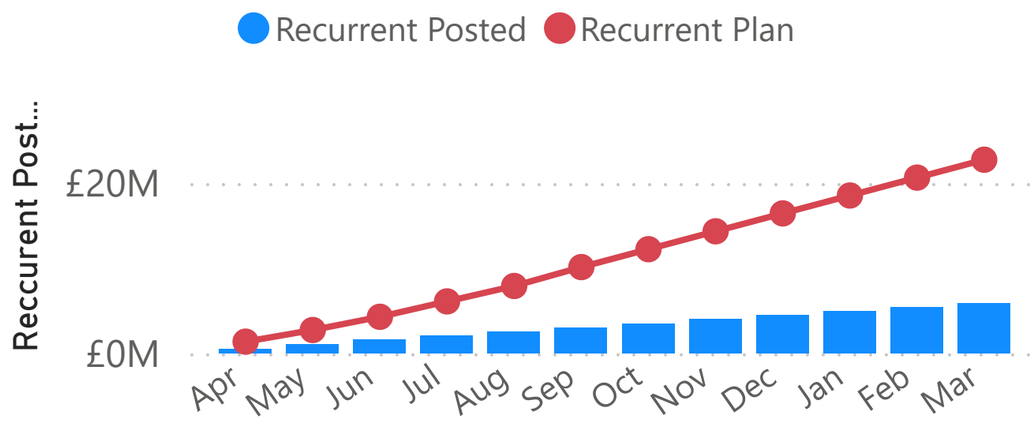
Current plan is £7.160m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress, identification of system wide schemes to deliver stretch target and management of in year pressures.

Actions:

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

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



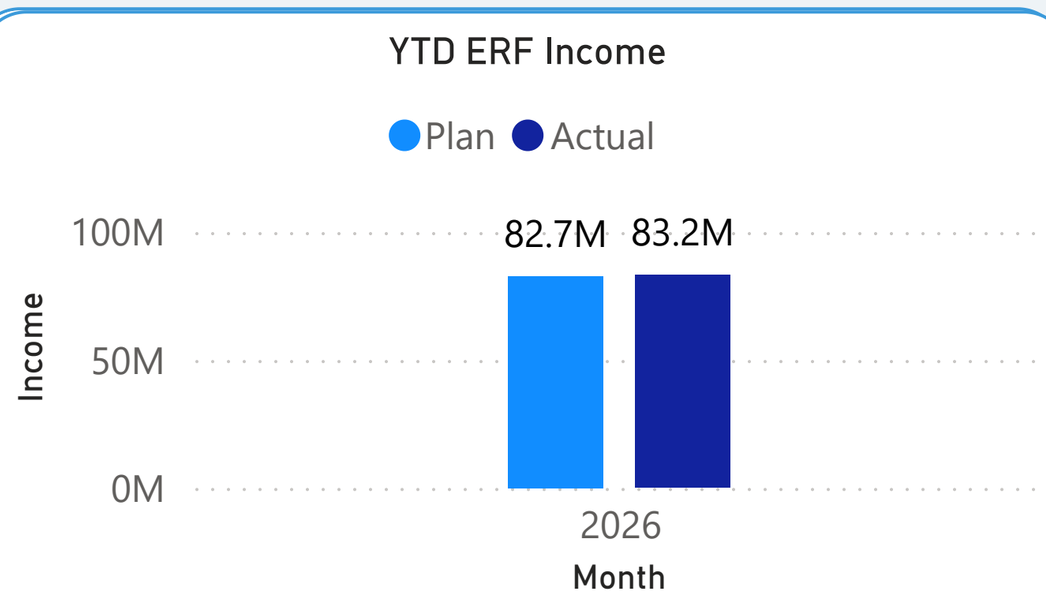
Technical Analysis:

Recurrent CIP identified is £12m which leaves a recurrent gap of £10.7m 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:

January performance estimated at 100%.

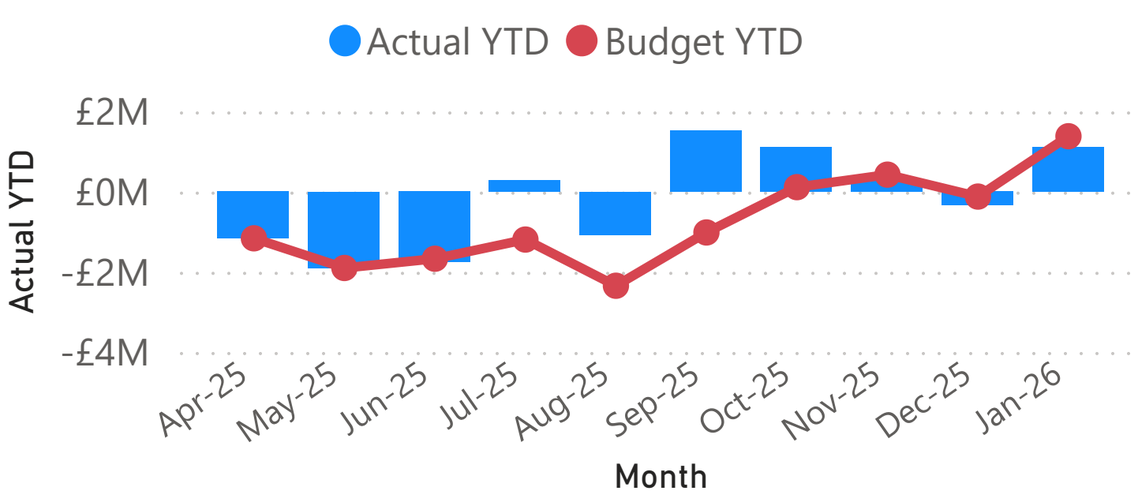
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

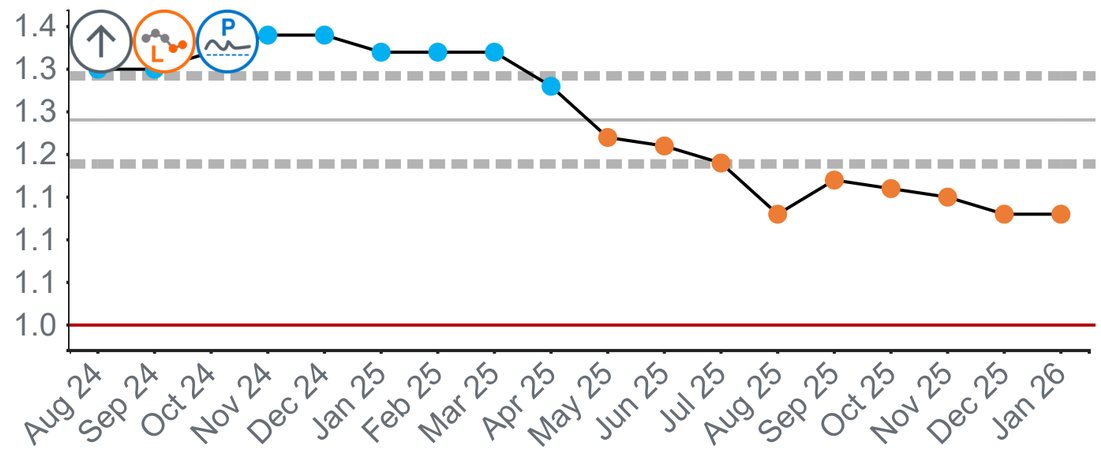
I&E distance from target (cumulative YTD)

Target: Internal

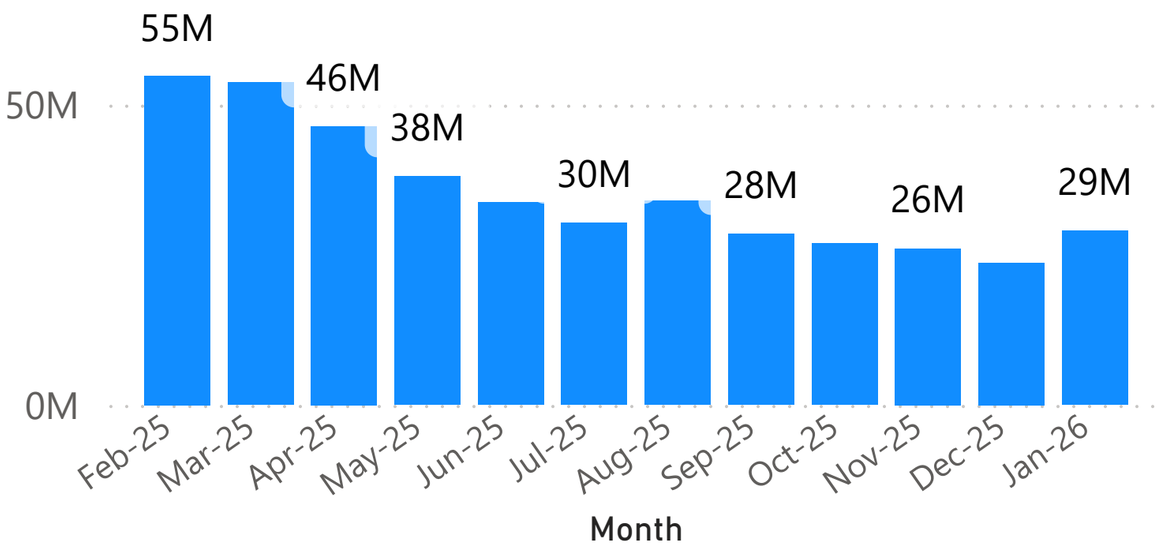


Liquidity

Target: Internal

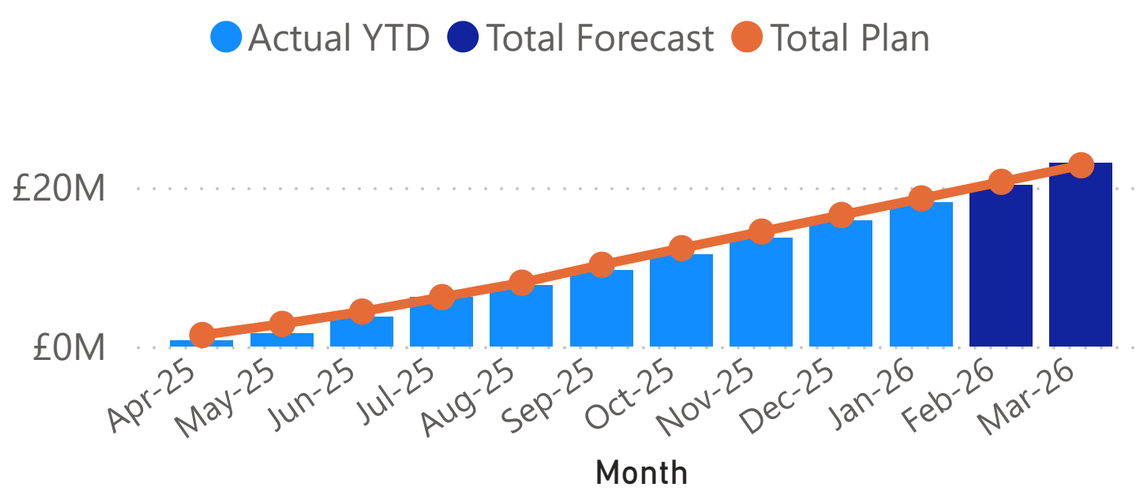


Cash In Bank



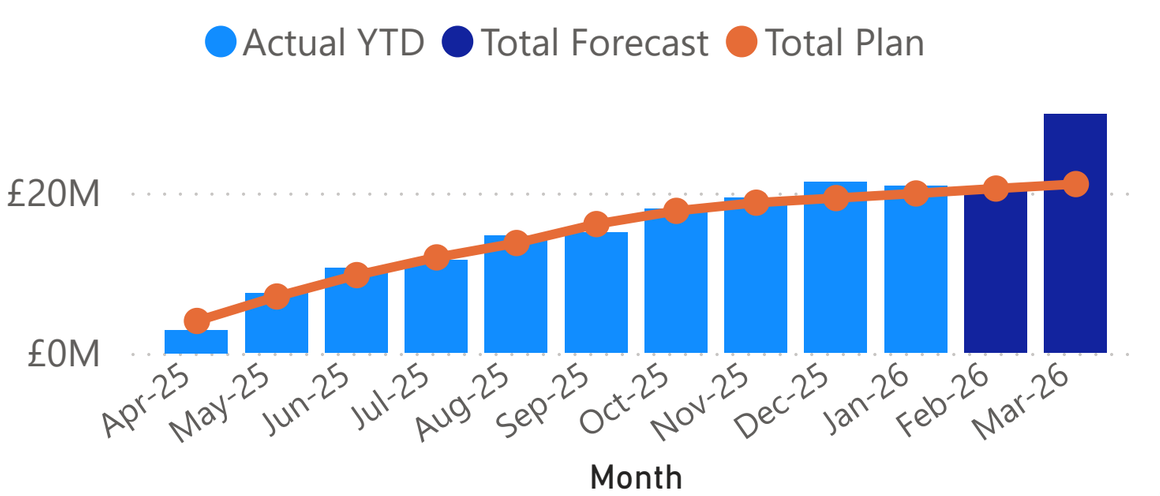
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights:

- 93% of high risks within review date (2 risks overdue which have now been updated)
- Continued positive engagement with risk owners at risk oversight meetings
- In-depth focus on all high risks at Risk Management forum

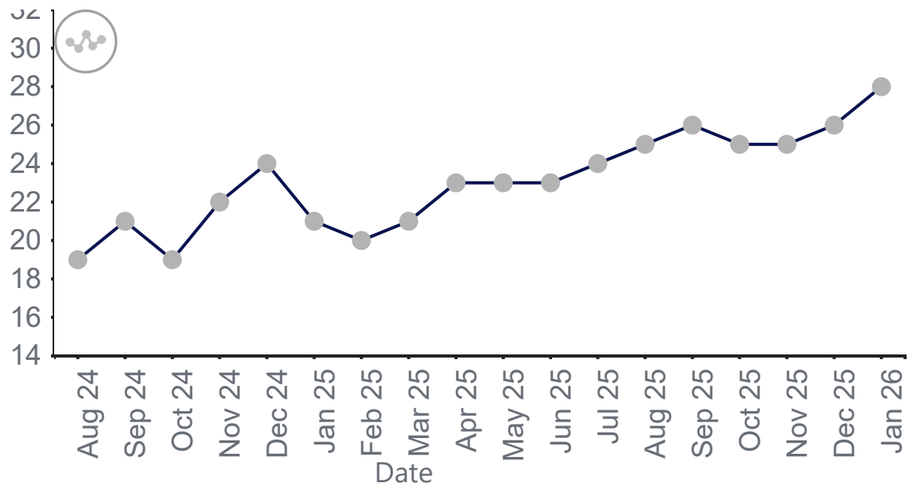
Areas of Concern:

- 32% high risks with actions past expected date of completion (9/28)
- Risk Appetite remains on hold pending Board discussion

Forward Look (with actions)

- Improved oversight and further assurance of high-risk actions and mitigations within/outside of Trust control now outlined within the Corporate Risk Register reporting into ARC. • Work with Medicine Division to roll out Risk appetite pending approval by Trust Board

Number of High Risks (scored 15 and above)



Technical Analysis:

28 high risks on the register at the end of January 2026.

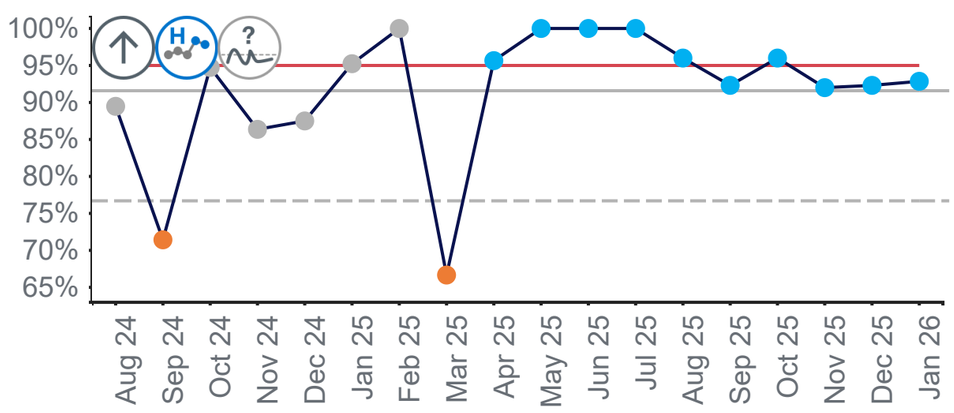
Actions:

Reporting categories as outlined below:

• Quality – Safety = 14 risks • Workforce – Sustainability = 5 risks • Compliance and Regulatory = 2 risks • Financial – Investment = 2 risks • Commercial = 2 risks • Financial – Compliance = 1 risk • Quality – Effectiveness = 1 risk • Clinical Innovation = 1 risk

% of High Risks within review date

Target: Internal



Technical Analysis:

Special cause variation with performance of 93% for Jan-26 of high risks within review date, sustained performance at 90%+ with December 2025 performance 92%. 10th consecutive month of performance greater than 90%.

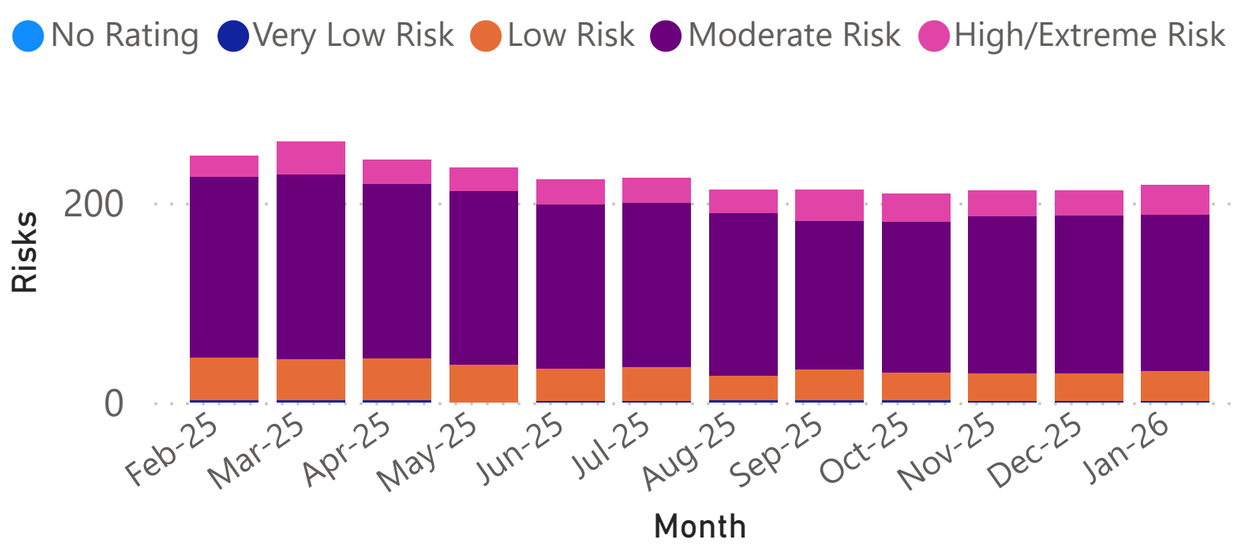
Actions:

93% of high risks within review date (2 risks overdue)

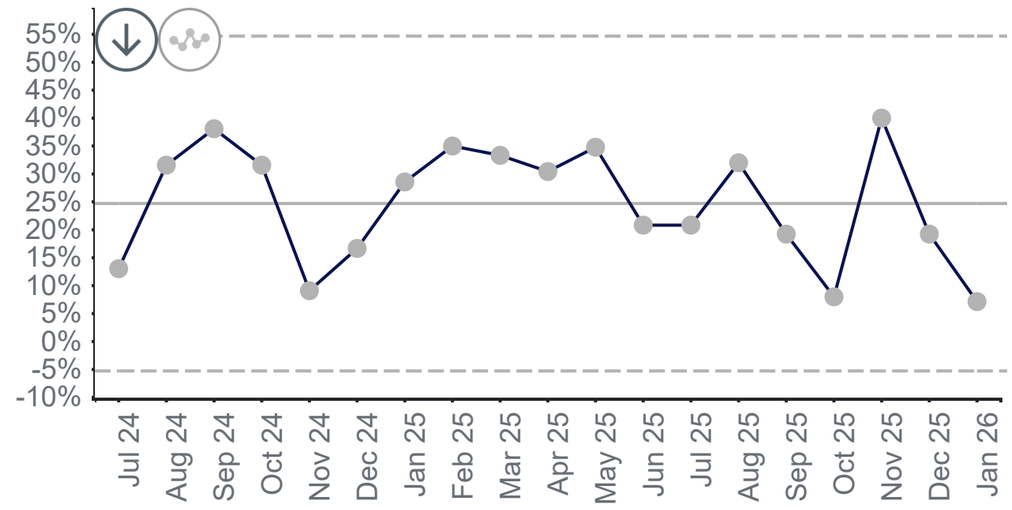
Risk watch metric: 32% (9 / 28) high risks with actions past expected date of completion

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

• No children or young people waiting over a year for follow up in Community Paediatrics
• Continued improvement in 18-week RTT for Community Paediatrics (75%) and reduction in waiting list size
• Community Therapy Services continue to meet 18 week RTT (Community Dietetics – 100%; SALT – 96%, Physio – 99% ; OT -100%)
• Improvement in number of children and young people starting treatment within 18 weeks of referral for Community Mental Health Services (61%)
• Mandatory training compliance remains above target (96%)
• Continued reduction in patient safety incidents rated low and no harm
• Number of complaints responded to within 25 days remains at 100% and PALS resolved within 5 days remains high (96%)
• Sefton MHST Specialist & Alternative Provision Team has been nominated for a National Council for Disabled Children SEND award for the Best Integrated Service or Team

Areas of Concern

• Increase in staff turnover (11.2%)
• Venus Centre closed due to unprecedented demand – impacting on referrals and capacity for Community Mental Health Services (Sefton). Escalated to ICB.
• Significant number of children and young people reported as waiting over 104 weeks to access Community Mental Health Services (394) – 68% actioned by end of M10, with 100% expected to be completed M11.
• Deterioration in timeliness to triage for ND assessments (72%)
• Increase in number of children & young people waiting over 52 weeks for treatment to start in Community Mental Health Services (Liverpool) (30). This is due to delays with recruitment, and an improvement plan is in place.
• Reduction in number of children and young people seen within 4 weeks in Eating Disorder Service (69%) 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 slightly in M10 (17%)
• Ongoing challenges with ADHD medication shortages which is impacting on waiting times for the treatment pathway

Forward Look (with actions)

-ND transformation programme:
• Work ongoing to streamline and validate data
• Review of the referral triage pathway to be undertaken
• New risk documentation to be completed for all children & young people open to service. A phased approach has been agreed.
• Demand & capacity work completed to identify resource needed to meet maximum 52 week wait shared with Executive Team (February 2026) and ICB.

-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.
• Recruitment ongoing, with additional posts requested to mitigate for gaps in service
• WNB rate remains high. Improvement within new assessment appointment type, deep dive into group appointments ongoing. Reminder calls using WNB predictor ongoing and action plan under review.

-Mental Health data reporting – work ongoing:
• Significant number of children and young people reported as waiting over 104 weeks to access Community Mental Health Services – this is a data quality issue, with improvement plan in place.
• 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 – due for executive review in February 2026
• MHSDS Phase 2 (Crisis Care) commenced, with Meditech developments completed in January 2026, testing planned for February 2026.
• IT and Operational Team working with IAPTUS to review scope of IAPTUS to Meditech data migration – options appraisal in development
• 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.

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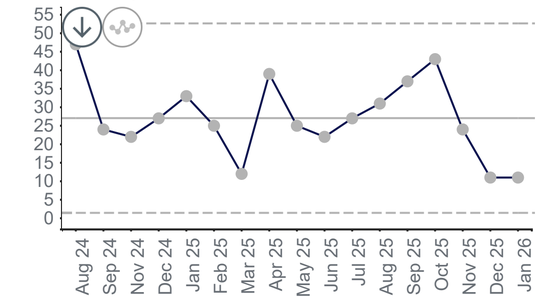
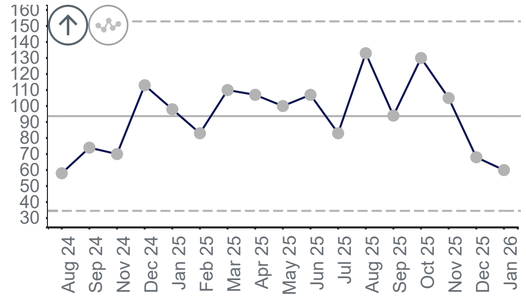
Divisional Performance Summary - Community & Mental Health

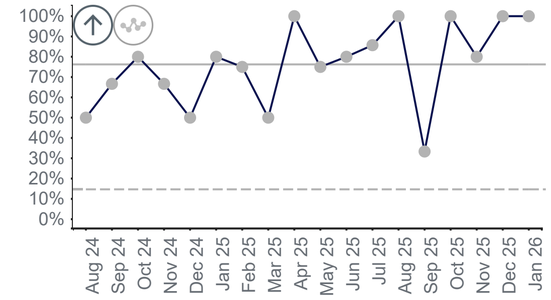
Patient Safety Incidents rated Low Harm & Above



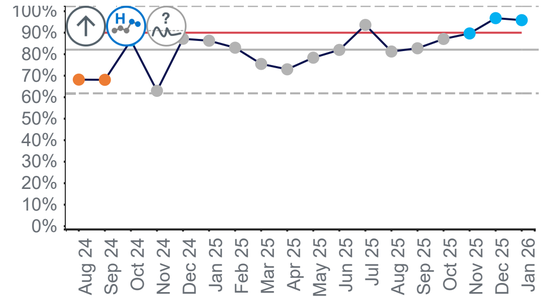
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

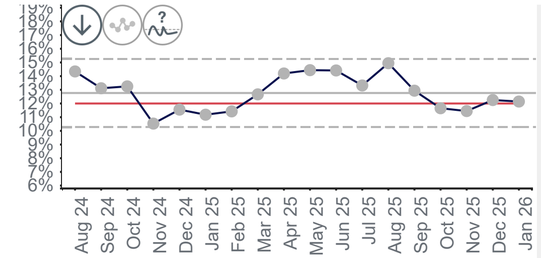


% PALS Resolved within 5 Days

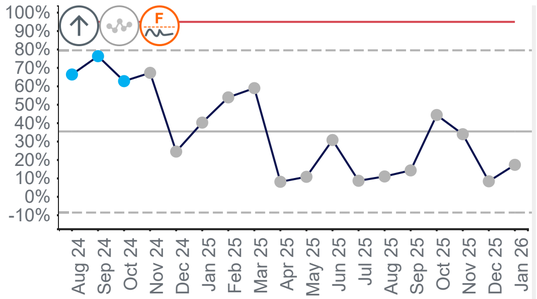


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

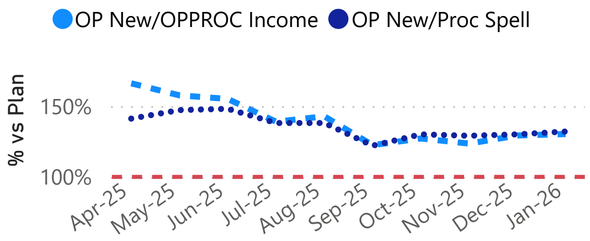


% of Clinical Letters completed within 10 Days

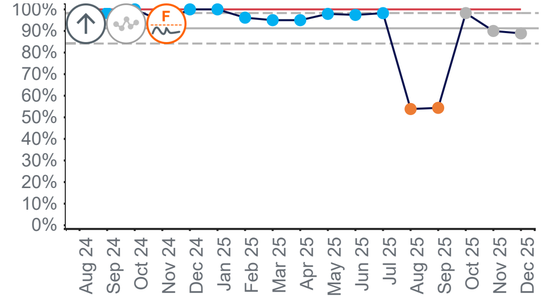


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

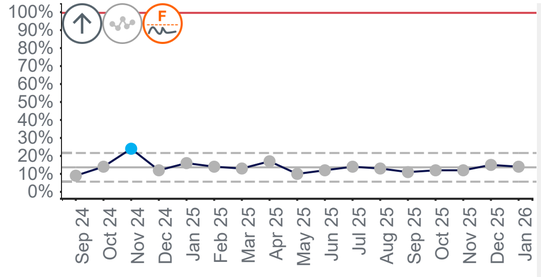
SLAM Performance



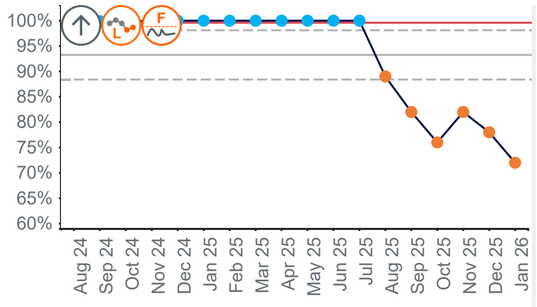
IHA: % complete within 20 days of referral to Alder Hey



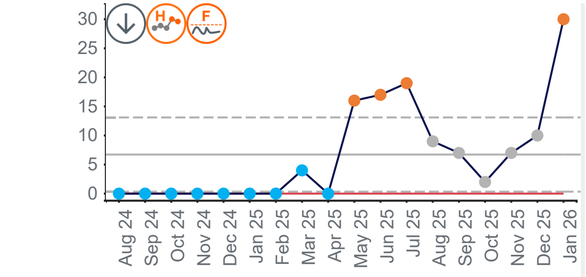
ND Assessment: % waiting <65 weeks for concluded diagnosis



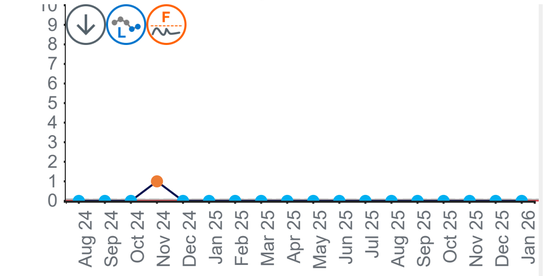
ND Assessment: % triage within 12 weeks



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



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



Integrated Performance Report | February 2026

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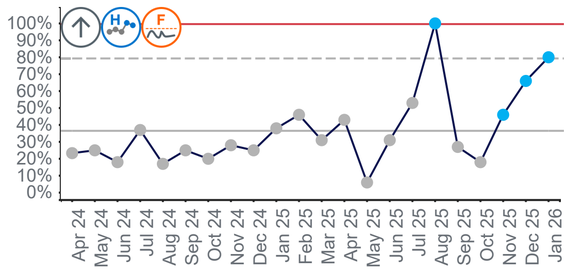
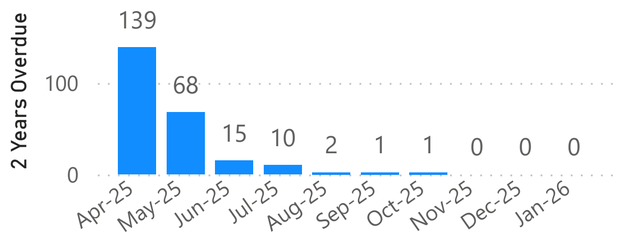
Divisional Performance Summary - Community & Mental Health

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

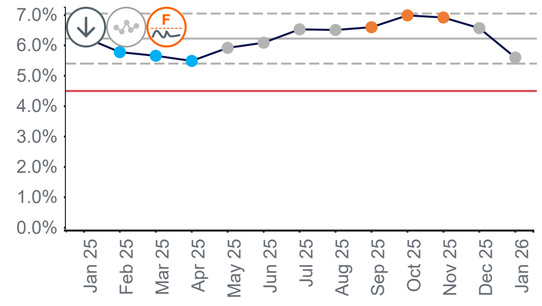


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

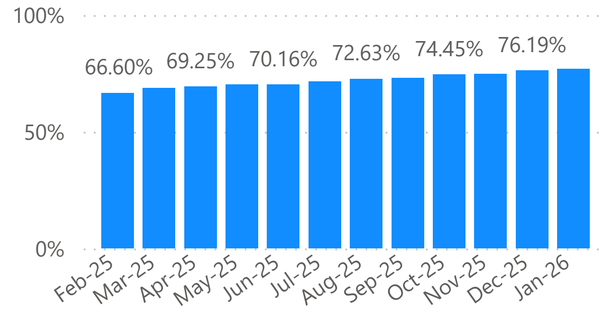
Vol overdue by 31st March 2026



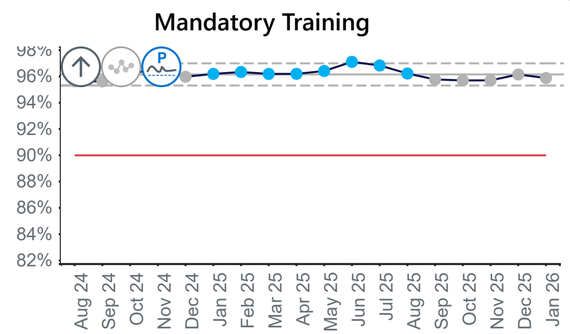
Sickness Absence Overall



Workforce Stability

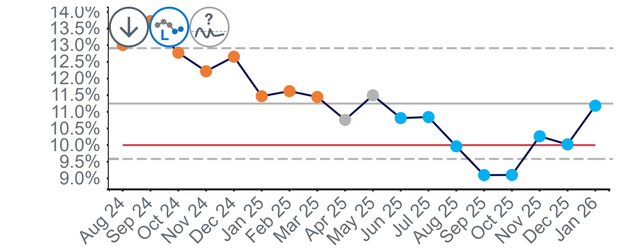


Mandatory Training

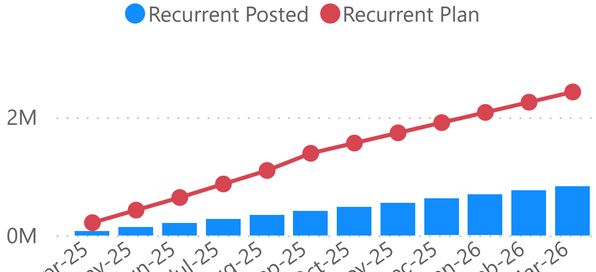


Staff Turnover

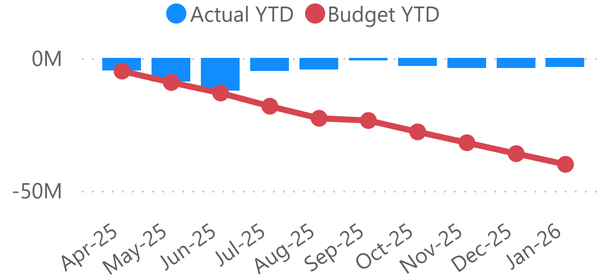
Target: Internal



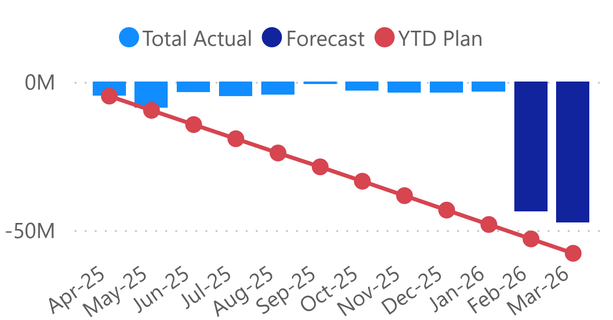
Recurrent Efficiency Plans Delivered (Forecast)



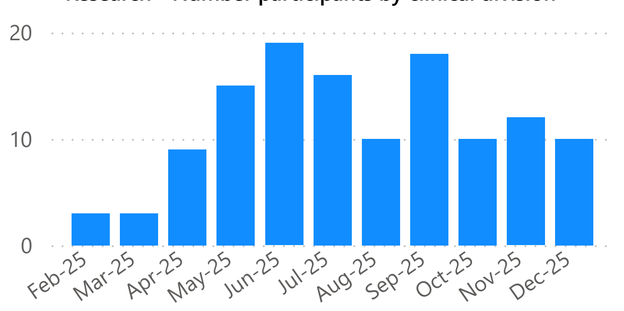
I&E distance from target (cumulative YTD)



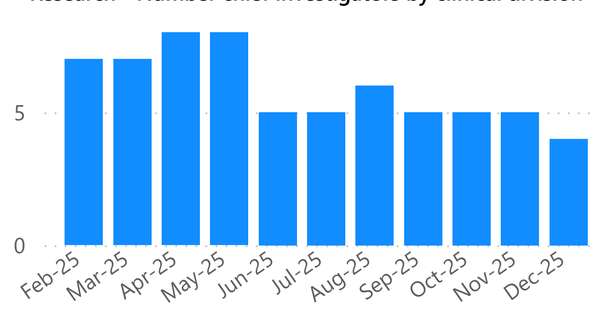
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• ED Performance in January has maintained above target at 86%.

• As a Division we have achieved 103% against the income plan across OP News, OPPROCs, Day case and Elective Pods in January.

• Across all specialties we have maintained 0 patients waiting over 52 weeks for elective treatment in January.

• The number of patients awaiting a follow up appointment over two years continues to reduce. This is now 219 in January 2026 compared to 1,107 in April 2025.

• Mandatory Training compliance remains above the Trust target at 92%.

Areas of Concern

• The number of diagnostics completed within 6 weeks of referral has declined in January with 90% achieved in the set time frame. The challenge areas for Medicine are Gastroenterology and Respiratory Medicine.

• There has been an increase in patient safety incidents rated low harm and above; January 2026 (n=26), December 2025 (n=19). To note this is still below the level in January 2025 (n=33).

• The number of clinic letters completed within 10 days has reduced further and is now at only 16%.

• The number of complaints resolved within 25 workdays was below the trust target in January 2026 with 60% responded to within this timeframe.

• Sickness within the Division remains consistently above 6%. This is posing challenges for the Division not only in terms of managing long term gaps within teams with minimal resilience but also short term absence with challenges covering acute sickness on the day for priority areas such as ED.

Forward Look (with actions)

• We have increased our theatre capacity for Gastroenterology to reduce the backlog of diagnostics outstanding. We are also reviewing the process from listing to theatre to reduce cancellations on the day.

• We are reviewing workforce plans with the sleep physiology teams to address current workforce gaps that are resulting in challenges in delivery of this diagnostic. We are also clinically reviewing the demand to identify patients that can have the diagnostic facilitated at home to improve this position further.

• We have implemented a RTW Assurance Group meeting to ensure sickness is being managed and RTW are being regularly undertaken so we can identify interventions required to reduce repeated sickness absence.

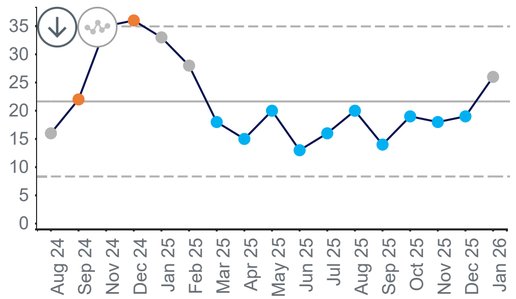
• We are reviewing how we can support complaints responses in a timely manner and the barriers to this to improve the position.

• We are meeting weekly to reviewing activity vs plan deliverables and the forecast against the remainder of the month to ensure delivery of the activity plan for the end of the financial year.

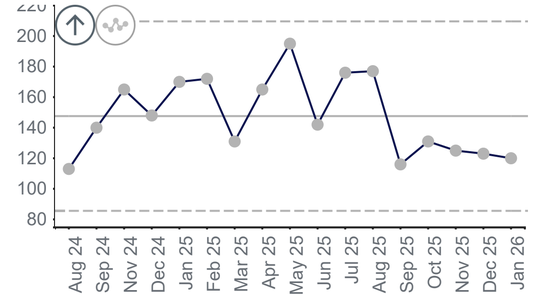
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

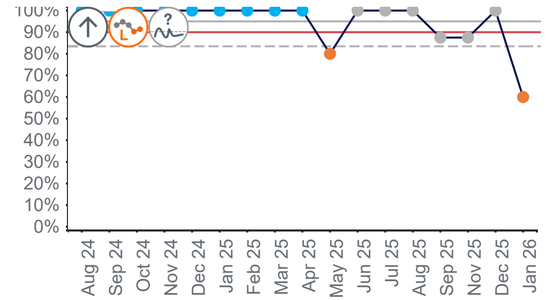
Patient Safety Incidents rated Low Harm & Above



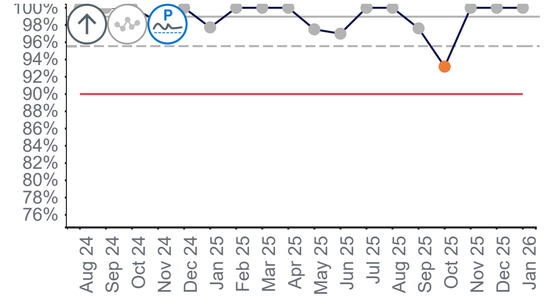
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

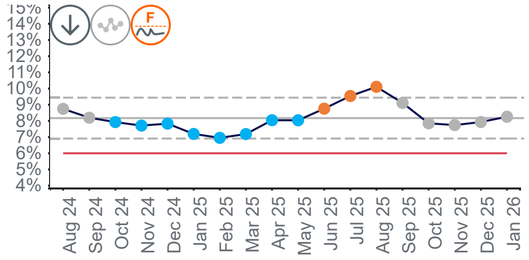


% PALS Resolved within 5 Days

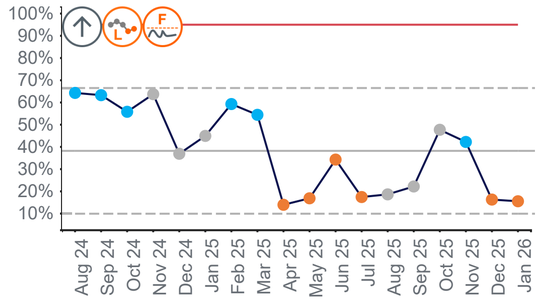


% Was Not Brought Rate (All OP: New and FU)

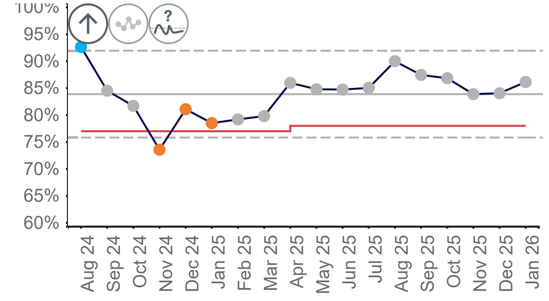
Target: Internal



% of Clinical Letters completed within 10 Days

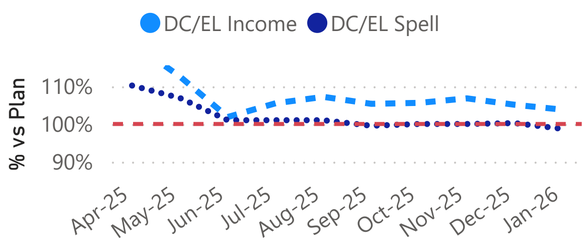


ED: % treated within 4 Hours



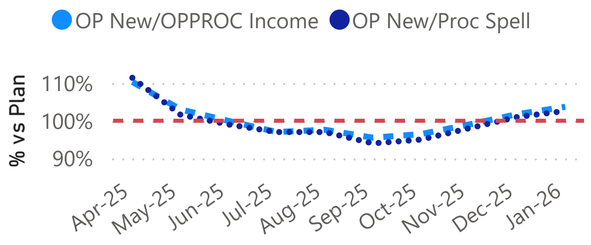
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

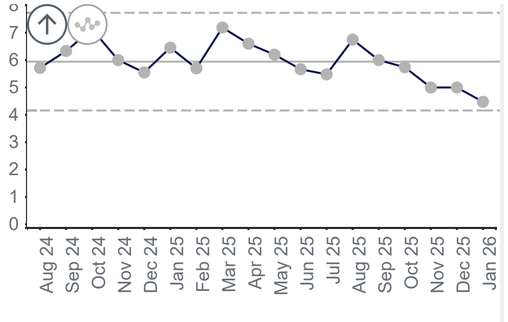


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

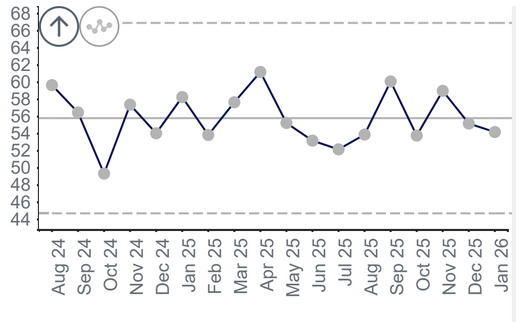
SLAM Performance



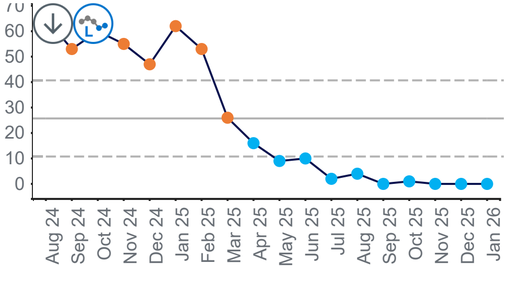
Inpatient Discharges per working day



Day Cases per working day



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



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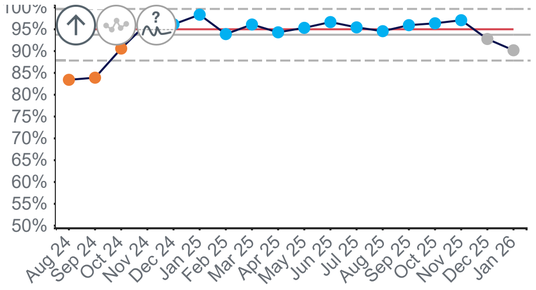
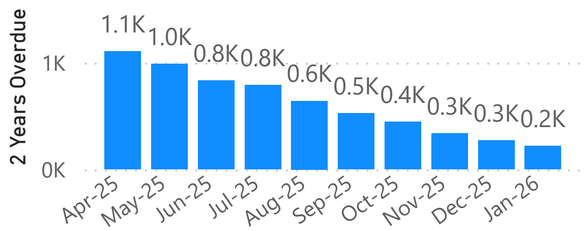
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

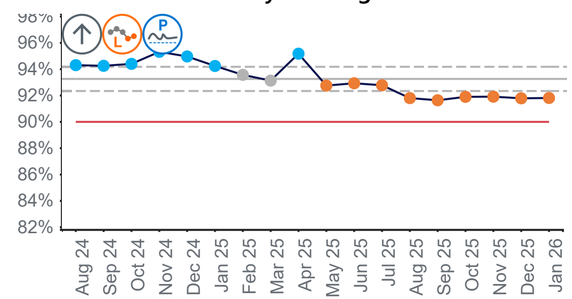


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

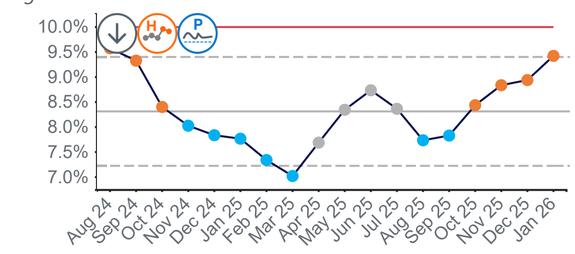


Mandatory Training

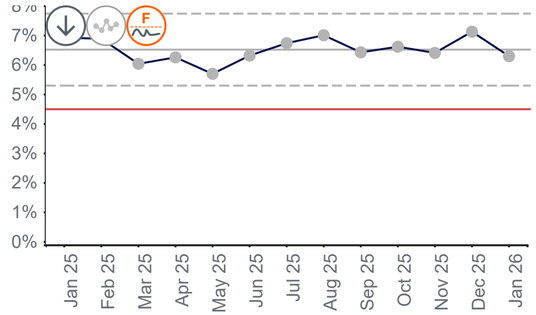


Staff Turnover

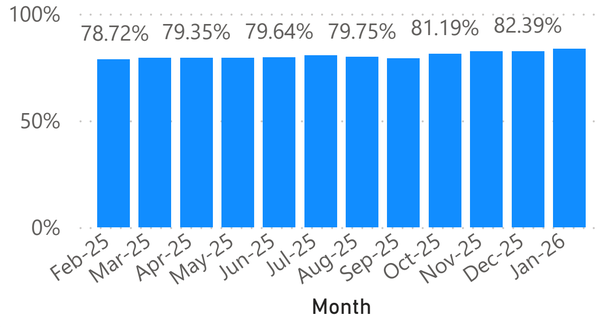
Target: Internal



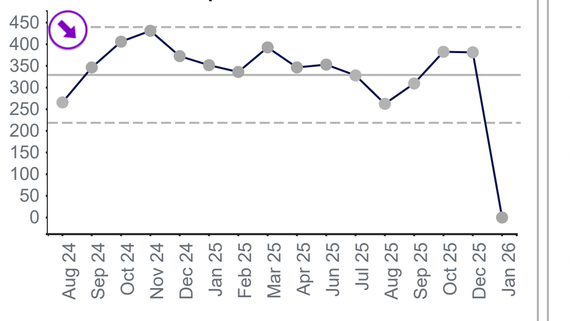
Sickness Absence Overall



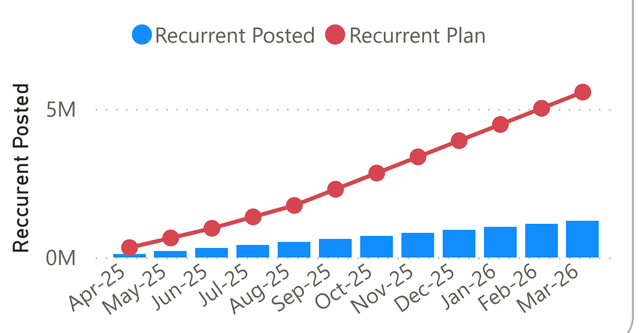
Workforce Stability



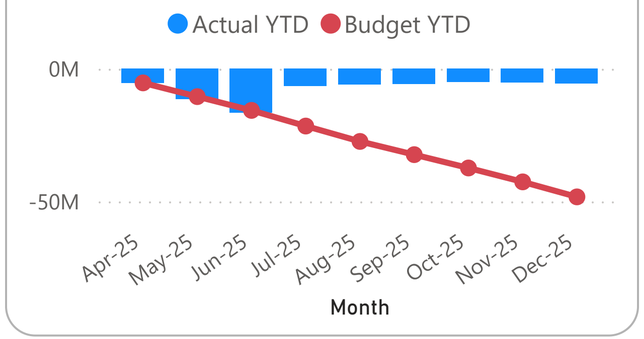
A&E Attendances per ED Consultant WTE



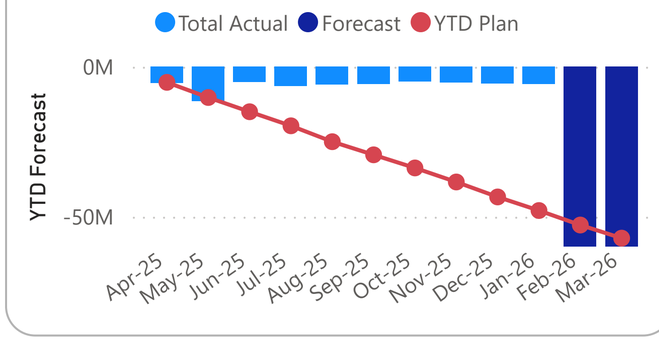
Recurrent Efficiency Plans Delivered (Forecast)



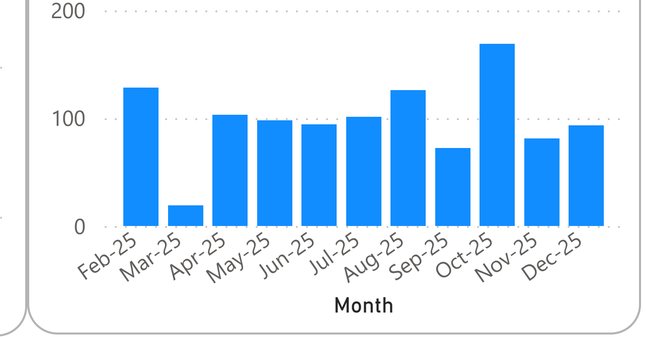
I&E distance from target (cumulative YTD)



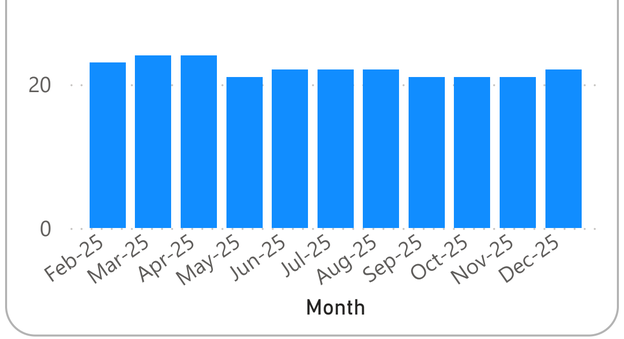
I&E Year End Forecast



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

- Outpatient activity remains above plan at 103% YTD
- M9 income freeze position identified an in month ERF improvement of 170k, giving an income overperformance of 39k.
- Day cases per working day increased to 51 in month following a slight dip over Christmas period. Day case unit is now maximised on a daily basis as a result of the day case productivity programme.
- Sickness absence although remains high divisionally at 8%, has reduced in month with a noted reduction in theatres and long term sickness overall
- Mandatory training remains above trust target and has done consistently for previous 18 months
- WNB although remains above trust target, has reduced in month. The opt in scheme which has run for 5 months and hopes to reduce the WNB for routine new patients has seen a WNB reduction over the past 5 months in targeted areas – ENT (-0.3%) and Dentistry (-3.8%).

Areas of Concern

- DM01 under target at 90% in month, additional theatre capacity planned in March, ongoing challenge within Audiology service with action plans being reviewed as part of a review.
- ERF income remains a pressure YTD with key recovery actions planned to secure additional capacity and increase depth of coding, alongside continued progression with optimised booking in outpatients.
- The division will not eliminate follow-up patients waiting over two years by March 2026; however, progress continues with the total decreasing month on month and key action plans in place

Forward Look (with actions)

- A pilot aimed at increasing the number of patients who have surgery and are discharged on the same day is set to begin in March. This pilot will involve expanding the capacity of the daycase ward and extending the hours during which a portion of the beds are available.
- Vision Screening Service was launched with Primary Eyecare Service in January- a distinctive change in pathway for CYP which will improve access to timely services and is expected to reduce WNB rates.
- Overdue Follow Ups Leads assigned in Plastics & Paediatric Surgery with recovery plans in place.
- Weekly meetings are held to monitor and support operational teams in reducing the number of patients waiting over 52 weeks by March 2026.

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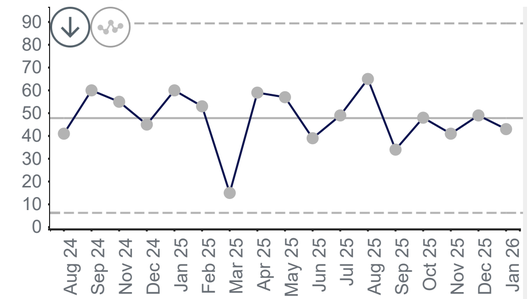
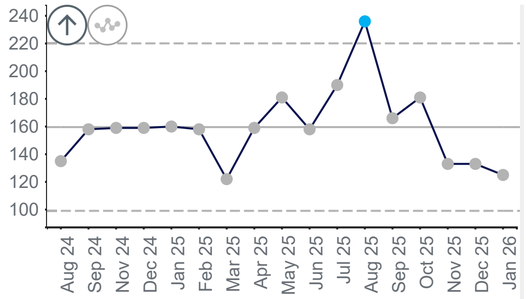
Divisional Performance Summary - Surgery

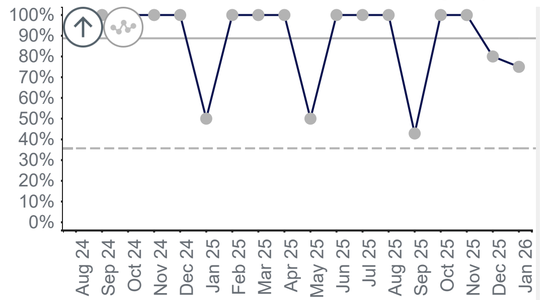
Patient Safety Incidents rated Low Harm & Above



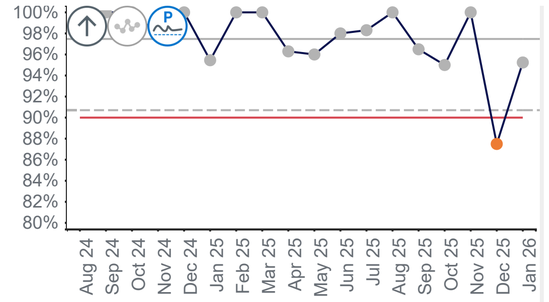
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

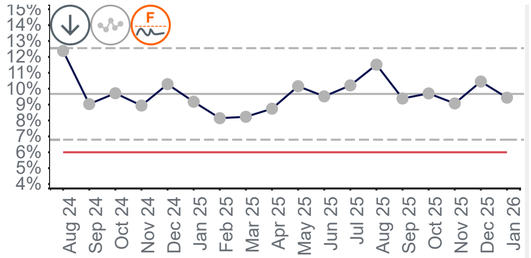


% PALS Resolved within 5 Days

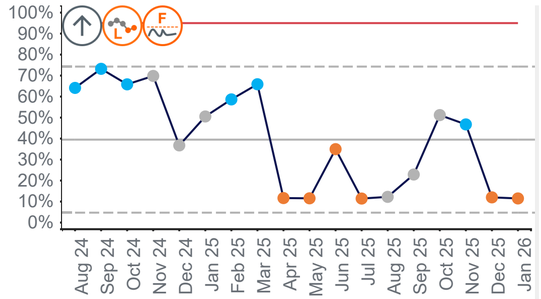


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

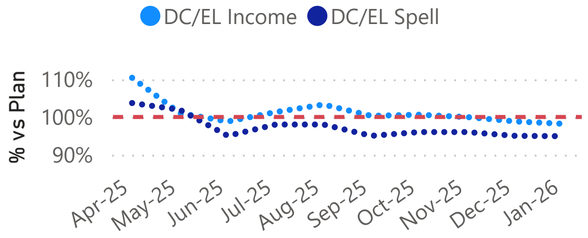


% of Clinical Letters completed within 10 Days



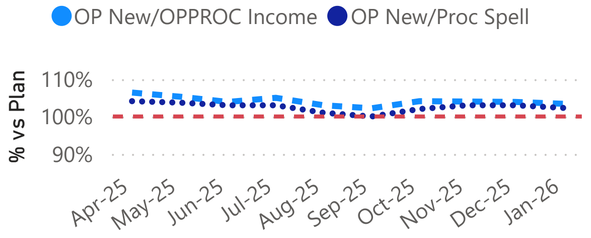
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

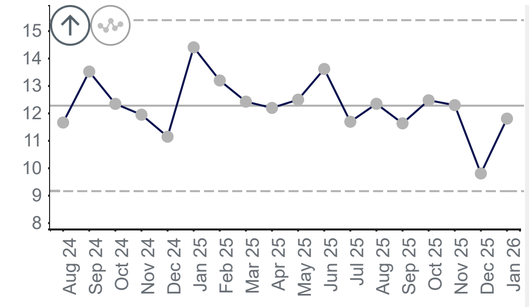


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

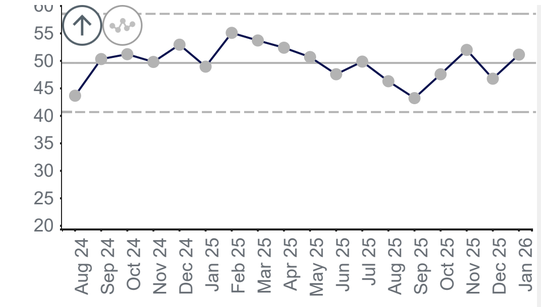
SLAM Performance



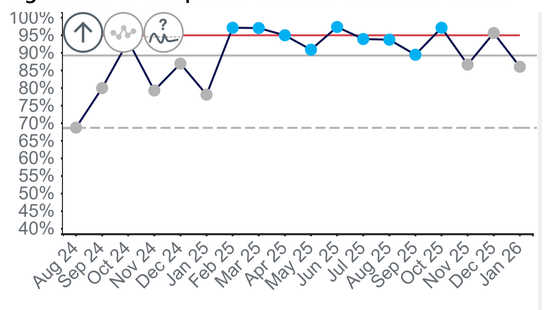
Inpatient Discharges per working day



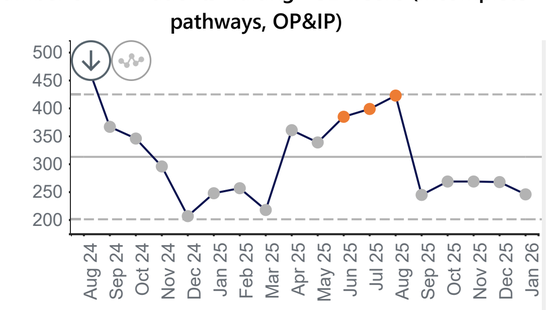
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



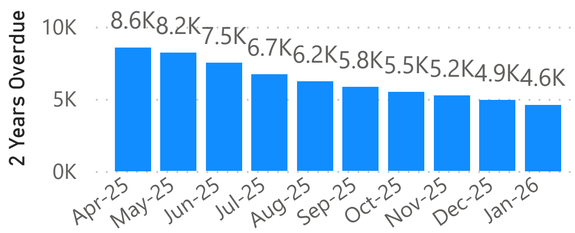
Integrated Performance Report | February 2026

Alder Hey Children's NHS Foundation Trust

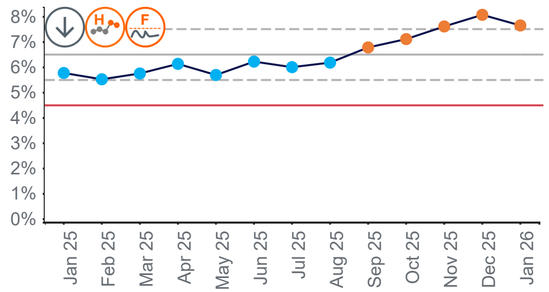
Divisional Performance Summary - Surgery

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

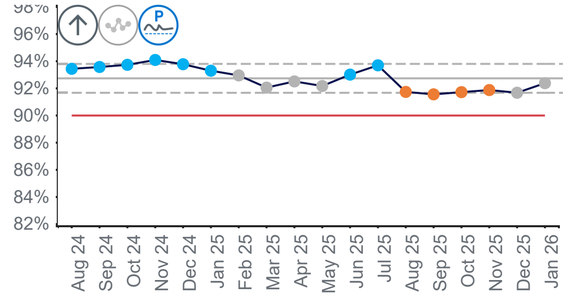
Vol overdue by 31st March 2026



Sickness Absence Overall

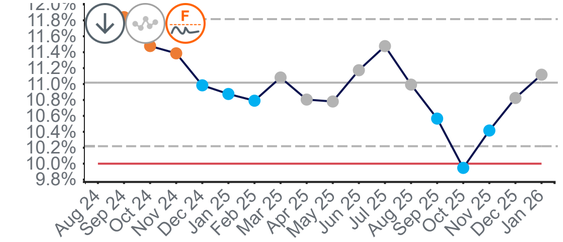


Mandatory Training

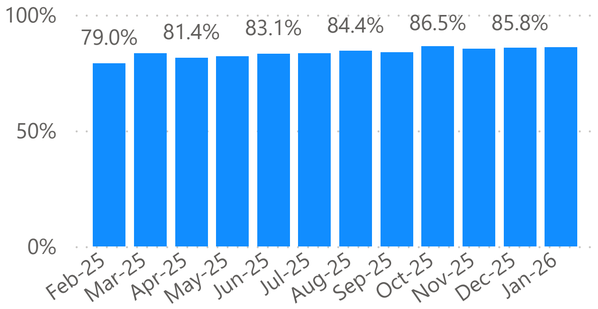


Staff Turnover

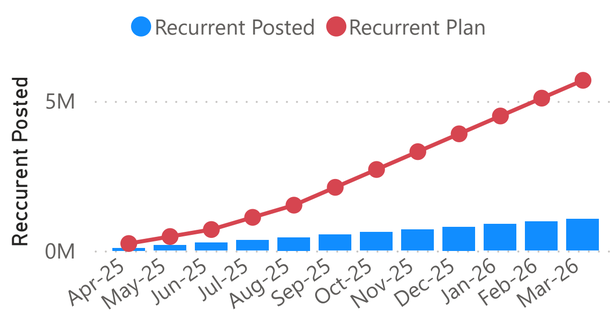
Target: Internal



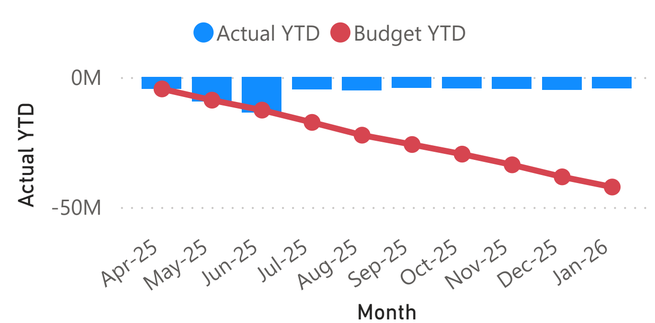
Workforce Stability



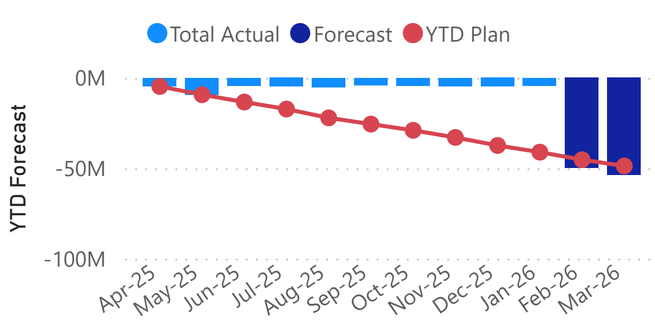
Recurrent Efficiency Plans Delivered (Forecast)



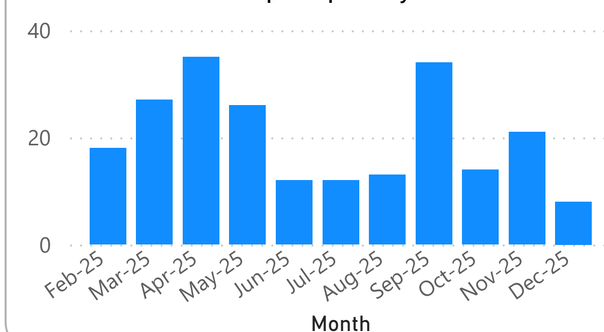
I&E distance from target (cumulative YTD)



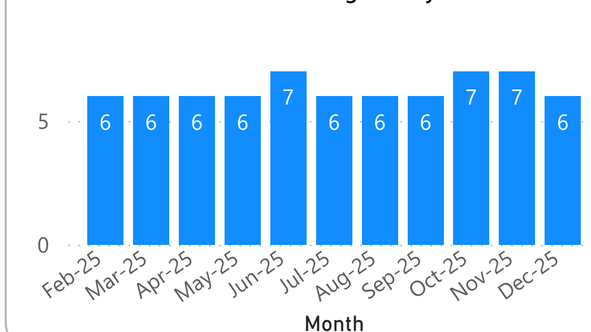
I&E Year End Forecast



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

No concerns re workforce metrics for research – sickness higher than target but being managed well and mainly drive by winter short term absences.

See Pioneering Breakthroughs section for research highlights.

Areas of Concern

See Pioneering Breakthroughs section

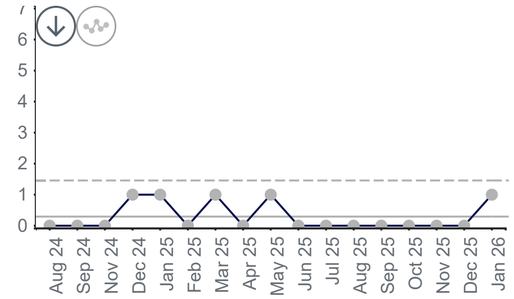
Forward Look (with actions)

See Pioneering Breakthroughs section

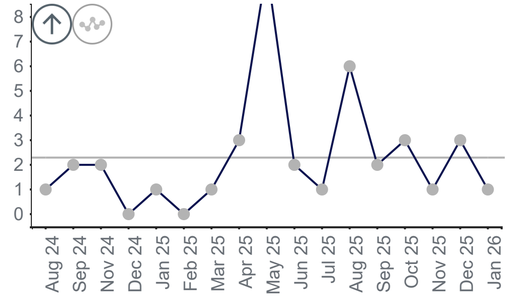
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

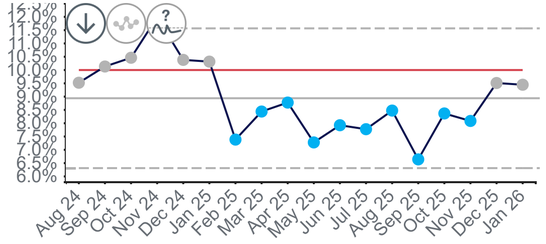


Patient Safety Incidents rated No Harm

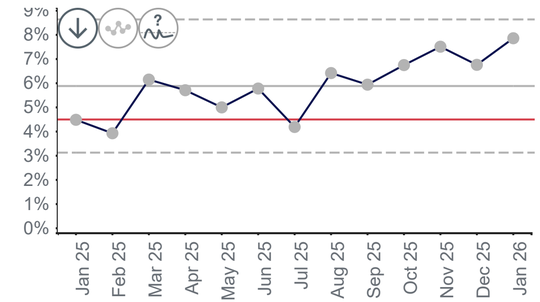


Staff Turnover

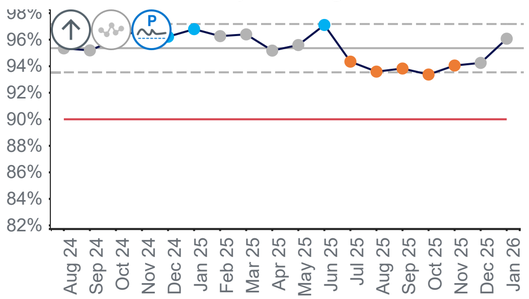
Target: Internal



Sickness Absence Overall

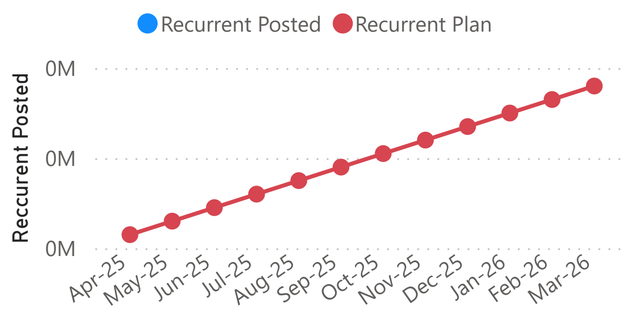


Mandatory Training

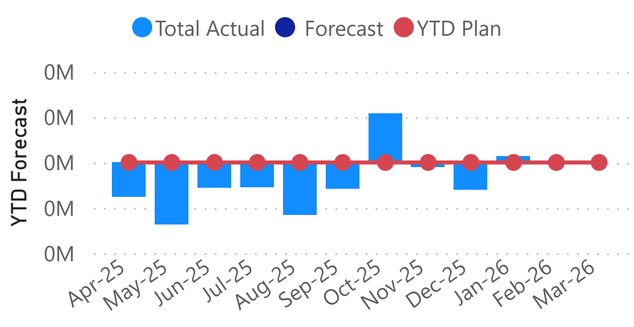


Workforce Stability

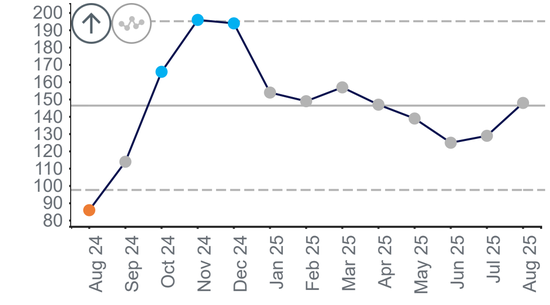
Recurrent Efficiency Plans Delivered (Forecast)



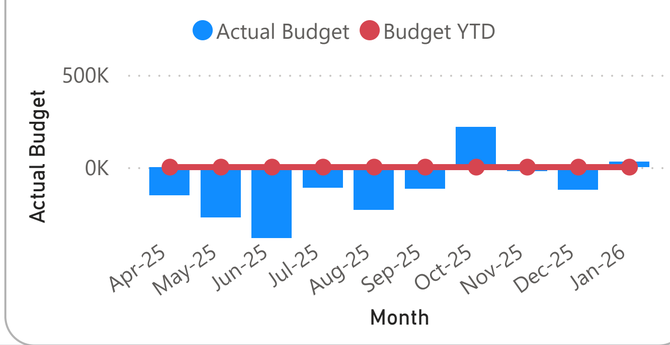
I&E Year End Forecast



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 16th February 2026; highlights from the January data include:

- PDR compliance for B7+ remains above Trust target at 94%
- Mandatory training remains above target at 93%
- Delivery of nearly £5.8m in CIP (exceeding the in-year target by £0.4m).
- 94% 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 19 documents have become overdue from December 2025; plans are in place to review this documentation in the coming period.

Areas of Concern

- Overall sickness absence remains above target at 7% for the month of January 2026.
- Long term sickness absence is sitting at 5% and is outside of Trust target of 2.5%.
- Short term sickness increased slightly to 2.4%.
- PDRs for all staff within corporate services is sitting at 84% against a 90% target.
- WTE is current above planned budgeted establishment by 101.10
- Remaining gap of £0.08m in Recurrent CIP

Forward Look (with actions)

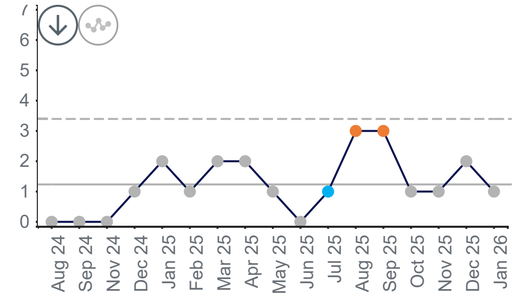
- Further analysis to distinguish between work-related and non-work-related stress absences.
- Focus on financial position, system finance and opportunities.
- Forward look for the collaborative in terms of how we interface with Fit for the Future.

Integrated Performance Report | February 2026

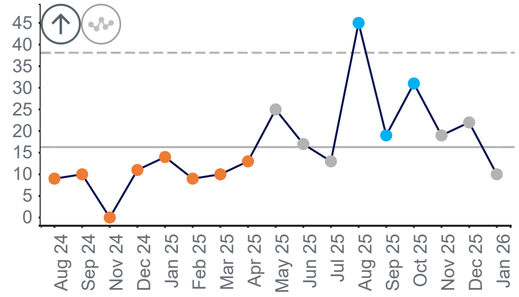
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

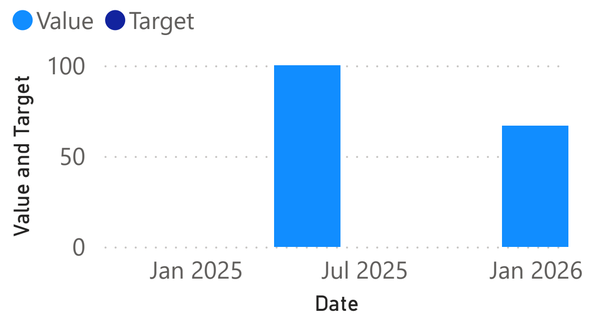
Patient Safety Incidents rated Low Harm & Above



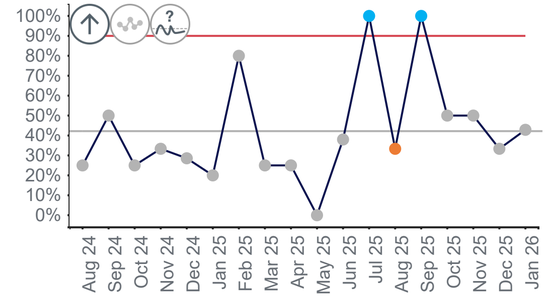
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

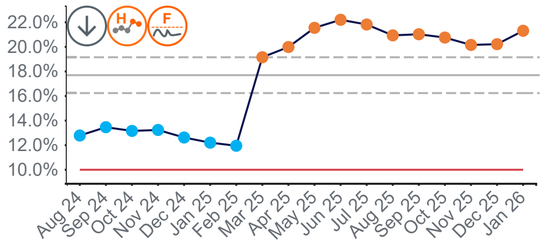


% PALS Resolved within 5 Days

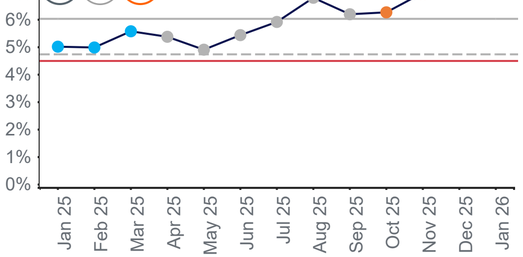


Staff Turnover

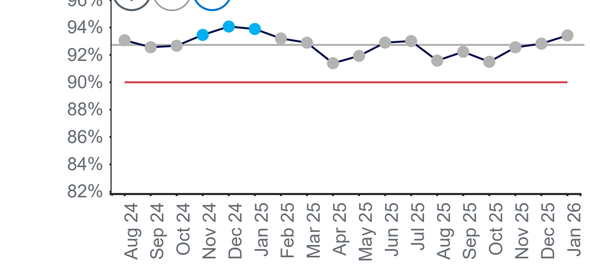
Target: Internal



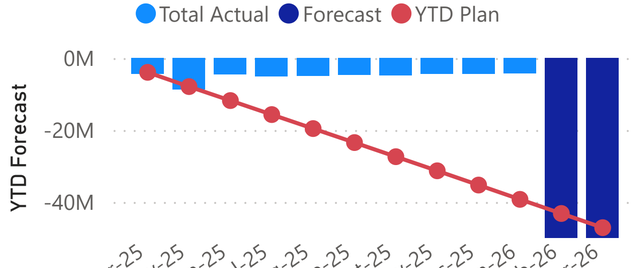
Sickness Absence Overall



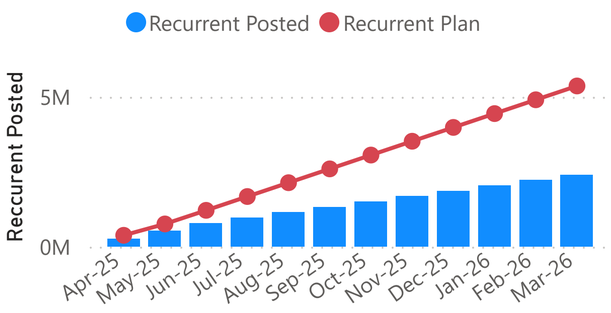
Mandatory Training



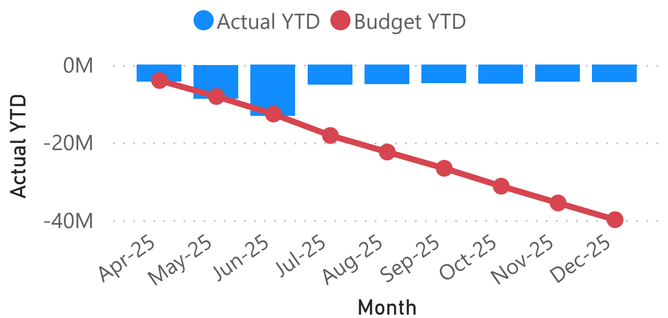
I&E Year End Forecast



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 January 2026 Staffing, CHPPD and Benchmark

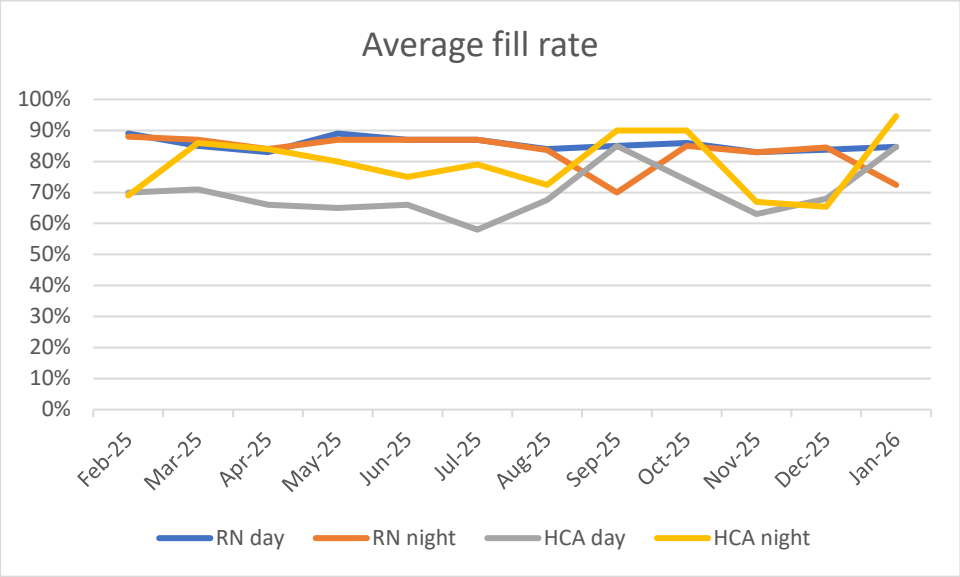
	Day		Night		Patients	CHPPD	National benchmark	Availablity		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate	Sep-25	RN - FTE	HCA - FTE	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of response	% Very good and good		
Burns Unit	85%		97%		87	20.60	18.87	530.51	31	0		0		0.00	0.00%	0.00	0.00%	1.84	0.35%	0	0.00%	0	0	0	0	4	100%	0	0
HDU	68%	29%	66%	45%	233	29.90	26.08	2,151.00	58.28	0.00		3.23		0.00	0.00%	0.00	0.00%	100.15	4.66%	0	0.00%	4	4	1	1	1	100%	0	0
ICU	82%	87%	84%	40%	471	36.20	36.07	4,980.12	101	0.00		1.00		0.00	0.00%	0.00	0.00%	337.43	6.78%	9	8.91%	5	5	0	0	2	100%	0	0
Ward 1cC	86%	65%	83%	107%	514	13.30	11.5	1,851.73	155.83	0		0.08		0.00	0.00%	0.00	0.00%	189.51	10.23%	36.52	23.44%	5	5	5	5	3	100.00%	0	0
Ward 1cN	94%		104%		230	16.80	18.12	1,223.47	24.8	0		1.63				0.00	0.00%	76.17	6.23%	0	0.00%	2	2	2	2	1	100%	0	0
Ward 3A	94%	55%	94%	127%	693	11.00	8.39	1,635.52	398.83	0		2.46		0.00	0.00%			255.53	15.62%	85.53	21.45%	0	0	0	0	17	94.00%	1	0
Ward 3B	92%	135%	90%		371	13.70	13.83	1,206.99	177.4	3.89		2.09		0.00	0.00%	0.00	0.00%	64.11	5.31%	10.56	595.00%	5	5	0	0	1	100%	0	0
Ward 3C	75%	66%	73%	77%	611	11.20	9.87	1,800.79	501.37	0.71		2.65				0.00	0.00%	131.48	7.30%	90.07	17.96%	5	5	0	0	8	87.50%	0	0
Ward 4A	76%	68%	73%	216%	701	11.20	9.33	2,036.60	160.37	0		2.99		0.00	0.00%	0.00	0.00%	273.03	13.41%	23.88	14.89%	3	3	0	0	17	94%	1	0
Ward 4B	87%	85%	73%	86%	547	15.00	4.72	1,188.50	1341.02	0		1.15		0.00	0.00%	0.00	0.00%	122.08	10.27%	180.97	13.50%	6	6	0	0	6	67%	1	0
Ward 4C	93%	62%	95%	59%	571	11.00	9.32	1,742.93	0	0		4.69		0.00	0.00%	0.00	0.00%	151.91	8.72%	17.79	8.52%	11	11	0	0	14	92.86%	0	1

The purpose of the Safe Staffing and Patient Quality Indicator Report is to provide a comprehensive summary of Nurse Registered and Unregistered staffing fill rates and Care Hours per Patient Day (CHPPD). The report highlights key areas of concern, particularly where staffing fill rates fall below 80% and considers the potential implications for patient experience and clinical outcomes. Staffing fill rates are calculated by comparing the planned number of Registered Nurses (RN) and Health Care Assistants (HCA) hours across both day and night shifts against the actual hours worked over the month. This information is captured daily through the electronic roster system, which generates an accurate monthly percentage fill rate. These rates include all hours worked by bank staff. The CHPPD benchmark used within the report is based on Model Hospital data from September 2025 which is the most recent dataset currently available. To note this benchmark may not fully align with current activity levels or patient acuity within the Trust.

With the exception of Ward 1C(Neonatal) and Ward 3B, all inpatient areas are currently reporting CHPPD levels above the benchmark. This variance is predominately driven by lower bed occupancy during the reporting period, resulting in a higher number of care hours delivered per patient than would typically be expected. As the staffing establishment is maintained to ensure safe minimum levels ,a reduction in patient numbers inflates the CHPPD calculation., Additionally, all beds were opened on 29th January across wards 3A (4 beds),4A (4 beds), and 3C (8 beds) which may influence overall staffing metrics as staffing levels have remained stable while the number of available beds increased only at the end of the month.

Nursing and care staff average fill rate January 2026		Nursing and care staff average fill rate January 2026	
Day average fill rate		**Night average fill rate**	
Registered (%)	**Care Staff (%)**	**Registered (%)**	**Care Staff (%)**
84.7% ↑	72.4 % ↑	84.7% ↑	94.6% ↑

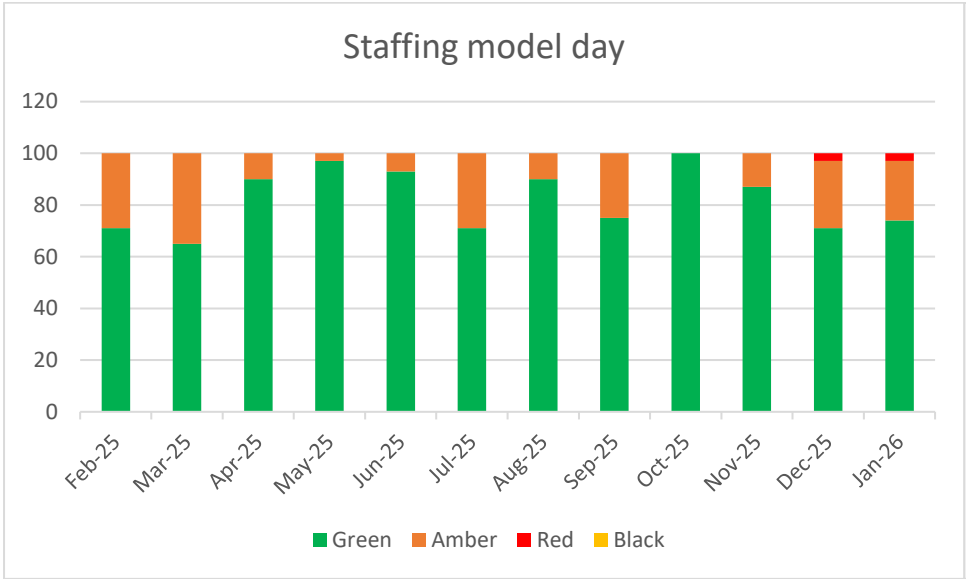
All fill rates have slightly increased. HCA night fill rate has significantly increased; this is due to an increase of 216% on 4a for to 1:1's.

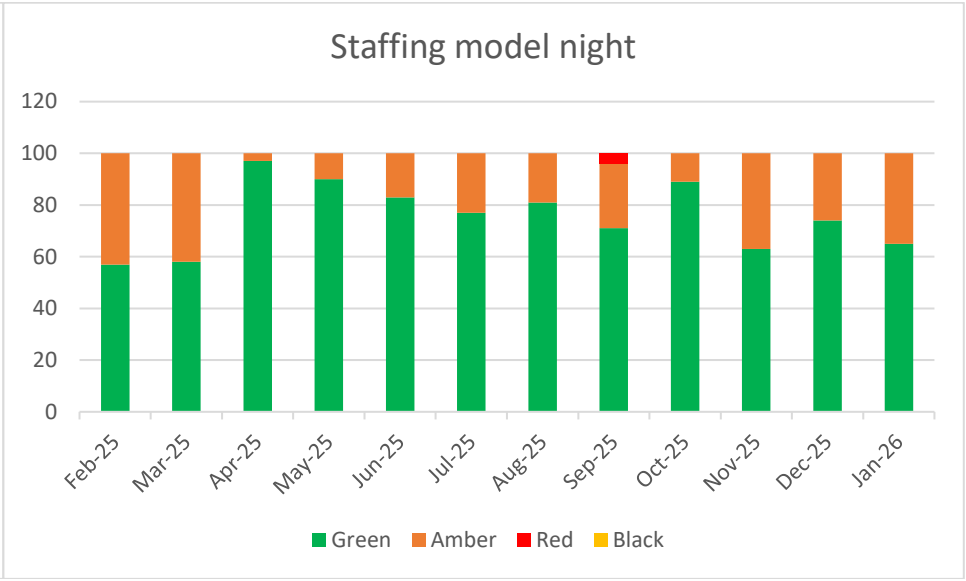


Summary of Staffing models February 2025- January 2026 Registered Nurses

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

January staffing status saw increased amber shifts across nights and 1 reported red shift on days.





Registered Nurse and Unregistered Bank Spend January 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 by 14.4% in January 2026 compared to December 2025. 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 Sunflower House where there are staffing gaps and specific nursing skills are required. There has been a deep dive reviewing the request for bank with the requirement for specific skills commonly listed as a reason. The senior nurses will continue to work together to address this, and Heads of Nursing continue to have oversight and scrutiny in ensuring the request for bank has gone through the correct process. To note there is no agency within the wards and specialist nursing teams. There continues to be a small amount in theatres, but this has significantly reduced.

Within the month of 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 7.2 % from December 2025 but continuing to remain low compared with the same period last year. This reduction is particularly positive given on-going substantive workforce gaps and higher than usual sickness levels across the Trust. Ward 3C, which had long standing substantive HCA vacancies, has strengthened its establishment with 3 new starters in June and a further 6 redeployed staff who commenced in September. In addition ,12 NHSP trainees have recently completed their competencies and have all been appointed to permanent HCA roles within the Trust, further reducing historic gaps. Substantive recruitment continues at pace, with prioritisation of high demand wards to maintain staffing resilience. These collective actions demonstrate strong grip, effective controls .and sustained improvement in workforce efficiency, contributing to reduced reliance on temporary staffing.

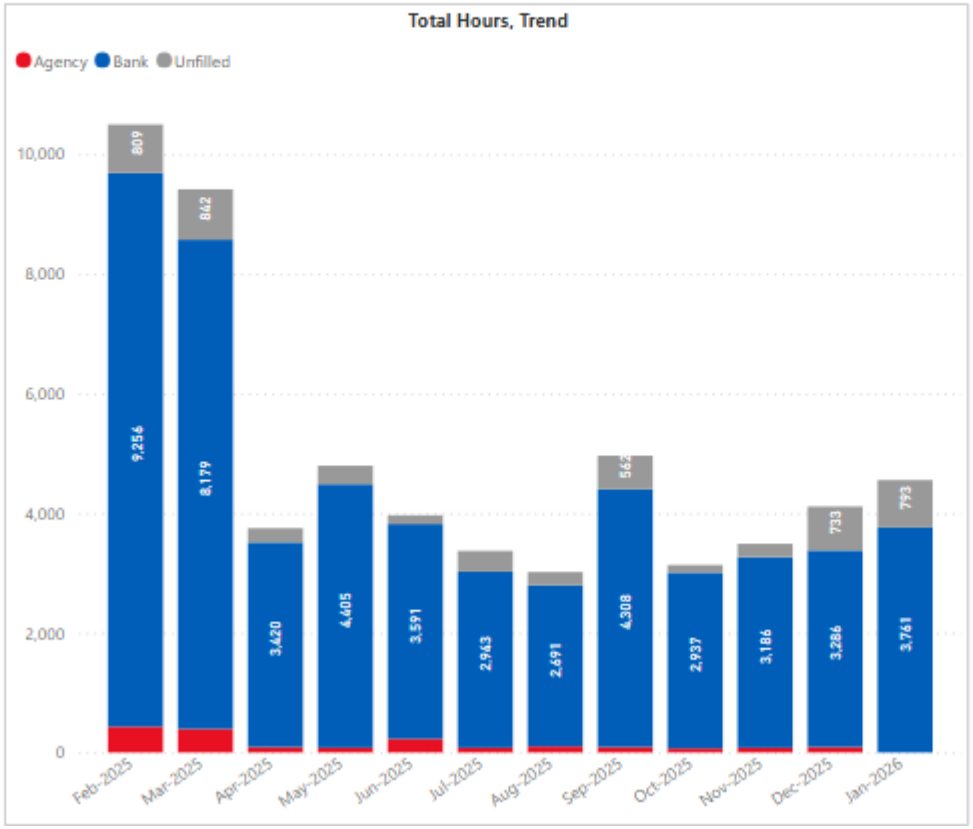
Registered Nurse Bank Spend January 2026

Staff Group
Hours Performance

NHS Professionals

YOY Comparison for Jan-2026

WTE	28.0 ! (57.6)
% Total Fill	82.6% ! (95.7%)
% Bank Fill	82.6% ! (89.7%)
% Agency Fill	(Blank) (6.0%)
% Unfilled	17.4% ! (4.3%)



Demand: in Jan-2026 totalled 4,553 hours (449 shifts), a change of 10.8% on Dec-2025

Bank: in Jan-2026 totalled 3,761 hours (376 shifts), a change of 14.4% on Dec-2025

Unfilled: in Jan-2026 totalled 793 hours (73 shifts), a change of 8.2% on Dec-2025

Agency: in Jan-2026 totalled hours (shifts), a change of -100.0% on Dec-2025

Unregistered Nurse Bank Spend January 2026

Staff Group
Hours Performance

NHS Professionals

YOY Comparison for Jan-2026

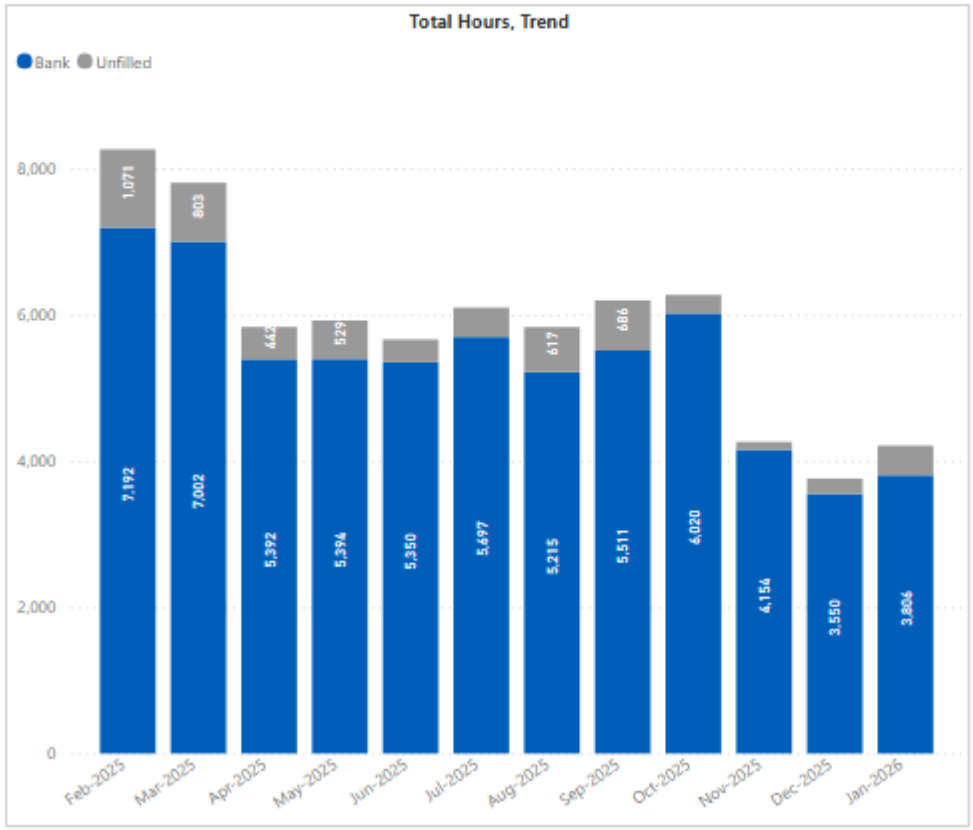
WTE
25.9 !
48.1

% Total Fill
90.4% !
91.5%

% Bank Fill
90.4% !
91.5%

% Agency Fill
(Blank)

% Unfilled
9.6% !
8.5%



Demand: in Jan-2026 totalled 4,210 hours (402 shifts), a change of 12.0% on Dec-2025

Bank: in Jan-2026 totalled 3,806 hours (363 shifts), a change of 7.2% on Dec-2025

Unfilled: in Jan-2026 totalled 405 hours (39 shifts), a change of 92.2% on Dec-2025

Agency: in Jan-2026 totalled hours (shifts), a change of -100.0% on Dec-2025

KPI E-Roster January 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 shits in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days **(5th January - 1st February 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)	46	31.76%	80.00	-45.17	0.00%	0		23.74%	13.10%	11.45%	0.43%	0.40%	0.00%	26.55%
Accident & Emergency - Nursing (912201)	42	24.22%	720.00	196.4	2.08%	201.5		20.18%	10.42%	2.38%	1.27%	7.42%	7.99%	30.63%
Burns Unit (915208)	41	15.57%	140.00	101.32	15.40%	290		15.64%	14.08%	0.89%	0.89%	0.44%	22.64%	38.94%
Critical Care Ward (913208)	41	16.09%	1200.00	1535.44	4.74%	908		17.59%	10.99%	1.26%	1.08%	8.02%	5.60%	26.95%
High Dependancy Unit (HDU) (913210)	44	22.81%	640.00	260.55	5.53%	391		34.81%	14.59%	2.62%	2.39%	6.64%	9.75%	36.00%
Medical Daycase Unit (911314)	48	13.64%	50.00	0.85	0.00%	0	12	8.29%	8.50%	0.87%	0.00%	1.38%	0.00%	10.75%
Outpatients (916503)	47	15.78%	420.00	-205.95	1.59%	72		21.60%	10.62%	0.51%	1.09%	13.34%	2.38%	29.26%
Sunflower House (912310)	25	36.67%	190.00	212.4	18.68%	718	53	23.63%	19.75%	5.70%	2.28%	6.17%	0.00%	37.89%
Surgical Daycase Unit (915418)	44	26.91%	85.00	24.08	7.99%	234.42	1	20.75%	14.24%	0.10%	2.35%	7.72%	3.93%	28.34%
Theatres - Cardiac & Cardiology (915405)	44	27.48%	130.00	11.5	0.00%	0		15.69%	10.43%	3.09%	0.73%	5.10%	0.00%	19.36%
Theatres - Emergency (915420)	44	26.67%	230.00	47.08	2.49%	55.25		2.63%	13.69%	0.76%	0.63%	6.44%	0.00%	21.87%
Theatres - IP Anaesthetics (915423)	41	31.13%	82.00	72.5	1.88%	60.5	1	11.09%	11.16%	0.11%	3.47%	13.21%	0.00%	27.95%
Theatres - IP Porters (915435)	44	48.53%	101.00	65	5.07%	58.75		19.96%	12.08%	0.00%	4.82%	23.21%	0.00%	40.11%
Theatres - IP Recovery (915422)	44	19.30%	103.00	-4.23	2.60%	42		13.15%	14.14%	0.19%	7.03%	3.79%	0.00%	25.16%
Theatres - IP Scrub (915424)	44	25.11%	128.00	14.25	2.91%	56.5		13.48%	12.20%	1.36%	0.32%	9.45%	10.71%	38.04%
Theatres - Ortho & Neuro Scrub (915436)	44	21.07%	37.80	0.5	0.77%	20.5		7.56%	7.35%	2.34%	0.48%	9.30%	0.00%	19.59%
Theatres - SDC Anaesthetics (915429)	44	55.08%	58.40	-1.82	15.23%	158.5		17.37%	5.83%	2.38%	3.02%	17.77%	5.85%	34.84%
Theatres - SDC Recovery (915430)	44	38.20%	177.30	39.98	10.26%	148		14.11%	8.57%	0.56%	4.44%	13.76%	0.00%	27.32%
Theatres - SDC Scrub (915421)	44	31.28%	532.00	-4.5	3.89%	78		17.88%	9.75%	1.68%	7.88%	14.39%	4.90%	38.59%
Ward 1C Cardiac (913307)	34	19.93%	361.00	308.45	4.42%	284.5		15.03%	12.68%	1.68%	3.43%	11.67%	5.47%	35.52%
Ward 1C Neonatal (913310)	51	42.50%	556.00	1933.43	0.00%	0		16.51%	12.16%	3.93%	0.31%	6.82%	7.15%	34.08%
Ward 3A (915309)	44	35.32%	371.00	134.77	16.87%	1202.5	38	16.70%	13.51%	1.89%	3.74%	17.96%	4.72%	41.83%
Ward 3B - Oncology (911208)	47	17.95%	555.00	147.21	2.78%	138	1	14.51%	15.29%	2.58%	1.08%	7.47%	2.95%	29.41%
Ward 3C (911313)	47	32.17%	607.00	208.83	2.44%	184		29.02%	11.81%	2.64%	4.02%	10.69%	5.52%	35.04%
Ward 4A (914210)	44	42.14%	634.00	67.53	16.88%	1280	46	23.71%	10.95%	1.00%	1.89%	14.29%	10.76%	39.77%
Ward 4B (914211)	44	25.96%	533.00	203.85	2.21%	184	9	19.47%	14.91%	1.34%	1.34%	13.10%	3.77%	34.45%
Ward 4C (912207)	48	17.50%	280.00	133.27	3.56%	207		12.45%	12.42%	1.31%	4.50%	8.95%	4.65%	32.03%

Trust Summary 5th January- 1st February 2026

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

- **Lead time 43 days (KPI 42 Days)**
- **Net hours have increased from 4098 to 5458 KPI 9001 to allow for up to a day to owe or be owed)**
- **Bank /Agency has increased from 6039 to 6973 hours. There was a reduction in December to 4144 but has since increased.**
- **Sickness has reduced but continues to remain high at 9.6% (KPI <5%)**
- **Annual Leave 12% (11%-17%) & other leave 2.4% (<5%) all within the agreed KPI's**
- **Study Leave reduced from 2.2% to 2% so now within KPI. (KPI 2%)**
- **Additional duties have increased from 126 to 161 shifts. (KPI 0)**

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	Compliments, Complaints and PALS report Q3 2025/26
Report of:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

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

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

Risk number	Risk description	Score

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

Compliments, Complaints and PALS Report – Q3 2025/26: SQAC 25th February 2026

Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q3 2025/26 and a thematic analysis of the top reasons for complaints and PALS
Vision and Goals	The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. Where care and treatment does not meet the standard of care expected, the Trust has a duty to listen to their concerns, wherever possible resolve at the first point of contact, investigate concerns, and provide a full, appropriate, and compassionate response.

Strategic Objective	To reduce the number of PALS concerns and formal complaints by increasing the number of issues that are resolved at the first point of contact
Driver Metric	• PALS concerns responded to within 5 working days • Formal complaints acknowledged within 3 working days • Formal complaints responded to within 25 working days
Graph Key	Medicine Surgery Community & Mental Health Research & Innov Corporate **NB Where no data on graphs is yellow or purple this indicates zero for these services**

Figure 1: Complaints received by Division in Q3

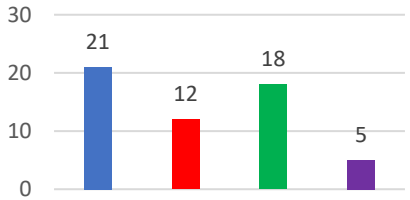


Figure 2: Number of complaints rolling 12 months

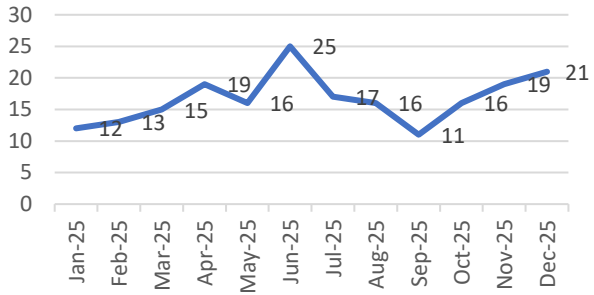


Figure 3: Primary category of complaints by Division in Q3

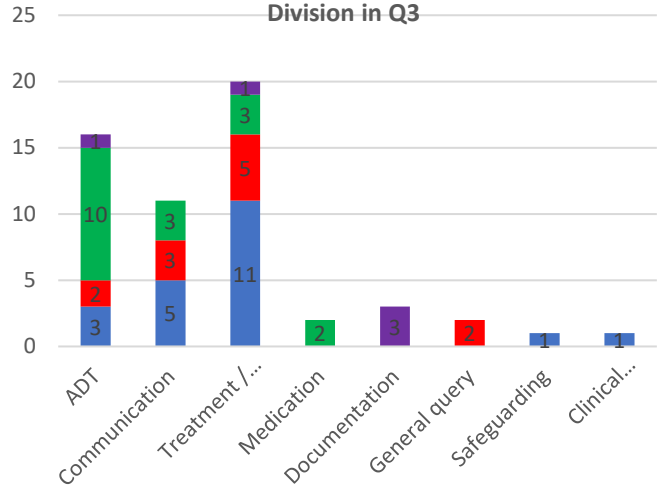


Figure 4: Compliance with 3 day acknowledgement of complaints rolling 12 months

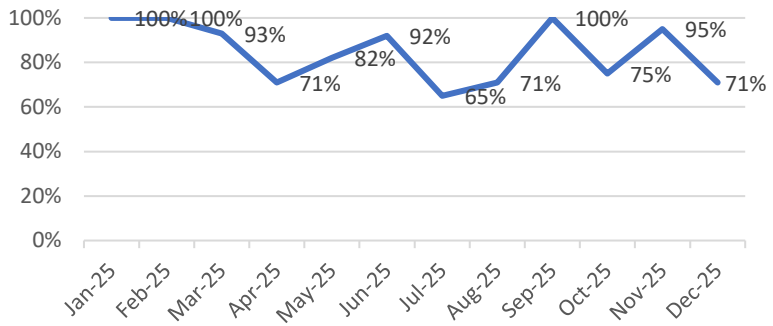


Figure 5: Compliance with 25 day response to complaints rolling 12 months

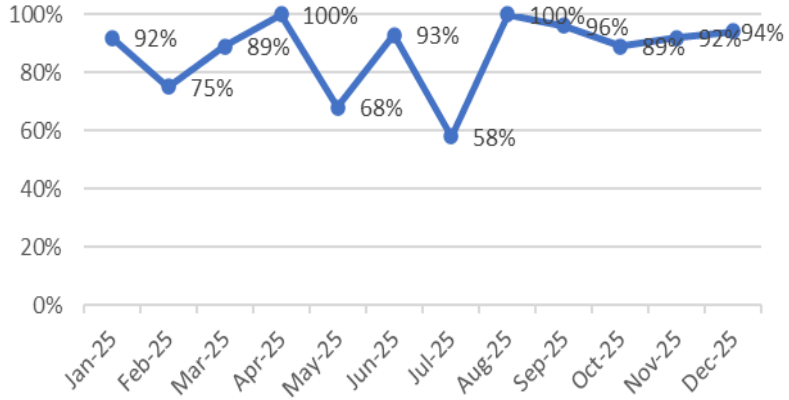
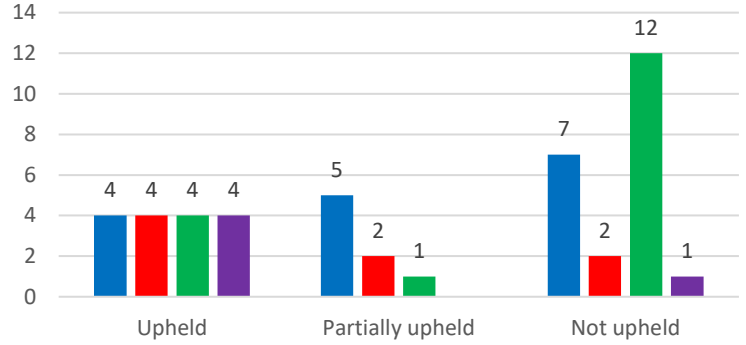
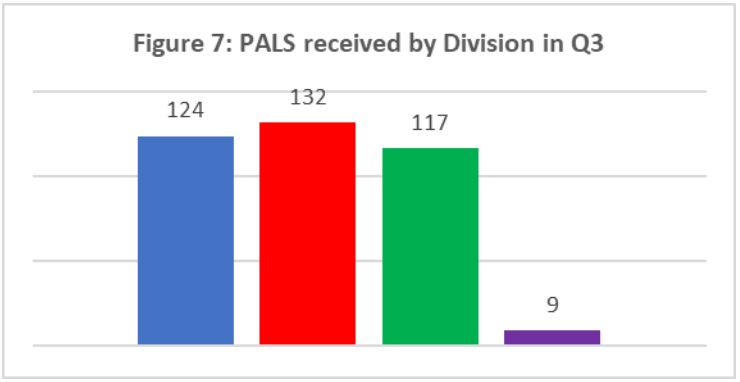


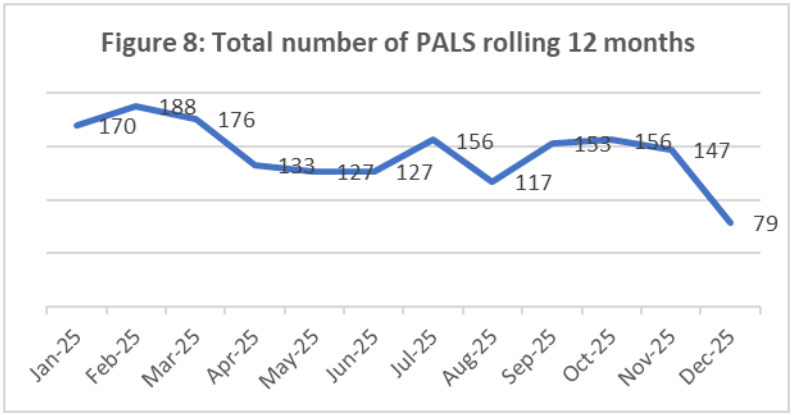
Figure 6: Outcome of complaints responded to by Division in Q3



Complaints: In Q3, 56 complaints received. Main reason continues to be treatment and procedure accounting for 36% of complaints received. Trust overall not compliant with the 3 day acknowledgement; average 80% compliance. 46 complaints investigated and responded to. Trust overall not complaint with the 25 working day response although compliance high at an average of 92%. The Divisions of Community & Mental Health, Medicine and Surgery achieved excellent compliance of 100%, 99% and 93% respectively. The Division of Community& Mental Health are to be particularly commended for achieving their highest compliance and sustained high performance by the Division of Medicine. 16 complaints fully upheld (34%), 8 partially upheld (17%), and 22 not upheld (48%).

Compliments, Complaints and PALS Report – Q3 2025/26

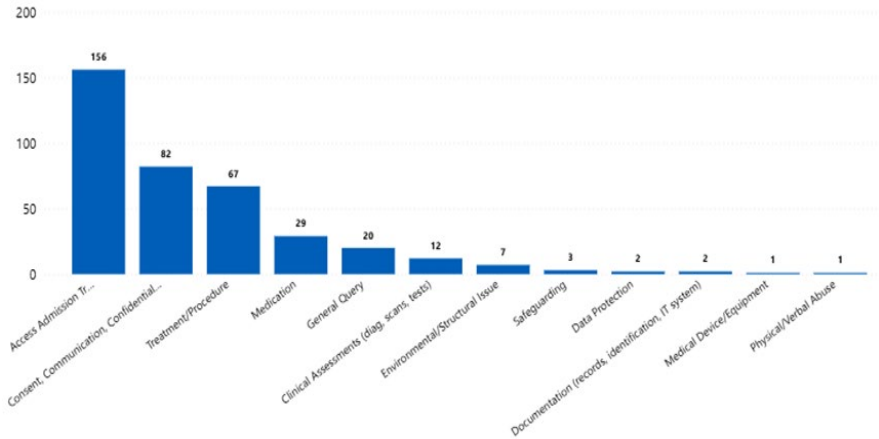


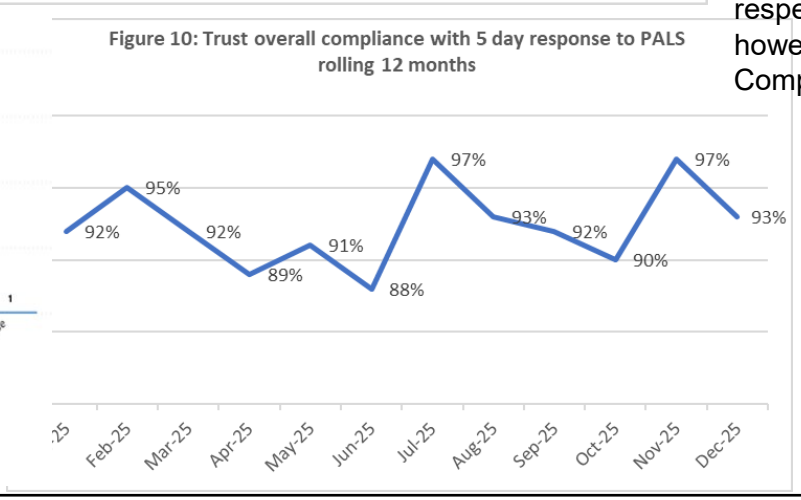


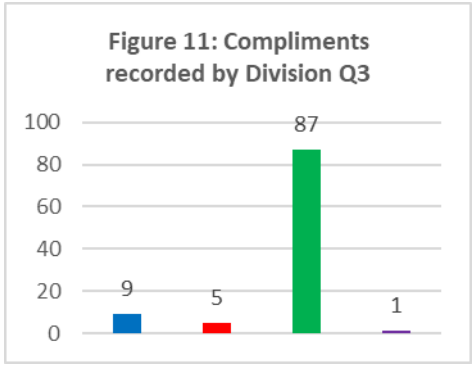
PHSO: No new PHSO cases opened in Q3. Three ongoing cases in the Division of Surgery and one case closed in the Division of Surgery in Division of Community and Mental Health

PALS: In Q3, 382 PALS concerns were received which is a significant decrease from Q2 (425). The main themes continue to be access to appointments accounting for 41% of the total in quarter and communication accounting for 21% of the total in quarter. High standard of compliance with the 5 working day response; average 93% compliance. The Divisions of Surgery, Medicine, and Community & Mental Health achieved excellent compliance of 97%, 94% and 91% respectively. Corporate services compliance decreased to 50% however their numbers are small which affects the percentage rate. Compliance is monitored at the Corporate Services Collaborative

Figure 9: Category of PALS Q3







Compliments: The Division of Community and Mental Health continue to record the largest number of compliments on InPhase

Success Highlights	• 93% of informal PALS concerns responded to within 5 working days • 92% of formal complaints responded to within 25 working days however there is room for improvement to ensure families receive a response in a timely manner • Significant improvement in compliance in the Division of Community & Mental Health who achieved 100% compliance in responding to formal complaints which is testament to the hard work and commitment to improvement. Continued and sustained high compliance in Divisions of Medicine and Surgery supporting our families to receive a prompt response to their concerns • Complaints and concerns policy under review in line with 2025 PHSO guidance; Divisions reviewing the process for receiving and triaging concerns and complaints
Feedback and lessons learnt	• Divisions capturing actions and sharing learning at the Patient Experience and Engagement Group
Escalation and Risks	• Data provided by BI team. There is sometimes changes to previous rolling data provided in previous reports

Actions and Lessons Learned from Formal Complaints closed in Q3 2025/26

- If staff have concerns regarding any aspect of the care plan, this should be escalated to the senior leadership team.
- Prioritise and improve communication with family and improve handover and record keeping to facilitate this
- Introduce families to the seclusion room as part of orientation and induction to the ward and review of mandatory seclusion documentation underway
- Review underway of the process for communicating changes in care plans. Additional daily Safety Huddle introduced where all patient documentation is available
- Record keeping audits to be undertaken
- Further guidance on age for independent attendance at out patient appointments to be recommunicated to reception staff
- PCO team have added the department email address to their voicemail so that parents have and alternative point of contact.
- Discuss the criteria for requesting imaging in patients with slow healing wounds after two courses of antibiotics.
- Reminder of the importance of escalating patients to member of the consultant team when parents have ongoing concerns.
- Service manager to review the laser inbox to ensure that families are responded to in a timely way.
- The importance of accuracy when documenting details of consultations in letters.
- Continue with the Quality Improvement Project to ensure timely administration of patient's own medications
- Children with rashes should be uncovered to be assessed at ED streaming desk or triage where appropriate, to ensure the most suitable care decisions are made
- The importance of clear, compassionate communication during consultations, particularly when discussing differential diagnoses

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**Safeguarding Children and Adults at Risk Annual Report 2024-2025**
Report of:	**Lisa Cooper** **Director of Community & Mental Health Services**
Paper Prepared by:	**Nichola Osborne** **Associate Director for Safeguarding and Statutory Services**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide an overview of Trust safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team from 01 April 2024 to 31 March 2025, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
2393	Safeguarding Training Compliance	9
271	Safeguarding Nursing Team Capacity	15
288	CAMHS Planned Safeguarding Supervision	15

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

Alder Hey Children's
NHS Foundation Trust

Safeguarding Children and Adults at Risk Annual Report 2024-2025

Safeguarding and Statutory Services

Executive Summary

The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2024 to 31 March 2025, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

The work activities undertaken by the Alder Hey Safeguarding Team during 2024/25 have been comprehensively documented within the quarterly safeguarding assurance reports received by the Safeguarding and Statutory Services Assurance Group (SASSAG) and the Safety and Quality Assurance (SQAC) Committee This report is intended to provide an overview and 'snapshot' of that work.

Successes during 2024/25 have included:

- Alder Hey Safeguarding Review by Mersey Internal Audit Agency (MIAA)
- Response to Fuller Inquiry Phase 1 Report
- Sexual Safety in the NHS work
- Recruitment of Named Professionals for Safeguarding

Challenges during 2024/25 have included:

- Gaps in Named Professionals for Safeguarding provision
- Recruitment of Vacant Safeguarding Nursing Roles
- Contributions to Local Safeguarding Adult Boards (LSABs), Local Safeguarding Children's Partnership (LSCPs) and Local Authorities.
- Supporting the safeguarding response to Southport

Whilst there are good safeguarding systems in place across Alder Hey, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope. With new and emerging risks in respect of contextual safeguarding being identified. As a result, Alder Hey must ensure that its safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee its safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in its care.

The identified safeguarding priorities for 2025/26 include:

- A comprehensive review of all safeguarding policies & standard operating procedures
- Digitalisation of the Service
- Improving Patient Experience
- Improving Child Death Statutory Processes

The Safeguarding Team remains committed to ensuring that children, young people, and adults at risk using Alder Hey services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with Trust colleagues and key partners to continuously improve systems to safeguard children, young people, and adults at risk.

Introduction

1. The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2024 to 31 March 2025, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

2. As such a condensed overview of the work activities undertaken by the Alder Hey Safeguarding Team during 2024/2025 are included in this report. These have previously been included in the quarterly safeguarding assurance reports received by the Safeguarding and Statutory Services Assurance Group (SASSAG) and the Safety and Quality Assurance (SQAC) Committee. This report is intended to provide an overview and 'snapshot' of that work.

3. The content of this report will be used to inform and assure Commissioners and may be used to inform and assure Local Safeguarding Children Partnerships (LSCPs) and Local Safeguarding Adult Boards (LSABs).

4. The report outlines the Alder Hey safeguarding governance arrangements and safeguarding activities within and relating to the Trust. It is designed to highlight key issues, working arrangements and recent developments.

5. Safeguarding is 'everybody's business' and the Alder Hey Safeguarding Team works to ensure that it continues to be the 'golden thread' running through all our services.

6. NHS England (2022) state in the Safeguarding Accountability and Assurance Framework (SAAF) that "*Fundamentally, it remains the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the wellbeing of those children and adults is at the heart of what we do*".

7. The Safeguarding Accountability and Assurance Framework (SAAF) (NHS England, 2024) clearly states that "*Fundamentally, every NHS organisation, and every individual healthcare professional working in the NHS, must ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied: **the needs of these at risk citizens and communities must be at the heart of everything the NHS does***" (page 16).

Alder Hey and Safeguarding Commissioning Arrangements

8. Alder Hey Children's NHS Foundation Trust employs is one of four stand-alone children's specialist providers in the country. Alder Hey provides a full range of secondary services to its local paediatric population as well as tertiary and quaternary care for a footprint stretching across the Northwest of England and beyond.

9. Alder Hey employs a workforce of 4,730 staff providing specialist healthcare to over 450,000 children and young people each year. In addition to the site at West Derby in North Liverpool, Alder Hey has a presence at a number of community outreach sites across Liverpool and Sefton. In collaboration with other providers, our staff also help

deliver care closer to children and young people's homes by holding local clinics at locations from Cumbria to Shropshire, in Wales and the Isle of Man.

10. The Trust provides a regional children's Tier 4 inpatient unit, Sunflower House, for children under the age of 13 who require mental health inpatient care. In partnership with the Royal Manchester Children's Hospital, Alder Hey also provides specialist gender-related care and support as part of the NHS Children Young People's Gender Service (North West).

11. Liverpool Place is the lead commissioner for the Alder Hey Safeguarding and Statutory Services across Liverpool, Sefton, and Knowsley, with Sefton Place taking the lead on the quality aspects of the contract. This means that Sefton Place undertakes a coordinating role on behalf of Cheshire and Merseyside Integrated Care Board (C&M ICB) for oversight of Safeguarding and Children in Care.

Legislative Frameworks - Safeguarding Children, Young People & Adults at Risk

Safeguarding Children and Young People

12. Safeguarding children and young people and promoting their welfare is defined as:

- Protecting children from maltreatment.
- Preventing wherever possible impairment of children's health or development.
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best outcomes.

13. Child protection is defined as being part of safeguarding and promoting welfare. It is the work done to protect specific children who are suffering, or are likely to suffer, significant harm.

14. The Working Together to Safeguard Children (2023) guidance is clear that children are best protected when professionals are clear about what is required of them and how they need to work together with others.

15. In addition, the guidance states that effective safeguarding can only be achieved by putting children at the centre of the system and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.

Safeguarding Adults at Risk

16. Safeguarding Adults at Risk of Abuse is defined in the Care Act (2014) as meaning:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.

- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, wishes, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances and therefore potential risks to their safety or wellbeing.

17. Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be some challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers and other professionals, where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

18. Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice.

19. Regardless of the developing context, all health organisations are required to adhere to the following arrangements and legislation (NHS England, 2024):

<table>
<tr><th colspan="3">Legislation for All</th></tr>
<tr><td colspan="3">▪ The Crime and Disorder Act 1998
▪ Female Genital Mutilation Act 2003
▪ Sexual Offences Act 2003
▪ Mental Capacity Act 2005
▪ Convention on the Rights of Persons with Disabilities 2006
▪ Mental Health Act 2007
▪ Children and Families Act 2014
▪ Modern Slavery Act 2015
▪ Serious Crime Act 2015
▪ Mental Capacity (Amendment) Act 2019
▪ NHS Constitution and Values (Updated January 2021)
▪ Domestic Abuse Act 2021
▪ Serious Violence Duty 2023
▪ Prevent Duty 2023</td></tr>
<tr><th>Safeguarding Legislation Specific to Children</th><th>Safeguarding Legislation Specific to Young People Transitioning into Adults, including Children in Care</th><th>Safeguarding Legislation Specific to Adults</th></tr>
<tr><td colspan="2">▪ United Nations Convention on the Rights of the Child 1989
▪ Children Act 1989 and 2004
▪ Promoting the Health of Looked After Children Statutory Guidance 2015
▪ Children and Social Work Act 2017
▪ Working Together to Safeguard Children Statutory Guidance 2023</td><td>▪ European Convention on Human Rights
▪ The Care Act 2014
▪ Care and Support Statutory Guidance – Section 14 Safeguarding</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019</td><td>Looked After Children: Knowledge, skills, and competencies of health care staff 2020</td><td>Adult Safeguarding: Roles and Competencies for Health Care Staff 2018</td></tr>
<tr><th colspan="3">Framework Specific to both Children and Adults</th></tr>
<tr><td colspan="3">Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2024</td></tr>
</table>

Alder Hey Safeguarding Governance Arrangements

20. All health providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

21. The Chief Nursing, Allied Health Professionals (AHP) & Experience Officer is the Board Executive Lead for safeguarding children and safeguarding adults at risk, with the Chief Executive retaining overall statutory responsibility.

22. The Chief Nursing, AHP & Experience Officer assumes all responsibilities expected of the Executive Lead for Safeguarding Children, Adults at Risk and Children in Care in line with the requirements of the NHS Contract, the NHS Safeguarding Accountability and Assurance Framework and the Safeguarding Children, Adults and Children in Care Intercollegiate Document. This includes executive responsibility in relation to:

    - Prevent Duty
    - Modern Slavery
    - Child Protection Information Sharing System (CP-IS)
    - Domestic Violence Duty
    - Serious Violence Duty

23. The Chief Nursing, AHP & Experience Officer also acts as the Executive Strategic Lead for Domestic Abuse and Sexual Violence and leads the Trust in the delivery of all the principles in the Sexual Safety in Healthcare Organisation Charter.

24. The Alder Hey Safeguarding Team forms part of Safeguarding and Statutory Services which sits within the Community and Mental Health Division. Day to day Director support for Safeguarding is the responsibility of the Director of Community & Mental Health Services.

25. Safeguarding and Statutory Services are led by the Associate Director for Safeguarding and Statutory Services supported by the Named Nurse and Named Doctor for Safeguarding Children, Young People and Adults.

26. The Clinical Director for Safeguarding and Statutory Services who commenced in post in December 2024 takes responsibility for leadership of the medical staff within the service.

27. The Associate Director for Safeguarding and Statutory Services is the identified statutory lead for Child Sexual Abuse and Exploitation, Forced Marriage, Prevent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Lead as required by the Standard NHS Contract.

28. The Associate Director for Safeguarding and Statutory Services meets with the Chief Nursing, AHP & Experience Officer regularly in relation to safeguarding matters, providing briefings to the Senior Leadership Team as appropriate to discuss issues such as serious safeguarding incidents, Acute Life-Threatening Events (ALTEs), Unexpected Deaths in Childhood (SUDICs) and allegations against staff members.

29. The Safeguarding and Statutory Services Assurance Group (SASSAG), chaired by the Director of Community & Mental Health Services, ensures Alder Hey effectively discharges the Trust's statutory responsibilities relating to safeguarding children, young

people and adults and those patients where additional vulnerabilities have been identified.

30. SASSAG provides assurance to the Trust Board via SQAC in the form of quarterly reports that safeguarding mechanisms and processes are integral to the work of the Trust regarding all service provision to ensure safety and better outcomes for children and young people.

31. The Safeguarding Operational Group (SOP) was established with the primary purpose is to ensure that safeguarding children and adults is a Trust wide priority with representation from all divisions. The group oversee safeguarding training compliance, discuss incident trends, and explore lessons learned from patient safety incident reviews, safeguarding inspections reports, serious safeguarding reviews such as Local Child Safeguarding Practice Reviews and allegations against staff.

Named Professionals for Safeguarding

32. Alder Hey has both an identified Named Nurse and Named Doctor for Safeguarding in line with the requirements of all NHS Providers as set out in the NHS Safeguarding Accountability and Assurance Framework (SAAF) (2024). The Associate Director for Safeguarding and Statutory Services leads the Named Professionals in their statutory responsibilities to ensure Trust safeguarding arrangements are robust.

33. Alder Hey's Named Professionals have a key role in promoting good professional practice within the Trust, supporting the local safeguarding system and processes, providing advice and expertise for staff, and ensuring safeguarding training is in place. They work closely with the Associate Director for Safeguarding and Statutory Services, Designated Professionals for Safeguarding in the relevant Place areas, and the LSCPs and LSABs.

34. A governance chart for Trust safeguarding arrangements has been provided in Appendix 1 of this report.

Internal and External Assurance Reporting Arrangements

Internal Safeguarding Reporting and Assurance

35. Health Providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

36. Providers must demonstrate that safeguarding is embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working (NHS England, 2024).

37. A Safeguarding Annual Report is provided to Trust Board following approval at SASSAG, and SQAC. The Safeguarding Quarterly Reports are provided to the SASSAG, and the SQAC for scrutiny and oversight as part of our safeguarding governance arrangements.

38. Briefing papers are completed by the Associate Director for Safeguarding and Statutory Services as appropriate to advise SQAC or Trust Board on new and emerging safeguarding issues as appropriate.

Cheshire & Merseyside Integrated Care Board (C&M ICB) Safeguarding Assurance

39. Data and quality analysis is provided quarterly to Designated Safeguarding Professionals at Sefton Place who act as 'Lead Commissioner' in line with commissioning arrangement and safeguarding contractual standards. Regular feedback regarding the level of assurance and quality of KPI submissions are provided by Designated Safeguarding Professionals at quarterly Business Meetings with the Associate Director for Safeguarding & Statutory Services and Named Professionals.

40. Designated Professionals for Safeguarding at C&M ICB are invited to attend SASSAG where there is discussion regarding the quality of KPI submissions. Their attendance at SASSAG supports openness, transparency and good working relationships between the Trust and our Commissioners.

Cheshire & Merseyside ICB Commissioning Standards

41. The Alder Hey Safeguarding Team are required to submit evidence bi-annually to Sefton Designated Safeguarding Professionals to outline compliance against NHS Cheshire & Merseyside ICB '*Safeguarding Children, Young People and Adults at Risk Commissioning Standards*'.

42. These safeguarding commissioning standards contain safeguarding audit frameworks which are based on Care Quality Commission (CQC) Fundamental Standards, Section 11 of the Children Act 2004, and the Care Act 2015.

43. The Safeguarding Team populated the audit tool with the support of relevant corporate and divisional colleagues to gather the appropriate evidence.

44. The audit tool includes 63 standards across ten Key Lines of Enquiry (KLOE) as follows:

- Leadership and Organisational Accountability
- Safeguarding Processes
- Safeguarding Policies
- Safeguarding Training and Development
- Safeguarding Children
- Safeguarding Adults at Risk
- Children in Care
- Mental Capacity Act
- Child Death Review
- Lampard

45. The last required submission was in Quarter 4 of 2023/24 with Scrutiny Meetings with Designated Safeguarding Professionals subsequently taking place where evidence was reviewed against all standards. feedback from C&M ICB was provided in Quarter 1 2024/25 and an action plan was developed by the Safeguarding Team to address any 'red' or 'amber' rated standards.

46. The Commissioning Standards Action Plan has been overseen by SASSAG and submitted to the C&M ICB Designated Professionals for review as part of the quarterly KPI submissions.

Alder Hey Safeguarding Service Structure

47. The Safeguarding Team are a specialist team who help, advise, and support staff in working together to safeguard children and adults at risk. The team consists of safeguarding nurses/practitioners, on-call consultants and doctors, health care assistants and pathway coordinators.

48. The Safeguarding Team works from the Rainbow Centre and is known widely across the Trust as the 'Rainbow Team'.

49. The role of the team is to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee Trust safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in our care.

50. The Safeguarding Team support the training and development of our workforce of over 4,700 staff in respect of safeguarding to recognise and respond to abuse to safeguarding children, young people, and adults at risk in the Trust's care at the earliest opportunity. They also provide a range of support and supervision to enable the safe decision making.

51. The Safeguarding Team is committed to ensuring that children, young people, and adults at risk using our services are safe, and that their health needs are met. The team work collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

52. The Safeguarding Nursing Duty Team is available Monday -Friday (9am-5pm). The on-call safeguarding consultants are available Monday-Sunday (9am -10pm). The safeguarding doctors provide advice and support to colleagues across the Trust and complete child protection medicals for those children who are suspected or known to have been abused.

53. The team is based within the Rainbow Centre which is situated on the ground floor near the Emergency Department and provides a 'hub' for the co-ordination of the safeguarding service across the whole of Alder Hey. The facilities include office space, a paediatric sexual assault referral centre (SARC) and an Achieving Best Evidence (ABE) interview suite, as well as two dedicated examination suites, which provide a calm, caring environment where children who are suspected of being abused can be medically and forensically examined and interviewed.

54. The Rainbow Centre is a dedicated examination centre and child protection service. Our doctors supported by health care assistants and nurses, examine, and advise on the medical aspects of suspected or actual child abuse. This includes physical and sexual abuse, presenting in the community, Emergency Department (ED), or in our inpatient wards or Outpatients Departments.

55. The Rainbow Centre offers a multi-agency approach to the treatment of abused children with close liaison between Police, Children's Social Care, and Alder Hey staff.

56. The Safeguarding Team works closely with Unscheduled Care, Burns and Plastics, Critical Care, Gastroenterology, Orthopaedics, Paediatric Surgery, Neurosurgery, Oncology, Ophthalmology, Radiology, CAMHS and Medical Photography colleagues in the management of some of the most complex child protection investigations within the region.

57. Alder Hey has a large catchment area and provides secondary health care for the boroughs of Liverpool, Knowsley and Sefton. It is also a tertiary referral centre for specialist services with a specialist Paediatric Intensive Care Unit and Major Trauma Team which receives patients from the local and regional areas, e.g., North Wales, Cheshire and Merseyside, and across the wider Northwest.

58. By arrangement with these Boroughs, Police and Children's Social Care, any children requiring medical examination, are referred as per protocol to the Rainbow Centre at Alder Hey, to be seen by a member of the specialist safeguarding on call team.

59. For those children and young people who are inpatients and concerns of possible abuse are raised, the consultant with responsibility for the child will follow the relevant Alder Hey safeguarding procedure and make a referral to the consultant on call for the Safeguarding Team.

60. The Safeguarding Team provides the paediatric input for joint examinations with Forensic Medical Examiners (FME) for examination of children with suspected sexual abuse. The Paediatric Sexual Assault Referral Centre (SARC), located within the Rainbow Centre, is commissioned by NHS England Specialist Commissioners, and led by the SARC Clinical Director. The SARC Clinical Director along with the SARC Nurse Manager ensure the highest standards are maintained, and that existing staff have regular training updates.

61. The Safeguarding Team is required to attend multi-agency meetings to discuss findings of medical assessments, produce confidential medical and/or court reports. They also respond to information requests from both partner agencies and the LSCPs in relation to significant safeguarding incidents or other safeguarding partnership functions, such as multi-agency audit or performance management.

62. The safeguarding specialist nursing and practitioner element of the team is an integral part of the Trust Safeguarding Service, providing leadership, support, and training across the organisation. They play a central role in supporting the medical team, and children, young people, adults at risk and their families involved in safeguarding investigations.

63. The safeguarding nurses and practitioners within the team provide safeguarding supervision to nursing and allied professional groups on all aspects of safeguarding. They also provide support should staff be required to produce a court report or attend court.

64. The team also deliver all face-to-face Level 3 safeguarding mandatory training across the Trust.

65. The Safeguarding Team follows the good practice principles highlighted in the National Service Framework for Children (2004), Working Together to Safeguard Children document (2023), the Children Act (1989, 2004) and the Care Act (2014) and aims to promote child and adult centered care, whilst helping and supporting families through the safeguarding process. The Team supports the safeguarding of vulnerable adults whilst

recognising the Mental Capacity Act (2005) and the need to 'Make Safeguarding Personal'.

Safeguarding Child Protection Peer Review

66. Peer Review is the evaluation of work by colleagues in the same field in order to maintain or enhance the quality of the work or performance. It is a process to ensure that a child protection assessment and the medical opinion are as robust, accurate and evidence based as possible.

67. In February 2025 the Safeguarding Child Protection Peer Review terms of reference were reviewed and updated to ensure they aligned with the Royal College of Paediatrics and Child Health (RCPCH)Child Protection Peer Review Guidance

68. Child Protection Peer Review Meetings are the forum within which the findings and examining clinicians' opinions of child protection medical assessments are reviewed. It applies to both planned child protection medical assessment (those examinations booked by Children's Social Care or the Police expressly for the purpose of child protection assessment) and unplanned child protection assessment (where the child protection concern has arisen following the child's presentation to the hospital or paediatric setting).

69. Relevant members of the Safeguarding Team meet via Microsoft Teams on a weekly basis to discuss, and quality assure child protection cases being managed within Alder Hey.

70. Guidance for 'Peer Review in Child Protection' from the Royal College of Paediatrics and Child Health (RCPCH) (2023) states that for Paediatricians, "*Peer Review in Child Protection has become an established component of the Clinical Governance Framework, providing a safe learning environment. Effective clinical governance 'ensures that risks are mitigated, adverse events are rapidly detected and investigated openly, and lessons are learned'. Child Protection Peer Review is expected by the judiciary, GMC, and professional bodies. Evidence of participation should be presented at appraisal and revalidation*."

71. In addition, safeguarding clinicians attend three meetings annually to complete joint peer reviews with the safeguarding colleagues from Manchester, Sheffield, Leeds, and Newcastle to ensure there is a consistent approach to the medical safeguarding investigation process relating to abusive head trauma by the specialist tertiary services within the Northwest (Northern Heads).

Child Sexual Abuse Peer Review

72. The Sexual Assault & Referral Centre (SARC) Child Sexual Abuse (CSA) Peer Review aims provides a proactive culture of learning where Forensic Health Professionals (FHP), paediatricians and clinical SARC staff can review cases, discuss procedures, process and evidence bases, underpinning diagnosis and management and in doing so, provide a supportive environment to debrief cases with peers undertaking similar work. In turn this will help prevent professional isolation and aid sharing of best practice.

73. CSA Peer Reviews are face to face and held bi-monthly face with the Safeguarding Clinical Team and the Forensic Medical Examiners (FMEs).

Safer Recruitment Practices and Managing Allegations Against Staff

74. A vital element of the Trust's safeguarding arrangements is our safer recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults.

75. Alder Hey has a robust Recruitment and Selection Policy, this includes the requirement for Disclosure and Barring Service (DBS) checks as part of our safer recruitment arrangements in line with the NHS Standard Contract General Conditions.

76. Offers of employment at Alder Hey are made on a conditional basis as they are subject to satisfactory NHS safer recruitment pre-employment checks, including verification of identity, right to work, references, qualifications, professional registration (where appropriate), a DBS check and occupational health check.

77. Once employed, all staff are subject to DBS checks every three years during their employment with the Trust.

78. Alder Hey Standard Operating Procedures for Safeguarding Children and Vulnerable Adults have been written in line with the Children Act (1989, 2004), Working Together to Safeguard Children, a guide to inter-agency working to safeguard and promote the welfare of children (2023), LSCPs and LSABs policies and procedures.

79. Section 18 of the Procedures for Safeguarding Children and Vulnerable Adults is used when allegations are made against a person who works with children and their own family has been subject to child protection investigations or criminal prosecution.

80. It is essential that any allegation of abuse made against a professional who works at Alder Hey is dealt with fairly, quickly, and consistently, in a way that provides effective protection for the child or adult at risk and at the same time supports the person who is the subject of the allegation.

81. Allegations may relate to a person who has:

- Behaved in a way that has harmed, or may have harmed, a child or children/ or an adult with care and support needs.
- Possibly committed a criminal offense against children or related to a child, or an adult with care and support needs.
- Behaved towards a child or children or an adult in need of safeguarding in a way that indicates they may pose a risk of harm to children or adults with care and support needs.
- Behaved or may have behaved in a way that indicates they may be unsuitable to work with children or adults with care and support needs.
- Behaved in a way which raises questions about their ability to provide a service to an adult with care and support needs which must be reviewed, for example a conviction for grievous bodily harm against a person who does not have care and support needs.

82. The above-named procedures are overseen and managed by the Associate Director for Safeguarding and Statutory Services in collaboration with the Deputy Chief People Officer who inform relevant senior leaders in the event of a concern.

83. Senior leaders then make a determination regarding whether a referral should be made to the Local Authority Designated Officer (LADO) under the 'Allegations against people who work with children LADO procedures' or to the LSAB under the 'People in a Position of Trust (PiPoT) with adults with care and support needs protocol'.

84. The Associate Director for Safeguarding and Statutory Services contributed to 18 LADO processes in 2024-25.

Safeguarding Training

85. Safeguarding is a key part of our Trust mandatory training requirements to develop and embed a culture that ensures safeguarding is acknowledged to be everybody's business and the 'Golden Thread' throughout all services.

86. The Trust is required to maintain safeguarding training for all staff at 90% and this forms part of safeguarding KPIs overseen by Designated Safeguarding Professionals at Liverpool Place on behalf of Cheshire and Merseyside Integrated Care Board (ICB).

87. The NHS England SAAF (2024) outlines that all health providers must have effective arrangements in place to train all staff commensurate with their role and in accordance with the following intercollegiate documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).
- Looked After Children: Roles and Competencies of Healthcare Staff (2020)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).

88. In addition, the SAAF states that safeguarding must be included in induction programmes for all staff and volunteers. Named Professionals for both Safeguarding and Children in Care present at the face-to-face induction day for all new staff.

89. The Safeguarding Team provides mandatory safeguarding training for both clinical and non-clinical staff in accordance with the Royal College of Paediatrics and Child Health (RCPCH) standards, Royal College of Nursing (RCN), General Medical Council (GMC), Nursing & Midwifery Council (NMC) and Working Together (2023).

90. The Intercollegiate Documents, provide a framework to indicate the level of safeguarding training required for individual staff groups. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth Edition Intercollegiate Document (January 2019) suggests specialist trusts such as Alder Hey should be accessing additional mandatory training, which would include more in-depth safeguarding children knowledge, safeguarding adults and Looked After Children.

91. Level 1 and 2 safeguarding children training is completed via e-learning (with additional face to face sessions for staff unable to access online learning). Staff requiring level 3

safeguarding children and level 2 safeguarding adults were being offered training face to face in person or via Microsoft Teams to maintain their compliance.

92. Compliance for safeguarding and prevent training has been as follows throughout 2024/2025:

Alder Hey Children's NHS Foundation Trust Overall Safeguarding Training Percentage % Compliance Rates				
Training Level (Target Compliance 90%)	**Q1 2024/25**	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**
Level 1 Safeguarding Adults (Every year)	**93.31%**	**93.18%**	**94.16%**	**92.79%**
Level 2 Safeguarding Adults (Every 3 years)	**92.91%**	**93.81%**	**93.53%**	**93.47%**
Level 1 Safeguarding Children (Every year)	**94.68%**	**92.88%**	**93.33%**	**89.89%**
Level 2 Safeguarding Children (Every 3 Years)	**93.97%**	**95%**	**92.99%**	**92.47%**
Level 3 Safeguarding Children & Adults (Every 3 Years)	**86.62%**	**85.80%**	**86.14%**	**82.12%**

93. Level 3 Safeguarding Children and Adults Training has continued remained below the 90% compliance target set by C&M ICB throughout 2024/25.

94. In 2024/25, 805 staff were trained in Level 3 Safeguarding over 26 sessions (see table below):

Safeguarding Training 2024/25	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Level 3 training sessions delivered	2	1	2	2	2	2	4	2	2	2	2	3
Total number of staff face to face	39	31	31	65	33	71	82	70	30	66	69	100
Total number of staff MS teams	20	0	20	0	24	0	26	0	28	-	-	-
Total number of cancelled places	7	14	14	21	19	26	14	24	14	16	14	17
Total number of did not attend on the day of training	0	0	11	8	5	5	6	3	10	8	14	25
Total number of staff trained per month	59	31	51	65	57	71	108	70	58	66	69	100
Total number of staff trained per quarter	141			193			236			235		
Total number of staff trained	**805**											

Total number of cancelled places	**200**
Total number of 'did not attend' on the day of training	**95**

95. The Safeguarding Team have continued to provide additional safeguarding training sessions in a bid to improve compliance. In addition, in Quarter 4 MS Teams sessions were replaced with face-to-face training sessions to increase capacity from 20 to 40 places.

96. The Safeguarding Team have continued to highlight the reduction in staff compliance to senior leads, service leads, team leaders and individual staff. Safeguarding training compliance is a standardised agenda item at the bi-monthly Safeguarding Operational Group (SOG) which is attended by senior leaders and Divisional Associate Chief Nurses and is held every two months.

97. The establishment of the SOG has helped the Safeguarding Team to have a more focused discussion regarding safeguarding training compliance and work more effectively with Divisional colleagues to address areas with poor compliance.

98. Training compliance continues to be shared with Designated Professionals at Sefton as part of the KPI quarterly reporting submission.

99. Training compliance is included in the safeguarding quarterly report submitted to SQAC to ensure senior oversight and action regarding supporting non-compliant staff to access mandatory training. The Safeguarding Team work closely with the Learning and Development Team and receive regular reports identifying all staff that are within 90 days of becoming non-compliant.

100. Work in planned in 2025/26 to work with Learning and Development colleagues to modernise the safeguarding training booking system address the issues regarding non-attendance at training.

Multi-Agency Safeguarding Processes

Multi-Agency Safeguarding Hub (MASH) Requests

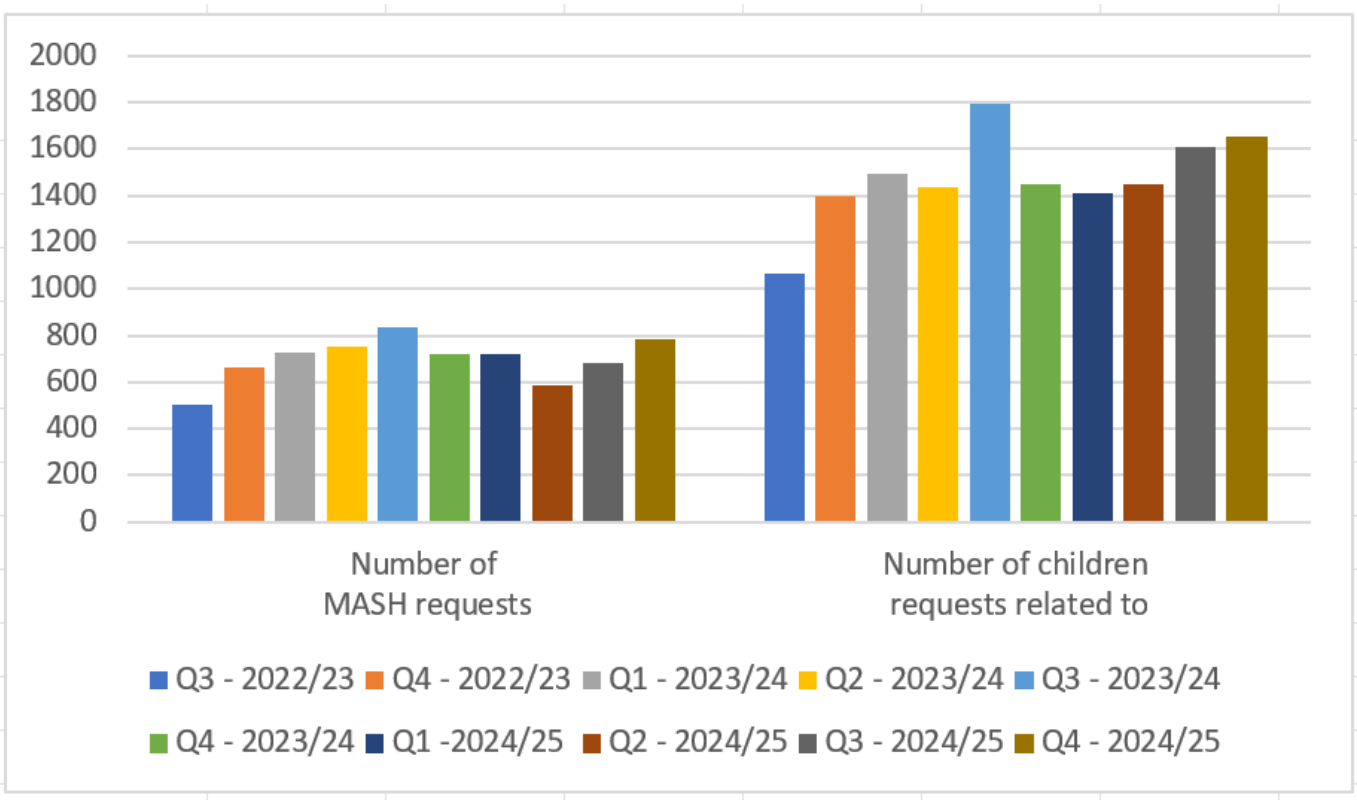
101. Alder Hey Safeguarding Team receives requests from five local authorities to share information with the Multi Agency Safeguarding Hubs (MASH) health representatives in respect of previous attendances and ongoing involvement for children where safeguarding concerns have been raised.

102. The MASH is the front door to Children's Social Care for all child protection and immediate safeguarding concerns which brings together agencies (and their information), to identify risks to children at the earliest possible point and respond with the most effective interventions.

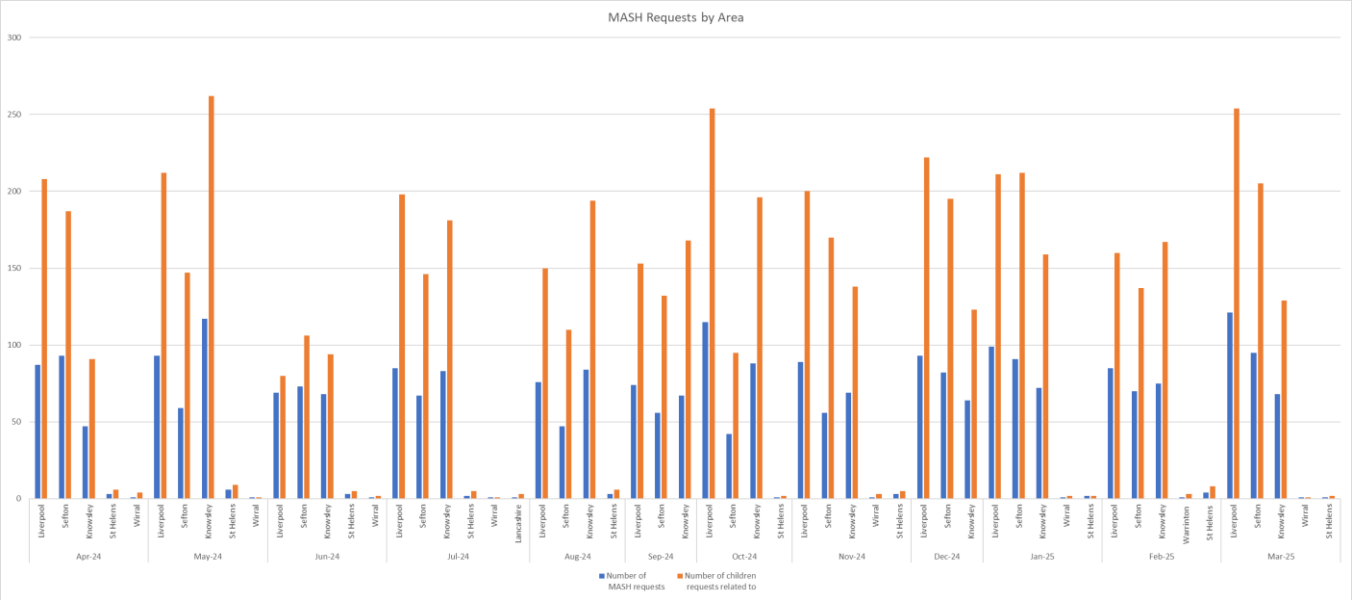
103. The Safeguarding Team first began collating MASH data in Quarter 3 of 2022/23. A summary of the data collated to date is outlined in the table below:

Quarter	2022/23		2023/24		2024/25	
	Number of MASH Requests	Number of children requests related to	Number of MASH Requests	Number of children requests related to	Number of MASH Requests	Number of children requests related to
Quarter 1	-	-	730	1497	721	1409
Quarter 2	-	-	753	1437	547	1447
Quarter 3	503	1067	838	1792	685	1612
Quarter 4	665	1401	719	1448	786	1652
Total	**1168***	**2468***	**3040**	**6174**	**2739**	**6120**

104. In 2024/25 the Safeguarding Team responded to **2739** MASH requests, relating to **6120** children from Liverpool, Sefton, Knowsley, Wirral and St Helen's (see graph below):



105. The graph below displays the MASH requests by Local Authority area:



106. When the data from 2023/24 is compared to 2024/25 there has been a **decrease of 9.9%** in the number of MASH requests however, the number of children MASH requests related to has only **slightly decreased by 0.87%**.

107. In 2023/24 there was concern regarding a significant increase in MASH requests, for example between Quarter 3 of 2022/23 and Quarter 3 of 2023/24 there was a 66.6% increase in the number of MASH requests. This has resulted in increased oversight of MASH and a MASH Health Meeting being held quarterly chaired by Designated Professionals for Safeguarding at Cheshire and Merseyside ICB to enable wider discussion with multi-agency partners.

108. MASH requests overall appear to have stabilised in 2024/25.

Statutory Safeguarding Inquiries and Reviews

109. The Safeguarding Team are required to contribute to the following statutory safeguarding reviews which are commissioned by LSCPs and LSABs:

Domestic Homicide Reviews (DHRs)

110. A DHR is convened by the Local Community Safety Partnership Board, is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

111. In 2024/25 the Safeguarding Team was asked to contribute to one DHR.

Safeguarding Adult Reviews (SARs)

112. A SAR is a multi-agency process that considers whether serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

113. In 2024/25 the Safeguarding Team have not been asked to contribute to any SARs.

Safeguarding Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs)

114. Safeguarding Rapid Reviews are initiated by Local Safeguarding Children Partnerships (LSCPs) following a serious child safeguarding incident where:

- Abuse or neglect of a child is known or suspected; and
- A child has died or been seriously harmed. This may include cases where a child has caused serious harm to someone else.

115. Following a serious safeguarding incident LSCPs conduct a Rapid Reviews which should identify, collate, and reflect on the facts of the case as quickly as possible to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

116. A Rapid Review will determine whether a Local Child Safeguarding Practice Review (LCSPR) should be commissioned using the criteria set out in Working Together 2023. A LCSPR is a multi-agency safeguarding review to identify improvements needed to local practice and wider systems.

117. In 2024/25 the Safeguarding Senior Leadership Team have completed **24 Rapid Review submissions** requested from Local Safeguarding Children Partnerships (LSCPs). This is a **60% increase** from the **15 Rapid Review submissions** requested in 2023/24.

118. The table below outlines the requests from LSCPs in 2024/25:

Place Area	**2024/25**			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Liverpool	3	1	4	1
Sefton	1	1	-	4
Knowsley	-	2	-	1
Cheshire West & Chester	1	-	-	-
Shropshire	-	-	-	1
Wirral	-	-	1	-
Tameside	-	-	-	-
Halton	-	1	-	-
Lancashire	-	1	-	-
Wigan	1	-	-	-
Total by Quarter	**6**	**6**	**5**	**7**
Total by Year	**24**			

119. This area of work is time consuming, complex and involves reviewing and critically analysing distressing information which has a significant impact on the capacity of the Safeguarding Team.

120. The Safeguarding Team also contribute to thematic and reflective reviews of cases of concern or 'near miss' scenarios which do not meet the threshold for a LCSPR.

121. A LCSPR is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death and there is cause for concern as to the way in which the relevant authority or persons have worked together to safeguard the child. LCSPRs replaced Serious Case Reviews.

122. The Safeguarding Team have a statutory responsibility to ensure that recommendations and any learning for the Trust from these reviews are appropriately actioned. This involves embedding learning and providing evidence to give assurance to Designated Professionals for Safeguarding at Place and LSCPs that learning has been embedded.

123. In 2024/25 the Safeguarding Team have contributed to **15** ongoing LCSPRs.

124. Themes in respect of safeguarding children reviews included domestic abuse, parental and child mental health, neglect, substance misuse, adverse childhood experiences (ACEs), suicide, child sexual abuse (CSA), child sexual exploitation (CSE), serious youth violence and child criminal exploitation (CCE).

125. Key learning themes from all safeguarding reviews across the life course include communication and information sharing between agencies, service user engagement, lack of professional curiosity and professional challenge and the need for improved record keeping.

126. LCSPRs should be completed and concluded within six months. However, the Covid 19 Pandemic resulted in the majority of LCSPRs taking significantly longer. This backlog in completion of LCSPRs has continued throughout 2024/25.

127. The Associate Director for Safeguarding and Statutory Services along with the Named Nurse for Safeguarding continue to work in partnership with Designated Nurses for Safeguarding Children in relation to active LCSPRs.

128. The Alder Hey Safeguarding Team continue to work with relevant services to embed the learning from these reviews and provide assurance both internally within the Trust and externally to Designated Professionals for Safeguarding and the relevant LSCPs.

Channel Panel

129. The Channel Panel is an early intervention safeguarding programme and the element of the national Prevent strategy that provides bespoke support to children and adults identified as being vulnerable to radicalisation, before their vulnerabilities are exploited by terrorist recruiters who would encourage them to support terrorism, and before they become involved in criminal terrorist related activity.

130. Like other safeguarding interventions, Channel Panel works by identifying individuals at risk of radicalisation via referral, assessing the nature and extent of the risk and then developing a support plan for the individual concerned. It is a confidential and voluntary programme. Referrals come from a wide range of partners including the police, health

professionals, schools, youth offending teams, children and adult services as well as members of the public.

131. The Channel Panel takes a multi-agency approach tailoring support to individual need. The type of support available is both bespoke and wide ranging and includes help with accessing mainstream services such as education, career advice, dealing with mental or emotional health issues, drug/alcohol abuse and theological or ideological mentoring from a specialist Channel Intervention Provider who works with the individual on a one-to-one basis.

132. As with other safeguarding work streams, Channel Panel is fluid in terms of the number and complexity of cases at any given time. The Safeguarding Team has attended monthly meetings and contributed to the discussion and sharing of information Channel Panel for both Liverpool and Sefton. The team support Channel Panel not just by attending and contributing to the meetings, but also by information sharing and acting as a conduit between Channel Panel and Alder Hey Services.

Safeguarding Team Meditech Orders

133. The Safeguarding Team also receives a significant number of safeguarding orders via our Electronic Patient Record System (EPRS) Meditech from across the Trust in relation to safeguarding issues which require specialist support and guidance. These may include concerns regarding parental substance misuse or parental mental health concerns, domestic abuse, chronic neglect, self-harm, Perplexing Presentations/Fabricated and Induced Illness, non-attendance known as 'Was Not Brought', non-compliance, or complex discharge issues.

134. Following work with Trust digital colleagues the Safeguarding Team now has a newly developed Meditech data dashboard. Access to this data allows the service to understand the demands in respect of Meditech safeguarding orders being reviewed and managed by the Safeguarding Specialist Nurses.

135. The data allows the service to look at data in terms of:

- Number of orders
- Routine and urgent orders
- Area the child lives
- Male/Female
- Speciality the order originates from
- Average and median turnaround times

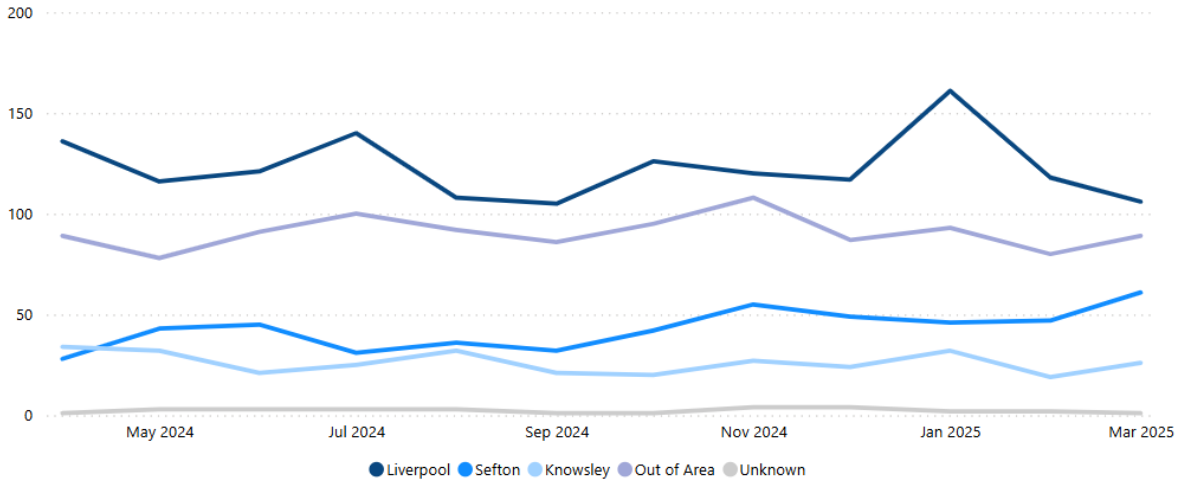
136. At the end of 2023/24 the first iteration of the Safeguarding Meditech Orders Dashboard highlighted that the Safeguarding Team received **3691** safeguarding orders in 2023/24 compared to **3415** safeguarding orders in 2024/25.

137. The data reflects that in 2024/25 1662 Safeguarding Meditech Orders were classified as **'routine'** and **'1753'** were classified as **'urgent'** compared with 2023/24 when **1759** Safeguarding Meditech Orders were classified as **'routine'** and **1932** were classified as **'urgent'** (see table and graph below):

Priority	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Routine 2023/24	137	157	179	180	178	130	129	132	118	146	125	148	**1759**
Routine 2024/25	120	137	130	132	135	114	146	160	136	156	149	147	**1662**
Urgent 2023/4	156	180	203	181	169	143	161	140	137	138	146	178	**1932**
Urgent 2024/25	168	135	148	167	136	131	138	154	145	178	117	136	**1753**
Total 2023/24	**293**	**337**	**382**	**361**	**347**	**273**	**290**	**272**	**255**	**284**	**271**	**326**	**3691**
Total 2024/25	**288**	**272**	**278**	**299**	**271**	**245**	**284**	**314**	**281**	**334**	**266**	**283**	**3415**

138. The data and graph below outline the areas the children resided in for Safeguarding Meditech Orders in 2024/25 as follows:

Locality	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Liverpool	136	116	121	140	108	105	126	120	117	161	118	106
Sefton	28	43	45	31	36	32	42	55	49	46	47	61
Knowsley	34	32	21	25	32	21	20	27	24	32	19	26
Out of Area	89	78	91	100	92	86	95	108	87	93	80	89
Unknown	1	3		3	3	1	1	4	4	2	2	1
	288	**272**	**278**	**299**	**271**	**245**	**284**	**314**	**281**	**334**	**266**	**283**



139. Access to this data helps the service to better understand demand and manage capacity going forward. The Safeguarding Team will continue to work with digital colleagues to gather relevant data to inform planning.

Successes During 2024/2025

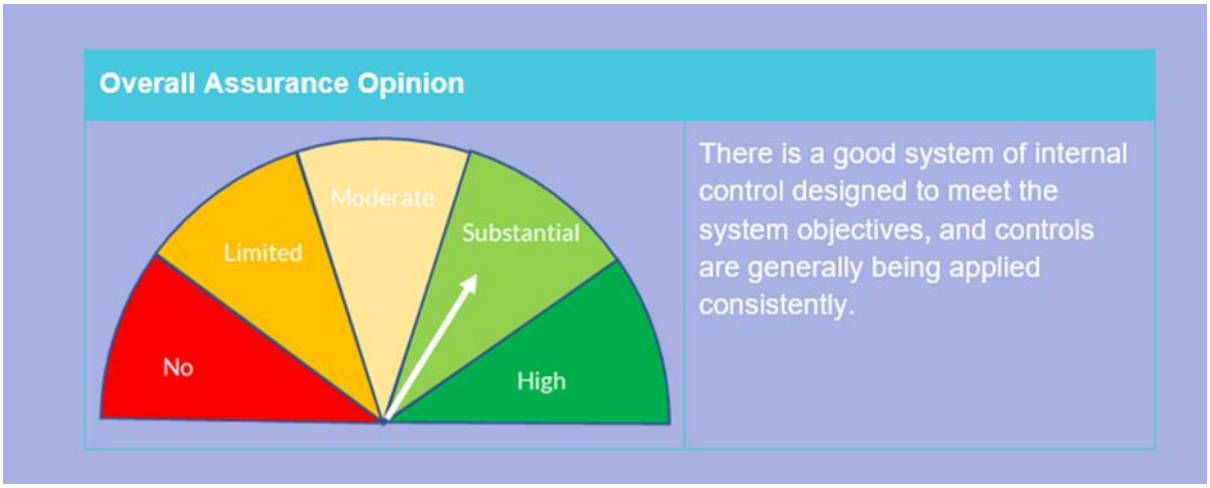
Alder Hey Safeguarding Review by Mersey Internal Audit Agency (MIAA)

140. The 2024/25 the Audit and Risk Committee commissioned MIAA to undertake a Safeguarding Audit of the Trust's systems and processes in relation to safeguarding, reviewing compliance with national policy and guidance.

141. The audit focused on six key terms of reference relating to:

- Policies and Procedures
- Governance
- Partnership Working
- Safeguarding Training
- Incident Reporting
- Performance Monitoring

142. The overall outcome of the audit was 'Significant assurance':



143. The objectives of the audit were reviewed and rated follows:

Objectives Reviewed	RAG Rating
Policies and procedures	Green
Assurance & risk management	Green
Partnership engagement	Green
Training	Green
Reporting system	Green
Performance framework	Green
Overall Rating	Substantial

144. The audit identified five key issues of low risk as follows:

Key Findings – Issues Identified	
	1. Policies and Procedures Trust policies and procedures relating to safeguarding have passed their review date. The Trust is in the process of updating the Safeguarding Procedures. All policies will then be updated accordingly.
	2. Terms of Reference for SASSAG and SOG In the light of changes in partnerships, staffing, and processes, group membership and standard agendas should be reviewed and both ToRs updated accordingly.
	3. Safeguarding supervision The review of safeguarding supervision should be completed alongside the peer review as planned, and any recommendations should be implemented on schedule.
	4. Review of Training Needs Analysis The Trust should review the Training Needs Analysis as planned and update its training offer as needed.
	5. Digitisation of the service The review of safeguarding-related policy and procedures is taking place alongside a review of all forms and documentation with a view to digitising the service. The Trust should develop and implement the digitisation project as planned.

145. The MIAA Safeguarding Audit of the Trust's systems and processes in relation to safeguarding, reviewing compliance with national policy and guidance in line with the Internal Audit Plan will be presented to the Audit and Risk Committee at the start of 2025/26.

146. The Safeguarding Team have developed an action plan to address the issues identified which will be overseen by the Safeguarding and Statutory Services Assurance Group (SASSAG) and provided to the Audit and Risk Committee as required.

Fuller Inquiry Phase 1

147. The Fuller Inquiry is an independent inquiry into the issues raised by the David Fuller case to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed.

148. The Phase 1 Report was published in November 2023 and made 17 recommendations for Maidstone and Tunbridge Wells NHS Trust.

149. Whilst the recommendations made in Phase 1 of the Fuller Inquiry pertained to Maidstone and Tunbridge Wells NHS Trust, it was agreed that Alder Hey Trust arrangements should be considered to ensure the security and dignity of the deceased children and young people in our care.

150. At the end of 2023/24 the Associate Director for Safeguarding and Statutory Services commenced work to review the 17 recommendations made in the Fuller Inquiry Phase 1 Report and self-assess Alder Hey's mortuary arrangements against these recommendations.

151. A briefing paper was provided to Trust Board at the start of 2024/25 in April 2024 which gave an overview of the Independent Inquiry, the recommendations outlined in the Phase 1 Report published in November 2023, the learning from the self-assessment work undertaken within Alder Hey in response to this, the actions required to achieve full assurance and the planned Phase 2 of the Inquiry.

152. The working group led by the Associate Director for Safeguarding and Statutory Services and the Associate Chief Nurse for the Division of Medicine has continued to meet throughout 2024/25.

153. An action plan has been devised and a security walkaround was completed in Quarter 1 to explore current security arrangements in the mortuary. Papers have been provided to SQAC to give an overview of progress and to inform next steps.

154. Phase 2 of the Inquiry will focus on the procedures and practices in place to safeguard the security and dignity of deceased people in other settings across England. It will also review the adequacy and effectiveness of the regulatory arrangements for the care of people after death.

155. It is anticipated that the Phase 2 Report will be published in Quarter 2 of 2025/26, and the recommendations will be considered by the Trust working group.

Sexual Safety in the NHS

156. In November 2023 Alder Hey Trust Board agreed to sign up to the Sexual Safety Charter which signals a commitment to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace.

157. An action plan was developed to ensure all ten charter commitments are in place. The action plan is overseen by the Sexual Safety Working Group which is led by the Associate Director for Safeguarding and Statutory Services.

158. The Working Group has representatives from safeguarding, nursing and governance, Human Resources and the Staff Advice and Liaison Service (SALS) and has met monthly during 2024/25 to progress the action plan.

159. A presentation on sexual safety was delivered to the Division of Surgery People and Well Being Group in Quarter 2. Further presentations were delivered to the Divisional Board Meeting for the Community & Mental Health Division, the Chief Nursing & AHP Officer Senior Leadership Team Meeting, and the Divisional Governance Meeting of the Division of Medicine in Quarter 3.

160. The Domestic Abuse and Sexual Violence Executive Lead and Operational Lead continue to attend quarterly webinars held by NHS England throughout 2024/25.

161. At the end of 2024/25 NHS England shared a National Policy Framework, Sexual Misconduct Policy Overview, eLearning training package and an Assurance Framework to support organisations in implementing the Sexual Safety Charter.

162. An update was provided in Quarter 4 to the People and Wellbeing Committee on the progress to date. Work will continue in 2025/26.

Recruitment of a Named Nurse and Named Doctor for Safeguarding

163. The Named Nurse for Safeguarding commenced in post on 01 May 2024.

164. The interviews took place for the Named Doctor for Safeguarding on 08 May 2024 which were conducted by the Chief Medical Officer, Director of Community & Mental Health Services, the Associate Director for Safeguarding and Statutory Services and a representative from the Royal College of Paediatrics and Child Health (RCPCH). The process included a panel face to face interview, a cross divisional staff focus group and a focus group with children and young people from the Forum. The role was successfully appointed to, and they commenced in post on 01 December 2024.

Challenges During 2024/2025

Named Professionals for Safeguarding

165. There have been challenges throughout 2024/25 in relation to Named Professional Safeguarding roles being fully completed due to key personnel being absent and subsequent vacancies.

166. This has significantly challenged the capacity of the senior nursing leaders regarding the management of safeguarding issues such as Perplexing Presentations and Fabricated and Induced Illness (FII) cases.

167. These challenges were added to the Service Risk Register, and mitigations put in place to maintain the service.

Recruitment of Vacant Safeguarding Nursing Roles

168. In Quarter 2 of 2024/25 there was significant recruitment to appoint vacant roles and recruit to roles due to new investment.

169. The Safeguarding Team will be advertising the following roles:
    - 1 WTE Band 8a Named Nurse/Named Professional for Safeguarding to support safeguarding in the Children and Young People Gender Service (CYPGS) – new investment.
    - 4 WTE Band 7 Safeguarding Specialist Nursing posts
        - 1 WTE to support safeguarding in the CYPGS – new investment.
        - 1 WTE to support Child and Adolescent Mental Health Services (CAMHS) safeguarding supervision – new investment.
        - 2 WTE for vacant posts.
    - Two WTE Band 6 Associate Safeguarding Nurse vacant posts.

170. Whilst the recruitment process has challenged capacity the additional investment into the service will have a positive impact on the services ability to manage increasing demand.

Contributions to Local Safeguarding Adult Boards (LSABs), Local Safeguarding Children's Partnership (LSCPs) and Local Authorities.

171. The Alder Hey Safeguarding Team continue to work with Designated Professionals to support the work of the LSCPs and LSABs (Liverpool, Sefton, and Knowsley) where appropriate. This has included developing action plans in response to recommendations and findings from Rapid Reviews/Critical Incident Meetings and Local Child Safeguarding Practice Reviews (LCSPRs) and Safeguarding Adult Reviews (SARs), ensuring they are robust and actively address any areas for practice improvement.

172. The Safeguarding Team has a vital role in embedding findings, recommendations and learning in front line practice; and ensuring Alder Hey can evidence impact of intervention. The team also takes a lead role in identifying wider thematic learning and ensuring that these themes inform our planning for workforce development, training, and quality assurance processes.

173. The introduction of the Children and Social Work Act (2017) brought about significant changes for safeguarding children. Local Safeguarding Children Board were abolished, and Local Safeguarding Children Partnerships were created. These changes resulted in NHS Provider Trusts being asked to step back from attendance at various LSCP forums Executives and Sub-Groups.

174. During 2024/25 the Alder Hey Safeguarding Team participation in LSCPs Sub-Groups has continued to dramatically increase along with the requirement to work with Local Authority Children's Social Care partners to support their improvement journeys. This has been a welcome development and has allowed the Trust to better contribute to multi-

agency safeguarding work, however it continues to significantly impact on the capacity of the Safeguarding Senior Leadership Team.

175. As part of our multi-agency work with LSCPs and LSABs the Safeguarding Team continues to participate in multi-agency audits and works to embed findings, recommendations and learning into front line practice, ensuring Alder Hey can evidence impact of intervention.

Southport

176. The Alder Hey Safeguarding Team has significantly supported the major incident response following the tragic events in Southport. This included being part of the Trust Tactical Command, overseeing statutory child death processes, supporting the criminal investigation, and taking a lead in the safeguarding response regarding the victims and the alleged perpetrator.

177. The team have continued to work with multi-agency safeguarding partners via the safeguarding Rapid Review process to identify learning responding to a number of competing demands within tight timescales.

178. The Associate Director for Safeguarding and Statutory Services will continue to work with colleagues from the Community and Mental Health Division to contribute to ongoing safeguarding multi-agency processes.

Safeguarding Priorities for 2025/2026

Safeguarding Policies & Standard Operating Procedures

179. During 2024/2025, the Safeguarding Team will comprehensively review all Trust Policies and SOPs owned by the team to ensure they are compliant with NICE guidelines, statutory guidance and LSCPs policies.

Digitalisation of the Service

180. The Safeguarding Team will continue work with digital colleagues to digitalise the Safeguarding Service. This work will help us to move away from paper-based records and increase business intelligence to inform future service delivery.

Improving Patient Experience

181. The Safeguarding Team will work with children and young people to improve the patient experience across Safeguarding and Statutory Services.

Improving Child Death Statutory Processes

182. The Safeguarding Team will work with colleagues including palliative care, chairs of Hospital Mortality Review Group (HMRG), Bereavement Team and Mortuary to improve statutory child death processes across the Trust.

183. This will include:
- Developing a Trust Wide Child Death and Bereavement Policy
- Reviewing and updating Child Death Order Sets within Meditech
- Develop a mortality module within InPhase
- Review attendance at key meetings related to child death such as HMRG and Child Death Overview Panel (CDOP).

Conclusion

184. The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee Trust safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in our care.

185. Work continues to train and develop the Alder Hey workforce to recognise and respond to abuse in order to safeguard children, young people, and adults at risk in the Trust's care at the earliest opportunity.

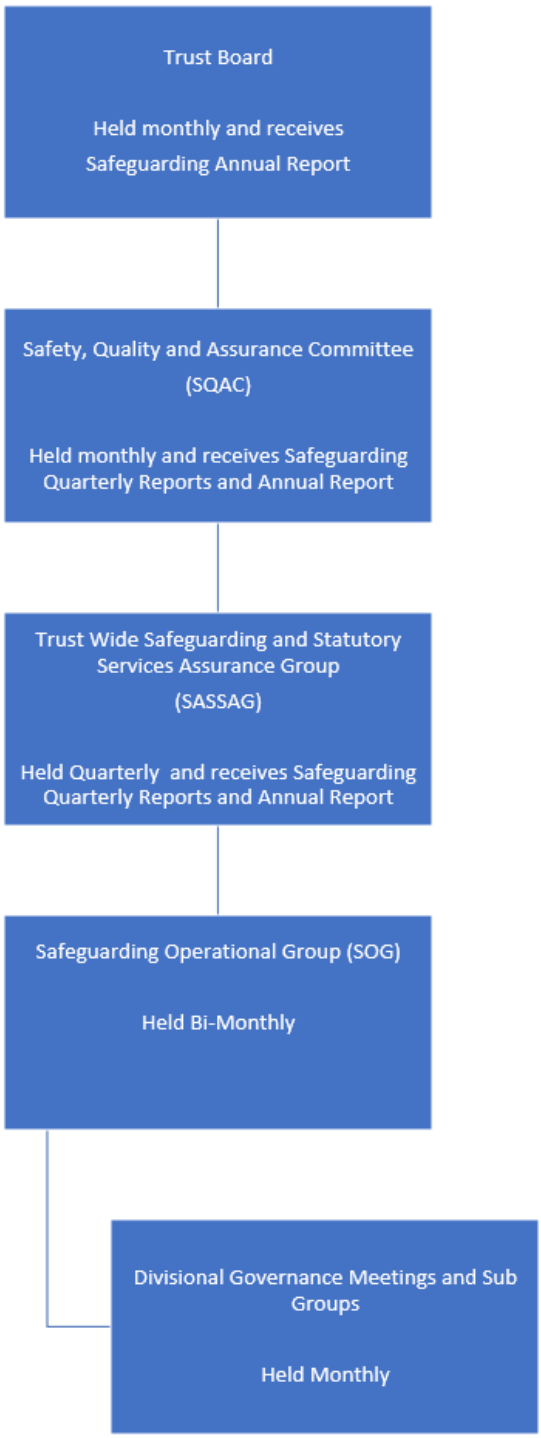
186. There are good safeguarding systems in place across the Trust. However, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope, and with new and emerging risks in respect of contextual safeguarding. As a result, the Trust must ensure that all safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

187. The Safeguarding Team remains committed to ensuring that children, young people, and adults at risk using our services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

188. This Safeguarding Annual Report for 2024/2025 has focused on the governance arrangements in place to deliver the safeguarding agenda; and the role that the Safeguarding Team plays in providing assurance, both internally and externally, so that the Trust fulfils its statutory safeguarding responsibilities.

189. Trust Board and the SQAC are asked to note the content of this report and accept assurances that systems and processes are in place to ensure Alder Hey Children's NHS Foundation Trust fulfils its statutory safeguarding responsibilities.

Appendix 1 – Alder Hey Children's NHS Foundation Trust Safeguarding and Statutory Services Governance Chart



BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**Children in Care Annual Report 2024-2025**
Report of:	**Lisa Cooper** **Director of Community & Mental Health Services**
Paper Prepared by:	**Nichola Osborne** **Associate Director for Safeguarding and Statutory Services**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide an overview of Trust Children in Care governance arrangements and a retrospective view of the work completed by the Children in Care Team from 01 April 2024 to 31 March 2025, to ensure the Trust meets its statutory responsibilities in respect of Children in Care.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
341	Named Doctor for Children in Care	16
453	Transferring and transcribing patient records following adoption	9
457	Children in Care Patient Demographics	6

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

Alder Hey Children's NHS Foundation Trust

Children in Care Annual Report 2024-2025

Alder Hey Safeguarding and Statutory Services

Executive Summary

The purpose of this annual report is to provide an overview of Alder Hey Children's NHS Foundation Trust (AHCH) arrangements for Children in Care (Looked After Children) and a retrospective view of the work completed in relation to this by the Safeguarding and Statutory Services Team for the reporting period 01 April 2024 to 31 March 2025. This annual report provides assurance that the Trust meets its statutory responsibilities in respect of Children in Care.

The work activities undertaken by the Trust's Safeguarding and Statutory Services Team, have been documented within the quarterly Key Performance Indicator Reports which have been prepared for the Cheshire and Merseyside Integrated Care Board (C&M ICB), and service delivery in line with the agreed service specification. Oversight and governance of internal performance is provided via the Safeguarding and Statutory Services Assurance Group and where appropriate the Community & Mental Health Divisional Governance Meeting and Board. This report is intended to provide an overview and 'snapshot' of that work.

Since 2023, the number of Children in Care nationally has started to decrease. With 2% decrease from March 2024. Currently Alder Hey primarily serves, Children in Care Services, for three Local Authorities (Liverpool, Sefton and Knowsley). Local data aligns with the national trend of a decreasing number of Children in Care as follows:

- Liverpool Children in Care -5.09% decrease
- Sefton Children in Care - 13.79% decrease
- Knowsley Children in Care - 3.62% decrease

Whilst there is decreasing numbers of Children in Care, it is evident that there has been an increase in the complexity of the health and social care issues being experienced by Children in Care. This requires Alder Hey to be adaptive in how it serves Children in Care and those transitioning who are subject to care orders into the adoption process and beyond.

Placement provision has seen shifts over the past year with Children in Care being more transient. There has been an increase, both nationally and locally in the number of children being placed outside their home Local Authority area.

The Safeguarding and Statutory Services Team continually seek to ensure that the Trust meets its statutory responsibilities in relation to Children in Care and has clear governance processes to ensure the health needs of Children in Care are met.

Introduction

1. The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (AHCH) arrangements for Children in Care (Looked After Children) and a retrospective view of the work completed by the Safeguarding and Statutory Services Team from 01 April 2024 to 31 March 2025 to outline how AHCH meets its statutory responsibilities in respect of Children in Care.

2. The report includes information to demonstrate the delivery of AHCH Statutory Services and partnership working with Community Children Looked After (CLA) Health teams in line with the service specification agreed by Cheshire and Merseyside Integrated Care Board (C&M ICB) Place areas, namely Liverpool, Sefton and Knowsley (known hereafter as 'C&M ICB') as the Responsible Commissioner.

3. Children in Care are referred to in legal terms as 'Looked After Children'. In England and Wales, the term 'Looked After Children' is defined in law under the Children Act 1989.

4. A child is 'Looked After' by a Local Authority if they are in their care, or they are provided with accommodation for more than 24 hours by the Local Authority. Looked After Children 'Children in Care' fall into four main groups:

   - **Section 20:** Children who are accommodated under voluntary agreement with their parents.
   - **Section 31 or Section 38:** Children who are the subject of a care order (s31) or interim care order (s38).
   - **Section 44 and 46:** Children who are the subject of emergency orders for their protection.
   - **Section 21:** Children who are compulsorily accommodated; this includes children remanded to the Local Authority or subject to a criminal justice supervision order with a residence requirement.

5. The term 'Looked After Children' includes Unaccompanied Asylum-Seeking Children (UASC), children in friends and family placements, and those children where the agency has authority to place the child for adoption. It does not include those children who have been permanently adopted or who are subject to a special guardianship or residency order.

6. Our children in Merseyside have requested that we refer to them as Children in Care or 'Our Children' and therefore this will be the term used in this report going forward where appropriate.

7. Children in Care share many of the same health issues as their peers however these are often more significant and complex and are more likely to be unmet. Many Children in Care continue to experience significant health inequalities once they have entered the care system. Meeting the health needs of these children and young people requires a clear focus on access to services. This approach can be assisted by the delivery of effective services and ensuring availability of individual practitioners to provide and co-ordinate care.

8. This report will be shared with Designated Professionals at C&M ICB and may be used to inform relevant Local Safeguarding Children Partnerships (LSCPs) Annual Reports and Local Authority Corporate Parenting Boards.

9. The report focuses on key drivers of work including the local and national context, Alder Hey arrangements for Children in Care and work with commissioners and other key partners.

10. The NHS has a major role in ensuring the timely and effective delivery of health services for Children in Care (Department of Education, 2015) therefore this report includes information about service performance and sets out the objectives and priorities for the coming year.

Statutory Frameworks, Legislation and Guidance

11. There are several pieces of legislation and guidance which inform responsibilities and requirements regarding working with Children in Care. The key documents are summarised below:

Legislation and Statutory Guidance Specific to children
• Promoting the Health of Looked After Children Statutory Guidance (2015) • United Nations Convention on the Rights of the Child 1989 • Children Act 1989 and 2004 • Children and Social Work Act 2017 • Leaving Care Act (2000) • Working Together to Safeguard Children Statutory Guidance (2023) • Looked After Children: Knowledge skills and competencies of health care staff (2020) • The Care Planning, Placement and Case Review (England) Regulations (2010)
Frameworks and Guidance
• Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2024) • Special educational needs and disability code of practice: 0-25 years (Department of Education and Department of Health, 2014) • Who Pays? Determining which NHS commissioner is responsible for commissioning health care services and making payments to providers (NHS England, 2025). • NICE Guideline NG205: Looked-after children and young people, published: 20 October 2021 • Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing (2015). • National NHS Payment Scheme (2024/25) • Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (2013) • Guide to the Children's Homes Regulations, including the Quality Standards (2015)

Overview of Commissioning Arrangements and Service Provision

12. Alder Hey Children's NHS Foundation Trust is commissioned by C&M ICB to provide services in relation to Children in Care, fostering and adoption.

13. The Service Level Agreement (SLA) provided by C&M ICB outlines the aims for the service are to assess, co-ordinate and meet the health needs of Children in Care ensuring statutory duties and corporate parenting responsibilities are met.

14. The overall intended outcomes required from this service provision include:

- A reduction in health inequalities demonstrated by the early identification and proactive management of health issues for Children in Care.

- An improvement in the overall health and wellbeing of Children in Care demonstrated by evidence of improved health outcomes for children who have entered the care system.

15. The service is commissioned to provide care to:
- All Children in Care who are in the care of the local authorities and living within the boundaries of the North Mersey region

- All other Children in Care new into care of local authorities other than Liverpool, Sefton and Knowsley who have recently moved into the North Mersey region and who are registered with a Liverpool, Sefton or Knowsley Place area GP or who are anticipated to register with Liverpool, Sefton or Knowsley Place area GP.

16. Liverpool Place is the lead commissioner for the Alder Hey Safeguarding and Statutory Services across Liverpool, Sefton, and Knowsley, with Sefton Place taking the lead on the quality aspects of the contract. This means that Sefton Place undertakes a coordinating role on behalf of Cheshire and Merseyside Integrated Care Board (C&M ICB) for oversight of Safeguarding and Children in Care.

17. Effectiveness of service delivery is assessed by Sefton Place, C&M ICB in line with the following objectives:

- To undertake timely (20 working days statutory timescale), high quality IHAs for Liverpool, Sefton and Knowsley.

- To undertake timely (28 working days statutory timescale), high quality children's permanency medicals (also known as adoption medicals) for Liverpool, Sefton and Knowsley.

- To undertake Adult Health Clearance Reports for adults wishing to be foster carers, adopters and Special Guardianship Orders (SGO) for Liverpool, Sefton and Knowsley.

- To coordinate and communicate with other specialist Children in Care health provider services.

- To communicate with Local Authorities and other key stakeholders.
- To provide a visibility of the service throughout the provider organisation.
- To deliver the Fostering Medical Advisor (FMA) role for Liverpool, Sefton and Knowsley.
- To deliver the Adoption Medical Advisor (AMA) for Liverpool, Sefton and Knowsley.
- To provide a Named Nurse and Named Doctor for Children in Care.
- To provide the Designated Doctor role for Children in Care to Sefton and Knowsley Place areas.
- To produce an Annual Report for Children in Care.
- To produce quarterly Key Performance Indicator (KPI) submissions.

18. The service is delivered in line with the following principles:

- A child/young person-centred integrated approach is fundamental to delivering excellent standards of care and delivery of services.
- The delivery of services is tailored to the individual and diverse needs of our Children in Care whenever possible.
- The needs of children, young people and families at the centre of our service delivery.
- Service delivery is in accordance with legislation regarding confidentiality, consent and safeguarding children.
- We consistently strive towards on-going continuous quality improvement.

Alder Hey Children in Care Governance Arrangements

19. Health Providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

20. The 'Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework' (SAAF) (2024) outlines that NHS Providers must demonstrate that safeguarding is embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working. These arrangements for Children in Care include:

- Contractual requirements as laid out in Schedule 32 of the NHS Standard Contract.
- Identification of a Named Nurse and Named Doctor for Children in Care.
- An annual report for Children in Care to be submitted to the Trust Board.
- Appropriate policies and procedures.

- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competencies.

21. The Chief Nursing, Allied Health Professional (AHP) and Experience Officer is the Board Executive Lead for Safeguarding and Children in Care; with the Chief Executive retaining overall statutory responsibility.

22. Services for Children in Care are provided by Safeguarding and Statutory Services which sits within the Community and Mental Health Division. Day to day Director support for Safeguarding is the responsibility of the Director of Community & Mental Health Services.

23. Safeguarding and Statutory Services are led by the Associate Director for Safeguarding and Statutory Services supported by the Named Professionals for Children in Care.

24. The Associate Director for Safeguarding and Statutory Services meets with the Chief Nursing, AHP and Experience Officer and Director Community & Mental Health Services regularly in relation to safeguarding and Children in Care matters, providing briefings to the Senior Leadership Team as appropriate.

Named Professionals for Children in Care

25. Named Professionals for Children in Care are a statutory requirement of all NHS Providers as set out in the SAAF (2024) and Looked After Children: Roles and Competencies of Healthcare Staff - Intercollegiate Document (RCN and RCPCH, 2020).

26. The Associate Director for Safeguarding and Statutory Services leads the Named Professionals in their statutory responsibilities to ensure arrangements for Children in Care within the Trust.

27. Alder Hey Named Professionals have a key role in promoting good professional practice within the Trust, supporting the local safeguarding system and processes, providing advice and expertise for staff, and ensuring training regarding Children in Care is in place. They work closely with the Associate Director for Safeguarding and Statutory Services, Designated Professionals for Children in Care in the relevant Place areas, and with Local Authority Partners.

28. In March 2022 Alder Hey appointed its first Named Nurse for Children in Care.

29. Work was undertaken throughout 2022/23 to separate the previously established hybrid role of Named Doctor and Designated Doctor for Children in Care to align with the requirements of Intercollegiate Document. As a result, a Business Case was developed in 2022/23 to try and secure funding from C&M ICB for the statutory role of Named Doctor for Children in Care which was unsuccessful.

30. Throughout 2024/25 – work has been completed to identify funding within the Trust and develop a job description for the Named Doctor for Children in Care. This was subsequently agreed with the Royal College for Child Health and Paediatrics (RCPCH). It is anticipated that the Named Doctor for Children in Care role will be advertised and recruited to in 2025/26.

31. A governance structure for Trust Children in Care arrangements has been provided in Appendix 1 of this report.

Internal and External Assurance Reporting Arrangements

32. Health Providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

33. A Children in Care Annual Report is provided to the Alder Hey Quality and Safety Committee (SQAC) and Trust Board.

34. Quarterly updates are provided to the Safeguarding and Statutory Services Assurance Group (SASSAG) for scrutiny and oversight as part of our safeguarding and Children in Care governance arrangements. Key issues from these meetings are reported into SQAC via the Safeguarding Quarterly Report and to the Divisional Governance Meetings or Board as appropriate.

35. The Safeguarding Operational Group (SOP) was established with the primary purpose is to ensure that safeguarding children, adults and Children in Care is a Trust wide priority with representation from all divisions. The Named Nurse for Children in Care co-chairs this meeting and ensures the group has oversight of Children in Care training compliance, discusses incident trends, and explore lessons learned from patient safety incident reviews, safeguarding and Children in Care inspections reports, serious safeguarding reviews such as Local Child Safeguarding Practice Reviews which pertain to Children in Care.

36. Information is also provided quarterly to Designated Professionals at Sefton Place who act as 'Lead Commissioner' in line with Key Performance Indictors (KPIs). Regular feedback regarding the level of assurance and quality of KPI submissions is provided by Designated Professionals for Children in Care at quarterly Business Meetings with the Associate Director for Safeguarding and Statutory Services and Named Professionals for Children in Care.

37. In addition to quarterly KPI submission C&M ICB also require the Trust to provide complete the Safeguarding Children, Young People and Adults at Risk Contractual Standards. This framework incorporates specific standards in relation to Children in Care and required the submission of evidence to assure commissioners that the Trust is fulfilling statutory responsibilities in respect of Children in Care.

38. C&M ICB Designated Professionals for Children in Care are invited to attend the SASSAG meetings where Children in Care KPI performance and assurance is a standardised agenda item.

39. Representatives from Alder Hey regularly attend Local Safeguarding Children Partnerships Board meetings and subgroups and in addition attend Corporate Parenting meetings as required.

Designated Professionals for Children in Care

40. The roles of the Designated Nurse and Designated Doctors are to promote the health and welfare of Children in Care by assisting commissioners of health services in fulfilling their responsibilities to improve the health of Children in Care and by influencing strategic health policy.

41. Alder Hey is commissioned by C&M ICB to provide the Designated Doctor for Children in Care function to Sefton and Knowsley Place areas. The Designated Doctor role is intended to be a strategic one, separate and distinct from any responsibilities for individual Children in Care and any other clinical roles within Alder Hey they may hold. The Designated Doctors within this role sit under the governance arrangements of the individual Place areas.

42. As outlined above work has been undertaken with Commissioners to ensure that the arrangements are clear regarding the commissioning of Designated Doctor roles from Alder Hey with dedicated time clearly outlined within relevant doctors' job plans.

Health Profile of Children in Care

43. It is universally recognised that children who come become Children in Care will already have had trauma and difficulties over and above those experienced by most of their peers. Most will have suffered abuse or neglect, or experienced bereavement, disability, or serious illness in one or both parents. Many are from disadvantaged backgrounds. Being a Child in Care can involve major and sometimes traumatic upheaval.

44. Changes and a lack of permanence in the arrangements for many of our children are unsettling and can hamper effective work by professionals. Additionally, there can be challenges in finding appropriate placements that meet basic emotional, physical, and cultural needs of children who are in the care of the Local Authority.

45. Two thirds of Children in Care have been found to have at least one physical health complaint such as speech and language problems, bedwetting, coordination difficulties or sight problems. There are also generally higher levels of teenage pregnancy and drug and/or alcohol use (Department of Education, 2015).

46. Almost half of Children in Care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults. (Department for Education and Department of Health and Social Care, 2015)

47. Research suggests that between 45% (Meltzer et al, 2003) and 72% (Sempik et al, 2008) of Children in Care have mental health problems that require professional support.

48. There is strong evidence that child maltreatment is a leading cause of poor mental health in childhood and throughout later life (Gilbert et al, 2009). A high proportion of children already have mental health difficulties at the point of entry to care. One

study conducted in 2008 found that 72% of children aged between five and 15 had some kind of emotional or behavioural problem at entry to care (Sempik et al, 2008).

49. Children in Care are more likely to have difficulties with their mental health. Nationally almost half of Children in Care have diagnosable mental health issues. Additionally, 11% are reported to be on the autistic spectrum and many others have developmental problems (Department of Education, 2015).

50. If mental health needs are unmet, it can increase children's risk of a variety of poor outcomes, including placement instability and poor educational attainment (Bazalgette, Rahilly and Trevelyan, 2015) and subsequently poor mental health into adulthood.

51. Statutory guidance (Department of Education, 2015) states that Commissioners and officers within the Local Authority who are responsible for Children in Care services should recognise and give due account to the greater physical, mental, and emotional health needs of Children in Care in their planning and practice.

52. Comprehensive local data regarding specific health needs of Children in Care within the Place areas Alder Hey are commissioned for is not currently available. Safeguarding and Statutory Services continue to work closely with its community partners to ensure the health and developmental needs for Children in Care are addressed quickly and robustly to improve long term health and wellbeing outcomes.

National Data for Children in Care

Statistical First Release (SFR) England

53. The demographics for Children in Care nationally are taken from the Statistical First Release (SFR) England. The 2025 release is published by the Department for Education and provides information on Children in Care in England, data is taken from the annual SSDA903 data collection which is collected from Local Authorities in England.

54. The latest statistics which are summarised below relate to the year ending 31 March 2025 and comparisons are to the year ending 31 March 2024. The standard period for data in this national data release is for the year ending 31 March 2021 to the year ending 31 March 2025. This means that some of the data provided below may be repeated in the next 2025/26 annual report depending on the publication and availability of Government data.

55. The Department for Education advises:

- 2021 was the year that the initial effects of the COVID-19 pandemic are visible in the statistics, so caution is advised in making comparisons between the current year and 2021.

- Many of the changes within the 2025 data release are influenced by changes in the number of UASC who a distinct cohort, with specific characteristics, for

example they are generally male, aged 16+ years, with relatively short periods of care.

56. The national headline facts and figures for 2024 are reported as follows:

57. The national headline facts and figures for 2025 are reported as follows:

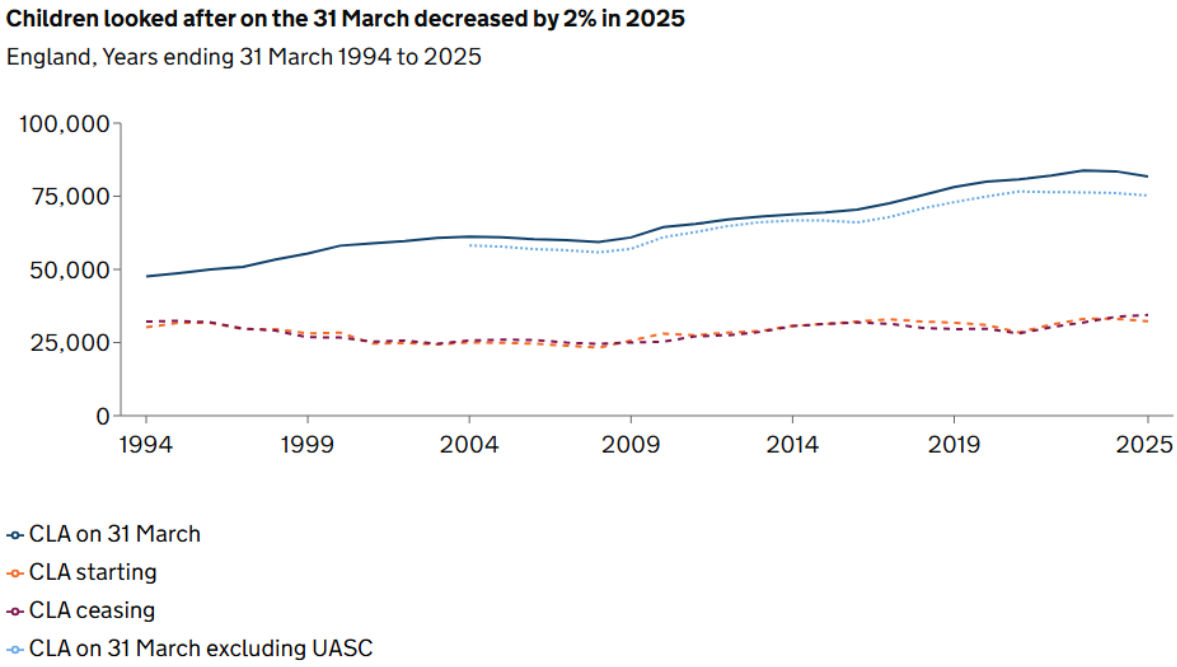
Numbers of Children in Care 2025

58. The number of Children in Care reported by Local Authorities on 31 March 2025 decreased by 2% (down 1,760 children) compared to last year - now at 81,770 children. This decrease is due to a fall of 1% in the number of non-UASC Children in Care (down 860 children) and a fall of 12% in the number of Children in Care who were UASC (down 900).

59. The rate of all Children in Care per 10,000 children aged under 18 years has decreased to 67 - down from 69 last year and down from a recent peak of 70 in both 2022 and 2023.

60. The number of children starting to be cared for by the Local Authorities during the year has fallen and the number of Children in Care ceasing during the year has risen. Children in Care ceasing due to being the subject of a special guardianship order (SGO) increased by 6% (up 220 children) and Children in Care adopted increased by 1% (up 20 children).

61. The chart below outlines the numbers of Children in Care nationally between 1994 and 2025:



(Source: SSDA903 2025, Department of Education)

62. The number of Children in Care in England and Wales increased every year between 2009 and 2023 (see chart above and table below). In 2018 the Department for Education advised the Children in Care population was growing faster than that of the UK child population. This appears to have stabilised over the last two years (see table of data below):

	looked after on 31 March	to be looked after during the year	be looked after during the year	excluding unaccompanied asylum-seeking children
2025	81,770	32,270	34,450	75,240
2024	83,530	33,130	33,780	76,090
2023	83,750	33,090	31,850	76,340
2022	82,090	31,100	30,230	76,410
2021	80,780	28,470	28,120	76,630
2020	80,000	31,010	29,710	74,920
2019	78,140	31,780	29,570	72,990
2018	75,360	32,190	30,050	70,800
2017	72,600	32,940	31,410	67,890
2016	70,400	32,160	31,850	66,060
2015	69,460	31,350	31,350	66,700
2014	68,790	30,730	30,600	66,740
2013	68,050	28,970	28,650	66,110
2012	67,070	28,390	27,520	64,840
2011	65,500	27,510	27,120	62,760
2010	64,460	28,090	25,310	60,980
2009	60,920	25,680	25,010	57,030

(Source: SSDA903 2025, Department of Education)

Reasons for Children coming into Local Authority Care

63. When a child is assessed by Children's Social Care (CSC) their primary need is recorded. For Children in Care this corresponds to most relevant need at the time the child came into the care of the Local Authority. This list is hierarchical and where more than one need is identified then the need 'highest' up the list is reported.

64. The proportion of Children in Care reported within each primary need has been broadly stable over the last five years.

65. Reasons recorded for being Children in Care include the following:
    - As a result of or because they were at risk of abuse or neglect
    - Primarily due to living in a family where the parenting capacity is chronically inadequate (family dysfunction)
    - Due to there being no parents available to provide for the child (absent parenting)
    - Due to living in a family that is going through a temporary crisis that diminishes the parental capacity to adequately meet some of the children's needs (family being in acute stress)
    - Due to the child's or parent's disability or illness
    - Due to low income or socially unacceptable behaviour

Placement Types

66. The majority of Children in Care were placed in foster placements, where an approved carer looks after the child. The number of children in foster placements have continued to decrease, down 2% to 54,820 (down 1,140 children) however the proportion of children in foster placements has remained the same as last year at 67%. Almost a quarter (24%) of foster placements are with a relative or friend who are an approved foster carer. The number of children in these placements also decreased by 2% to 13,360 (down 220 children).

67. The number of Children in Care placed for adoption decreased by 22% to 1,660 children (down 460 children) - the proportion of all Children in Care who were placed for adoption is 2%. Placed for adoption means the child has gone to live with prospective adopters. A child may be placed for adoption with the formal consent of the child's parents/guardian or with a placement order from a court and may be placed for adoption with their current foster carer or with a stranger or relative who is an approved adopter.

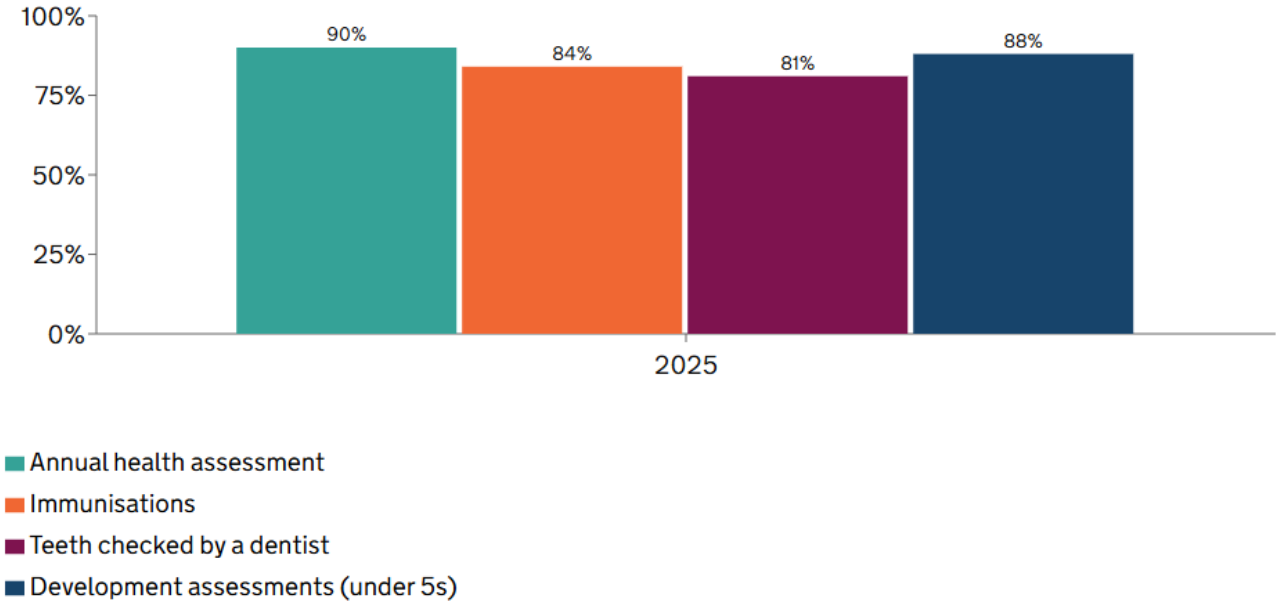
68. Children in Care placed in children's homes including secure children's homes increased by 9% (770 children) to 9,480, which is 12% of Children in Care.

69. Supported accommodation providers accommodated 7,520 children (9%), there were a further 2,050 children placed in 'Other placements' which was 3% of all Children in Care.

Overall National Children in Care Health Findings

70. Children in Care are offered statutory health assessments to monitor the physical, development and emotional wellbeing continually through their journey in care.

71. Nationally most Children in Care are reported to be up to date with their health care and immunisations (se table below) - figures are similar to last year. During the COVID-19 pandemic the proportion of Children in Care with their teeth checked during the year by a dentist fell to 41% but this proportion is now reported to be closer to pre-pandemic levels



(Source: SSDA903 2025, Department of Education)

Substance Misuse

72. Nationally 3% of Children in Care were identified as having a substance misuse problem which is the same as last year and the same as in 2021.

73. An intervention was received for 41% of children who were identified as having a substance misuse problem, up from 39% last year. Interventions may include for example, advice and guidance, therapeutic support or support targeting the problems that are causing difficulties for the young person, like family contact, placement stability, school attendance or the young person's mental health.

Emotional and Behavioural Health (SDQ scores)

74. Strengths and Difficulties Questionnaire (SDQ) is a behavioural screening questionnaire. Its primary purpose is to give social workers and health professionals information about a child's wellbeing. A score of 0 to 13 is considered normal, 14 to 16 is borderline, and 17 to 40 is a cause for concern.

75. For Children in Care aged 5 to 16 years (43,220 children), an SDQ score was reported for 78% of them - up slightly from 77% last year. The average score reported was 14.9 - up from 14.7 last year and up from 13.7 reported in 2021.

76. Of these 43,220 children:

- 45% had 'normal' emotional and behavioural health (down slightly from 46%)
- 13% had 'borderline' scores (same as last year)
- 42% had scores which were a cause for concern (up slightly from 41%).
- In 2025, 44% of males had a score which was a cause for concern compared to 40% of females.

77. In the younger age groups, a greater proportion of males than females have scores which were a cause for concern; however, for 15- and 16-year-olds, this switches and a greater proportion of females than males have a score which is a cause for concern.

Local Profile of Children in Care

Overview of Merseyside Children in Care

78. Liverpool, Sefton, and Knowsley data reported nationally has been outlined in tables below to give an overview of Merseyside Children in Care. In line with the decreases being seen nationally, this data shows that the number of Children in Care in Merseyside has decreased again from the previous year. The table below compares data published nationally from 2019/2020 with data from 2024/25:

Number of Children in Care	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% Increase/ Decrease
Liverpool	1,424	1,517	1596	1477	1490	1416	4.96% decrease
Sefton	566	613	598	611	581	506	12.9% decrease
Knowsley	307	313	298	328	337	325	3.56% decrease
Total Number	**2297**	**2443**	**2492**	**2416**	**2408**	**2247**	**Overall 6.68% decrease between 2023/24 and 2024/25**

79. Provision of placements within the Local Authorities is a national challenge, with placement types varying based on individual children's family network, vulnerabilities and needs. The table below compares data reported nationally from 2019/2020 with data from 2024/2025 looking at the number of children placed outside of their home Local Authorities:

Children in Care Placed Out of Borough	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% Increase / Decrease from last year
Liverpool Children placed outside of Local Authority area	619	679	690	669	686	661	3.6% decrease
Sefton Children placed outside of Local Authority area	211	236	151	165	234	234	% maintain
Knowsley Children placed outside of Local Authority area	149	223	235	165	168	165	1.7% decrease

80. Reflective of the above data, which saw an annual decrease in the number of Children in Care placed outside of their home Local Authority, the below table demonstrates an overall increase of Children from other Local Authorities placed within the three Place areas Alder Hey serves:

Number of CiCOLAs	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% Increase/ Decrease from last year
Children in Care of Other Local Authorities (CiCOLAs) placed in Liverpool	256	276	294	292	297	262	11.7% decrease
CiCOLAs placed in Sefton	279	286	283	372	373	309	17.1% decrease
CiCOLAs	217	223	228	222	228	238	4.3%

placed in Knowsley							increase

Overview of Alder Hey Children's NHS Foundation Trust IHA Data

81. Alder Hey are commissioned to provide Initial Health Assessments (IHA) for Children in Care within the three Place areas, Liverpool, Sefton, and Knowsley. The table below compares Alder Hey data regarding the number of IHA's requested in 2020/2021 with the data for 2024/2025:

IHA Requests	2020/21	2021/22	2022/23	2023/24	2024/25	% Increase/Decrease from last year
Liverpool	541	478	284	329	343	4.2% increase
Sefton	211	161	164	126	132	4.8% increase
Knowsley	100	80	106	79	90	13.9% increase
Children in Care of Other Local Authorities (CiCOLA)	67	107	167	164	131	20% decrease

82. An increase in requests across the three Place areas was noted, this is potentially due decrease to the number of children placed out of borough at the point of becoming Children in Care. Whereas the number of children placed within the Place areas from other Local Authorities decreased, which suggests that this cohort of children tend to move into our Local Authority areas at a later point of their care journey.

83. In addition to IHAs, Alder Hey are commissioned to complete adoption medicals for Children in Care within the three Place areas, Liverpool, Sefton, and Knowsley. The table below compares the number of IHA's requested for 2020/21 with the data for 2024/25:

Adoption Medical Requests	2020/21	2021/22	2022/23	2023/24	2024/25	% Increase/Decrease
Liverpool	125	92	65	55	113	105% increase
Sefton	58	30	46	41	39	4.8% decrease
Knowsley	25	22	22	32	27	15.6% decrease
Children in Care of Other Local Authorities (CiCOLA)	8	5	2	0	0	% Maintain

84. There has been a 0.6% increase in adoptions nationally from 2024-2025. It is noted in the table above that there has been 105% increase in the number of requests for adoption medicals between 2023/24 and 2024/25. This could be due to Liverpool Local Authority returning to pre-covid 19 pandemic practices of operating a twin tracking model. This means that processes for adoption are commenced to reduce any possible delays whilst decisions are being undertaken. The data above would support this as numbers have returned to those seen in 2020/21.

Health Assessments: Initial Health Assessments (IHAs) and Review Health Assessments (RHAs)

85. During 2024/2025, 195 IHA's were completed for Unaccompanied Asylum-Seeking Children (UASC) this equates to 28% of IHA's completed in year. Of these 136 UASC where within the care of one of our three place areas.

86. To support compliance with statutory timescales, there is an agreed expectation that the Local Authority areas will notify partner agencies of a child entering care and request an Initial Health Assessment within 4 working days. Delays in notifications have been highlighted as an area of improvement. During 2024/2025 there were just 35% of requests for IHA across all the Local Authority areas which met the required timescale.

87. Dental health for children attending IHA's, dental health is a key area of discussion. In 88% of IHA examinations, it was deemed that there was sufficient discussion around dental health and oral examination completed.

88. Immunisation status is reviewed as part of the IHA process. For the period 2024/25, IHA data indicates:

- 28% of children were up to date as per the National Childhood Schedule
- 1.6% of children had an unconfirmed immunisation status at time of IHA
- 7.3% Infants pending first immunisations as per the National Childhood Schedule
- 32.8% of children had an incomplete immunisation schedule for age.
- Of those that had incomplete immunisations, 204 (66%) were Unaccompanied Asylum-Seeking Children (UASC).

89. Children in Care with Special Educational Needs and/or Disability (SEND) requirements are identified at referral for Initial Health Assessment. The data collected indicates the following numbers (see table below):

CiC with Special Educational Needs and/or SEND	2022/23	2023/24	2024/25	% Increase/ Decrease from last year
Liverpool	18	42	22	47.6% decrease
Sefton	12	13	22	69.2% increase
Knowsley	4	5	9	80% increase
Children in Care of Other Local Authorities (CiCOLA)	0	4	8	100% increase

Service User Feedback/Consultation and Engagement with Children in Care

90. During 2024/25 the Children in Care Team have sought to consult and engage with Children in Care in several ways. These have included obtaining feedback using QR codes for IHA patient experience, engaging with the Children in Care community and their carers, also via Alder Hey supporting and empowering our Care Leavers.

91. Feedback from children, young people and foster carers has been obtained for IHA information leaflets to support development and circulation.

92. There has been work completed with the Sefton Making a Difference (MAD) participation group to begin discussing ways we can improve children and young people input for service development and IHA uptake.

93. In 2024/25 Alder Hey have been supported by the Madlug company to distribute bags for Children in Care who experience placement moves upon discharge. Feedback from care staff supporting a child who received a Madlug 'You are incredible', highlighted this 'act of kindness, is brilliant and shows that Alder Hey care about the children in these difficult positions.' The child was grateful also and pleased to leave the hospital with a holdall, opposed to multiple carrier bags.

94. The Specialist Nurse for Children in Care attended a Children at Risk Research development network workshop hosted by Liverpool University. The workshop brought together providers, commissioners and care experienced young people to explore how services can be more child focused and inclusive.

95. Alder Hey have worked with the Thrive Careers Hub, as part of National Care Leavers Week in October 2024 to promote employment opportunities within administrative services within the Trust.

96. The Service has engaged with the Liverpool participation group for Unaccompanied Asylum-Seeking Children (UASC) to seek their views and opinions on Initial Health Assessments (IHA). This feedback enabled Alder Hey Children in Care team to lead work developing a pilot UASC specific IHA document, approved by Liverpool Place and now being considered by the wider Cheshire and Merseyside ICB for utilisation.

97. During 2024/2025, feedback obtained from our 'You tell us' QR feedback from IHA clinics provided the following feedback:

- *What do you think was done well at the assessment?*

Child or young person response – 'The whole assessment was good'

- *What could we do better?*

Child or young person response – 'Nothing, everything was fine'
Child or young person response – 'Nothing, everything was good'

- *Do you feel we asked the right questions to identify your (childs) health and wellbeing needs?*

Family Member/carer response – 'Yes'

Challenges During 2024/2025

98. The post of Named Doctor for Children in Care has remained vacant throughout 2024/25. The gap of a dedicated lead Doctor impacts on the training and development of new clinical staff, service development from a clinician perspective, reduction in medical oversight for IHA quality and provision of clinician supervision.

99. Impact of was not brought and short notice cancellations on IHA compliance for Children and Young People residing in residential homes.

100. There has been an increased number of Children in Care from other local authorities, moving into the local areas and coming to the attention of Crisis or local CAMHS services prior to any movement in notifications being shared with Alder Hey and records being updated with the relevant information, history and demographics. This has resulted in risk factors not being known and delays in being able to obtain information and support for the children and their carers/placements.

101. Post adoption medical record process has been an area of high focus, however, there have been challenges in reviewing and adapting the most recent NHS England guidance to be implemented within the trust. Challenges related to the digital capability and complexities relating to information being shared for Children in Care who have successful adoptions.

102. IHA referrals have fluctuated over 2024/25 month to month, which placed some strain on IHA clinic capacity and impacted on timescales for scheduling in some cases. We have also had several failed and cancelled appointments which has had a consequence on clinic capacity.

Achievements for 2024/25

103. During 2024/25 IHA compliance significantly increased regarding statutory timescales. Statutory compliance was 92% at one point.

104. The Children in Care information has been provided to inpatient wards as part of the safeguarding visibility project.

105. Training session have been offered to Children Social Care colleagues in both Liverpool and Sefton boroughs. Sefton session focused on supporting CSC understanding of Children in Care health needs and Initial Health Assessments. Liverpool training was jointly delivered with Liverpool Social Workers from the Adoption team, focusing on awareness of Adoption Medical processes and statutory expectations.

106. A comprehensive Blood Borne Infection (BBI) Standard Operating Procedure (SOP) has been developed The SOP supports clinicians, administrators, Children in Care nurses and infectious diseases team to ensure timely identification of BBI requirement, consent, screening and any onward referrals.

107. The ‘It's the small gestures, that can make a difference’ project was rolled out. The Project funded for 6 months, offering Young People a £10 Costa voucher, thanking

them for their participation in their IHA appointment and encouraging them to enjoy a treat. Through November and December, 20 vouchers were collected by young people.

Key Priorities for 2025/26

108. Alder Hey Children in Care key priorities for 2025/2026 are:

- To progress the recruitment of a Named Doctor for Children in Care to fulfil the statutory organisational requirement and strengthen the specialist knowledge and training offered to doctors delivering Children in Care services across Alder Hey.

- To work with Commissioners, Community Health teams and Local Authority colleagues to review the information sharing processes associated with Children in Care, aiming to identify barriers and promote effective working across services.

- To review data collection processes and tools internally, to ensure consistency and accuracy of data collated to inform internal and external reporting.

- Full review of Children in Care policies and procedures to be completed for all aspects of Safeguarding and Statutory Services across Alder Hey.

- Training opportunities related to Children in Care to be explored for appropriate Trust wide job roles to support experience of children and families/carers.

- Reduce the number of incidents, PALs and complaints associated to Children in Care and children subject to adoption orders, through review of demographic change processes and general staff training and awareness. In addition, to review of information sharing processes with partner community Children Looked After health teams and Local Authorities.

- Improve the quality of IHAs, to ensure health assessments are age appropriate, recognising risk and demonstrating discussion and signposting of relevant public health topics.

Conclusion

109. Alder Hey Safeguarding and Statutory Services Team continue to ensure that the Trust meets its statutory responsibilities in relation to Children in Care and has clear governance processes to monitor the arrangements of commissioned health services for Children in Care.

110. As a result of the number of Children in Care being placed outside of their home Local Authority, there needs to be a review of information sharing processes across services for these children, to minimise the impact of delays to treatments and health interventions when they move between placements and geographical areas.

111. Work continues in partnership with the community Children Looked After Teams to achieve timely and quality services for Children in Care, ensuring positive communication and information sharing is achieved.

112. The Safeguarding and Statutory Services Team is committed to meeting the health needs of the Children in Care population of Merseyside and Cheshire, in addition to Children in Care accessing Alder Hey services from wider areas.

113. The Safeguarding and Statutory Services Team will continue to work collaboratively with the Local Authorities, Cheshire and Merseyside Integrated Care Board and key partners to continuously improve systems and quality of care.

References

1. Bazalgette, L., Rahilly, T., and Trevelyan, G. (2015) NSPCC Achieving emotional wellbeing for looked after children - A whole system approach. Available at: https://learning.nspcc.org.uk/children-and-families-at-risk/children-in-care [Accessed 08.12.2025]

2. Department for Education and Department of Health and Social Care (2015) Promoting the health and well-being of looked-after children - Statutory guidance for local authorities, clinical commissioning groups and NHS England. Available at: Promoting the health and wellbeing of looked-after children - GOV.UK [Accessed 08.12.2025]

Appendix 1 – Alder Hey Children's NHS Foundation Trust Safeguarding and Statutory Services Governance Chart

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 25th February 2026**
Report of:	**Fiona Beveridge, Committee Chair**
Paper Prepared by:	SQAC Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the Safety Quality Assurance Committee meeting held on 25th February 2026, along with the approved minutes from the 21st January 2026 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	

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

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

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

1. Executive Summary

The 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 21.01.26	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Patient Safety update	Report noted
Safeguarding Quarter 3 report	Report noted
Safe waiting list update	Report noted
EPRR Quarterly update	Report noted
Compliments, Complaints & PALS Quarter 3 report	Report noted
Patient Experience and Engagement/Family Feedback Report Quarter 3	Report noted
Children & Young People Engagement Report	Report noted
EDS22 Summary Report	Report noted
Clinical Ethics Report	Report noted
Southport AR Learning Review	Report noted
Clinical Effectiveness and Outcomes Board Chairs Highlight Report	Report noted
Board Assurance Framework	Report noted
Biannual Aggregated analysis report	Report noted
Children & Young People's Gender Service (North) Quarter 3 Report	Report noted
Medicine Management Policy – C37	Policy Ratified
Merseyside Joint Agency Protocol Acute Life-Threatening Event (ALTE)	Protocol Ratified
Merseyside Joint Agency Protocol Sudden Unexpected Death in Childhood (SUDIC) for Children aged 0 to 18 years	Protocol Ratified
Safeguarding Supervision Policy	Policy Ratified
Rub don't scrub an alternative to surgical hand antiseptsis Standard Operating Procedure	SOP Ratified
RM50 – Labelling, packaging, handling and delivery of Laboratory Specimens Policy	Policy Ratified
Isolation Precautions Policy – C17	Policy Ratified
Lockdown Plan	Plan Ratified

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

None

4. Positive highlights of note

- SQAC considered a balanced range of reports, including regular

cyclical reports covering areas of challenge or development.

- SQAC engaged in substantive discussion on a range of key topics, acknowledged progress in addressing a number of risks and recognised that a range of challenges remain.
- SQAC was assured that the Divisions and other key areas of the organisation are systematically monitoring their data, proactively addressing identified issues, learning from incidents, and remaining committed to ongoing improvement.
- SQAC received reassurance that challenges and issues within the committee are openly and transparently addressed, with a continued emphasis on learning from incidents and substantial assurance obtained as a result.
- SQAC confirmed that committee members possess a comprehensive understanding of any significant issues under review or areas of concern. The committee is assured that risks are monitored regularly and appropriate actions are implemented as needed.

5. Issues for other committees

None

6. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 21st January 2026
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	ABa
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director, Community & Mental Health Division	LC
	Gerald Meehan	Non-Executive Director	GM
	Laura Rad	Head of Nursing – Clinical Research	LR
	Rachael Pennington	Associate Chief Nurse – Surgical Division	RP
	Jackie Rooney	Associate Director of Nursing & Governance	JR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Veronica Greenwood	Director of Allied Health Professionals (AHP's)	VG
25-26-220	Kelly Black	Deputy Head of Neonatal Nursing, LNP	KBL
25-26-220	Deborah Edwards	K Black's Deputy, LNP	DE
25-26-221	Lynsey Boggan	Clinical Lead for Neurodevelopmental Services	LB
25-26-222	David Porter	Consultant Infection & Immunology, Sepsis Lead	DP
25-26-222	Kim Hewitson	Sepsis Nurse	KH
25-26-224	Nichola Osborne	Associate Director for Safeguarding and Statutory Service	NO
25-26-225	Paul Sanderson	Chief Pharmacist	PS
Observing	Judith Jones	Assistant Director (Clinical and Patient Benefits) System Assurance & Regulation Financial Reset & Accountability, NHSE	JJ
	Jill Preece	Governance Manager	JP
Apologies:	Alfie Bass	Chief Medical Officer	AB
	Jenny Devine	Governor	JD
	Ava Kilbride	Governor	AK
	Jackie Pointon	Associate Chief Nurse, Community & Mental Health Division	JP

25/26/215 Welcome and Apologies
The Chair welcomed everyone to the meeting and apologies were noted.
FB welcomed Judith Jones, Assistant Director (Clinical and Patient Benefits) System Assurance & Regulation Financial Reset & Accountability, NHSE who was observing this meeting.

25/26/216 Declarations of Interest - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

25/26/217 Minutes of the Previous Meeting
The Committee members were content to **APPROVE** the minutes of the meeting held on 17th December 2025.

25/26/218 Matters Arising/Review of Action log
The action log was reviewed and updated.

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

25/26/219 Divisional Updates
Division of Medicine
CW presented the Medicine Division update and drew attention to a few key points from the report including:-

Highlights:-

- The division reported sustained and consistent improvement in safety and quality metrics, attributed to stronger clinical oversight, reliable multidisciplinary team (MDT) working, and a clear focus on safety and quality despite financial challenges. Targeted interventions are implemented promptly when metrics dip, resulting in greater stability and reduced unwarranted variation.
- A recent sepsis metric dip was traced to an oncology patient where antibiotics were not changed as advised, highlighting a communication gap and providing learning for future cases.
- The long-standing high-level risk in metabolic medicine is being addressed through approval and recruitment of a consultant and nurse specialist. The risk score is maintained until posts are filled.
- Microbiology services had improved with the appointment of a consultant scientist, providing a sustainable response to national shortages.

Challenges and progress:-

- The Emergency Department experienced exceptional demand in December 2025, managed through early tactical command and effective patient flow, with learning captured for future surges.
- Pharmacy capacity remains a risk, particularly around turnaround times and medicine safety, with ongoing close oversight.
- Neurology risk remains high but is improving due to recent workforce appointments and further consultant support expected.
- Priorities for the next period include completion of business continuity plans and maintaining strong training compliance, with a focus on safeguarding and sepsis training for medics.

GM referred to the high Emergency department attendance in December, specifically whether some presentations could have been managed elsewhere, and whether there is a systematic approach to address this within the broader system. CW confirmed that there is active collaboration with urgent care and external agencies to redirect green patients, noting that many cases were efficiently managed upon arrival. This underscores the need for continued efforts with external partners.
AB inquired about oncology service challenges, including high demand and outliers, and whether there are sufficient actions or if additional support is needed. CW had noted an average of one oncology outlier per day and a decline in outliers over the past year, with ongoing work to manage surges and improve patient flow. CW advised that she is meeting with the clinical lead to further analyse the figures and understand underlying causes. CW committed to presenting additional data regarding oncology outliers at the next meeting. AB recommended incorporating anticipated changes to oncology capacity and pathways into future discussions, as well as evaluating the potential use of the mobile unit to facilitate care closer to home.

Division of Surgery

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

Highlights:-

- Ward 1C Cardiac had received IPC team of the month for a marked reduction in hospital acquired infections and compliance with the surveillance policy.

Challenges:-

- Incident review identified gaps in the referral process for patients who repeatedly cancel or rebook appointments; work is underway to align processes and improve communication with referrers.
- Sepsis and mandatory training compliance are trending downward; the division is focusing on improving compliance in sepsis and safeguarding, with daily and weekly reviews and shared learning.
- There had been a slight increase in lower graded pressure ulcers, device-related; targeted work is ongoing to prevent these.
- Business continuity training is scheduled, with all plans drafted and being updated to correct templates.

ES commented positively on the inclusion of the Burns peer review in the report and requested that, once complete, the findings and any learning be shared with the Governance Manager and highlighted in the next meeting cycle.

RP agreed, stating that the Burns team has an action plan and that RP would provide an update to the next meeting (or when the plan is completed).

FB observed that both the Medicine and Surgery divisions are anticipated to demonstrate significant progress in their business continuity metrics, with an expectation of achieving completion by the end of the financial year. FB expressed appreciation for these developments being highlighted in future meetings.

Clinical Research Division

LR presented the Clinical Research Division update,

Highlights:-

- Significant progress had been achieved in addressing vacancies, particularly within commercial studies, as interviews are in progress and the retention of qualified temporary staff is being considered.

Challenges and progress:-

- There are ongoing issues with a new door within the CRF Unit which have resulted in increased incidents; a discussion had taken place at Patient Safety Strategy Board stating that all issues relating to Trust wide doors should be escalated to the Health and Safety Committee.
- Work is ongoing to ensure staff use the correct versions of patient-facing documents, with a deadline for updating all documents by the end of February 2026.
- Division are experiencing Oncology staffing challenges due to complex trials and absences; prioritisation of trials and patient safety is in place.
- There has been a decrease in sepsis compliance which is being addressed.
- The implementation of a new reporting system has led to an increase in reported research governance incidents; however, this trend is anticipated to stabilise over time.

AB acknowledged a recurring theme around suboptimal environments in both the Research and the Community & Mental Health Divisional updates. AB emphasised the need for action to resolve estate defects, including issues with doors. AB stated that he and the Chief Financial Officer are expediting changes, even if compensation is sought at a later date. AB indicated that ongoing progress would be monitored with the objective of achieving a timely resolution.

FB agreed, noting that both reports provide evidence of unmet estate maintenance targets, which supports ongoing efforts to resolve these broader issues.

FB expressed her thanks to LR for the clarity and for the ongoing follow-up on current challenges.

Community and Mental Health Division

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

Highlights:-

- The division had seen increased compliance in sepsis training.
- The division has noted improvements in Complaint and PALS response times.
- The Staff survey completion rate was high at 66%.
- E Mental Health Act paperwork is now live, reducing the risk of missing documentation for detained children.

Challenges:-

- There are increasing number of parents altering ADHD medication doses without prescriber authorisation, and over-18s remaining in the service due to delayed transition to adult services. The division is collaborating with parent carer forums and patient safety partners to address these risks and has escalated transition issues to the ICB.
- Infrastructure issues at Sunflower House and Blossom House (water, heating, lift failures) continue to impact service delivery, with weekly estates meetings ongoing.
- Vacancies in administration and clinical roles are affecting care delivery and achievement of targets; efforts are underway to streamline approval processes.

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

25/26/220 Liverpool Neonatal Partnership Monthly update

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

- Two new paediatric clinical leads and a parent representative have been appointed to support partnership working and parent engagement.
- A family support worker role had been created to aid parent education and discharge.
- Staff qualification compliance is now consistent, supporting preparation for the new unit opening.
- Sickness absence remains high, with no specific themes identified; HR support and wellbeing initiatives are in place.
- Parent survey response rates are low; an improvement plan has been developed.
- The Neonatal LocSSIP audit undertaken by MIAA in November 2025 identified areas for improvement; an action plan is in development.
- The National Neonatal Audit Programme (NNAP) quality metrics are improving but not yet consistent; ongoing improvement plans are in place.
- A joint governance framework is being developed with MIAA for third-line assurance, with phased implementation and evaluation planned.

Resolved: KB would work with the BI team to enhance the LNP dashboard to include benchmarking information, SPC charts, to enable an enhanced LNP report in March 2026. With neonatal transfer tracking to be included in phase 2.

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

25/26/221 Update on improvements to Neurodevelopmental Pathways Report

LB presented the Update on improvements to Neurodevelopmental Pathways Report and drew attention to a few key points from the report including:

- The service had undergone a formal transformation Programme since May 2024, resulting in a single diagnostic and assessment pathway and a treatment pathway, making it the only provider in Cheshire & Merseyside with this model. The service is currently rated as outstanding by CQC.
- Referrals had increased by 190% since COVID, leading to a large caseload and delays in assessment. The transformation programme included workstreams on clinical model, digital improvements, and capacity/demand management.
- Efficiency improvements: Pilot work reduced clinician involvement per case from 15 to 9 and family appointments from 5 to 3, improving patient experience and reducing duplication.
- Risks include an extensive waiting list, delays in assessment with the current target of 52 weeks not being achieved, shortages of ADHD medication, and delays in transitioning to adult services.

Innovations:

- ND team now joins community safety huddles for risk escalation with direct access to the Divisional Director for urgent cases.
- A bespoke neurodevelopmental assessment and safety planning tool is available in Meditech, integrated with CAMHS risk assessments.
- Lead clinicians provide daily support for families, offer complex needs pathways, and use partnership assessments to fast-track referrals.
- Electronic system enables single ASD/ADHD referrals and a new form tracks caseloads and risk levels (routine, enhanced, urgent).
- Peer support workers (experienced parents/carers) engage families and follow up with those at risk of missing appointments.
- Digital tools include a locally adapted profiling tool, improved Meditech forms, and library transcription.
- Skill mix includes band 5 nurses and clinical associate psychologists.
- The treatment team prioritise medication safety, restarting clinics, and collaborates with Cardiac team on nurse cardiac check training.
- CLEO electronic prescribing has launched; an audit is set for six months.
- Capacity and demand analysis is ongoing for future service planning.
- Priority actions: Continue risk stratification, digital enablement, shared care, and complete capacity/demand exercise by end of January.
- Ongoing engagement with parent carer forums and monthly Transformation Board Meetings.

FB referred to the sustainability of improvements and questioned whether the risk of the team being overwhelmed is mostly a system risk or an internal risk. LB responded that the profiling tool may

help reduce demand by meeting needs earlier, however more appointments are required to meet demand; LB stated that further analysis will clarify future requirements.
KB highlighted the issue of the service performing over 1500 uncommissioned assessments annually, questioning sustainability in the current financial climate and referred to the impact on waiting lists if this activity ceased. KB referred to the improvements and benefits for those children/young people on the pathway; however, the long waits remain for those children/young people not yet assessed.
LB advised that pre-diagnosis support is available from referral, with partnership agreements ensuring families receive training and support regardless of diagnosis. LC confirmed that peer support and welcome meetings are provided and stated that the referral processes had been strengthened to ensure schools provide evidence of support before referral.

LC confirmed that over-performance is escalated monthly to commissioners and that the Trust may need to reconsider this activity in future financial planning. LC emphasised the system-wide nature of the issue and the importance of support regardless of diagnosis.

FB requested quarterly Neurodevelopmental updates be presented to SQAC focusing on risk management, given the pathway's status as a key corporate risk.
Resolved: SQAC received and **NOTED** the update on improvements to Neurodevelopmental Pathways Report and welcomed future Quarterly Neurodevelopmental reports.

---- Safe ----

25/26/222 **Sepsis Report**

DP presented the Sepsis Report and drew attention to a few key points from the report including focus on progress since the last meeting, current performance, and ongoing challenges.

- DP referred to the metric of administration of antibiotics to inpatients within 60 minutes of a sepsis diagnosis and advised that in the most recent quarter, performance fell below the 90% compliance threshold, with monthly data showing that even a small number of breaches can substantially impact overall rates. Most instances exceeding the target were marginally above the 60-minute window, typically occurring within 90 to 100 minutes.
- Compliance with the 90-minute antibiotic administration target remains consistently above 90% for both Inpatient and Emergency Department patient groups. Performance within the Emergency Department had demonstrated sustained improvement over multiple years.
- Sepsis training compliance had experienced a modest decline, notably among medical and dental staff - a trend that continues to present challenges. The team is actively working to finalise the dashboard, standardise emergency department and inpatient protocols, and revise staff roles and responsibilities related to sepsis training. Approval has been granted to update mandatory training assignments, with the objective of enhancing compliance in the forthcoming cycle.
- FB confirmed that SQAC had escalated the sepsis training issue to the People Committee and to the Executive Team, seeking clarity on consequences for non-compliance and exploring further actions to enforce mandatory training.

FB emphasised the importance of correct training assignments and frequency, noting the ongoing work to address these issues.
GM referred to clinical judgment involved in delaying antibiotics for further investigation, particularly for newer staff, and queried whether additional training could help. DP clarified that while new staff may be more cautious, face-to-face induction and ongoing nurse training is provided, and any individual incidents are followed up by the sepsis nurse.
GM expressed his thanks to DP for the clarity of the report and the explanation of training and escalation processes.
FB expressed her thanks to DP for the report and confirmed that the committee would be kept updated on progress, especially regarding training compliance and dashboard development.
Resolved: SQAC received and **NOTED** the Sepsis Report

25/26/223 **Patient Safety Update**

JR presented the Patient Safety update and drew attention to a few key points within the report:-
The Patient Safety Programme Board met on 18th December 2025.
Highlights:-

- Workstream 1 (Metrics): The Trust continues to report incidents positively, with a downward trend in incidents of low or above harm and no harm per thousand bed days.
- Restrictive practice incidents and medication errors are decreasing.
- The BI team is addressing discrepancies in PSII data to avoid double counting.
- Workstream 23 (NatSSIPs): Is now formalised and reporting monthly to Patient Safety Board. Baseline assessment had been completed using MIAA standards, informing the workstream's development and delivery plan. Next steps include digitalising the process, developing a comprehensive assurance framework, and involving patient safety partners.
- Workstream 17 (Antimicrobial Resistance): A Steering group has been established; activities have been held during World Antimicrobial Awareness Week. Reporting metrics had shifted from antimicrobial consumption to resistance data due to previous unreliability.
- The Trust is currently awaiting a peer review report from UKHSA; point-of-care testing funding approved for the community team.
- Workstream 26 (Patient Safety Culture): Baseline assessment had been completed using staff survey feedback; the Patient safety team are using NHS Scotland's safety culture cards for further insight during PSIs/AARs; There is a delay in building the thriving teams index, which has been escalated to the digital team.
- Workstream 24 (Deteriorating Patient): Patient Safety Strategy Board noted the report, however the report was not discussed due to the absence of the lead; overdue actions were not discussed.
- Resuscitation: Mortality app in Inphase is live, enabling digital upgrade of resuscitation data; there are no recommendations from the National Cardiac Arrest Audit.
- Sepsis training compliance <90% target compliance with lowest levels seen in medical and dental staff.

Challenges:

- Variability in the escalation/de-escalation process for apparent life-threatening events (ALTE) after resuscitation; a working group has been established to develop a standardised pathway.
- There remains an ongoing risk (score 9) associated with not achieving the 90% resuscitation training target; current compliance stands at 85%. A task and finish group is actively collaborating with divisions to address this issue.
- Sepsis dashboard escalation was initially requested; however, this is now being addressed.

FB advised that resuscitation training was one of three modules escalated to the People Committee for further review.

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

25/26/224 Children in Care Annual Report

NO presented the statutory Children in Care Annual Report which detailed governance, statutory responsibilities, performance, and challenges for the reporting year. NO advised that the report is submitted later in the year to include national data.

- Alder Hey's data reflects the national trend of a reduction in children in care, with a 2% national decrease and a 6.68% decrease across Liverpool, Sefton, and Knowsley.
- Despite fewer children in care, requests for initial health assessments (IHA) had increased in all three areas.
- There is a notable increase (105%) in requests for adoption medicals from Liverpool, attributed to a return to pre-COVID twin tracking practices. There is ongoing work with Local Authority colleagues to manage this.

Highlights:-

- Participation groups had been established for children, young people, and carers to improve IHA experiences and support, with a focus on unaccompanied asylum-seeking children.
- Collaboration with Madlug ensures that children taken into care receive appropriate holdalls, replacing bin bags or carrier bags and enhancing dignity.
- IHA compliance performance has shown significant improvement, rising from approximately 5% in the past to around 90% currently, subject to some monthly fluctuations.
- Colleagues are collaborating with the infectious diseases team to modernise BBI processes and enhance digital systems.

Ongoing Challenges:-

- Statutory named doctor role for children in care remains unfilled; recruitment is ongoing.

- There had been a rise in the number of children placed in the region by other Local Authorities, many of whom present to the Emergency Department in crisis and require comprehensive liaison and care planning.
- There is ongoing pressures arising from children who are placed at short notice in private residential care, often presenting with considerable emotional needs. The team is responsible for escalating concerns appropriately and coordinating care with the originating Local Authorities.
- Priorities for the Current Year: include Recruitment of named doctor, Improved data collection and policy/procedure review and Enhanced quality of IHAs for children and young people.

GM praised the report and progress made to date, especially the collaboration with Madlug. GM referred to the payment system for children placed from other boroughs and the pressures this creates. NO advised that statutory guidance covers payments for IHAs, however most children remain in their originating area for assessments. NO advised that the main pressure is on the team supporting ED and mental health colleagues, especially for children placed in crisis without coordinated plans.
FB thanked NO and the team for their ongoing work.
Resolved: SQAC received and **NOTED** the Children in Care Annual Report

25/26/225 **Drugs & Therapeutics Quarterly Report**

PS presented the Drugs & Therapeutics Quarterly Report highlighting the ongoing improvements and key issues. SQAC acknowledged that the report is evolving as the committee matures.

- Two risks had been closed (Risk 42 and Risk 121).
- A New risk had been added: inability to provide a full ward service due to stretched staffing.
- Medicines management and administration audits are ongoing; findings and actions are now included within the report for transparency and learning.
- Audit calendar tracks progress and status, with examples provided for committee awareness.
- Outstanding actions in non-medical prescribing committee due to attendance issues, which is being addressed by the Non-Medical Prescribing Committee Chair.
- The Medical Gas Committee had been identified as requiring further development; initiatives are underway to reset and enhance engagement.
- MMOC is currently addressing the challenge of outdated medicines documentation on DMS, with plans underway to resolve this issue.
- The Patient Group Directions (PGDs) will be transitioned to the Non-Medical Prescribing Committee.
- Two moderate harm incidents were noted in Quarter 3.
- The target of reducing the number of ten-fold incidents by 10% Tenfold incidents would not be achieved, actions undertaken include changes within the electronic prescribing system, changes to guidelines, introduction of new infusion pump software and drug-specific thematic reviews.
- Controlled drug audit compliance is now displayed using barcodes with trend analyses; while overall compliance had decreased marginally, it remains stable.
- PS reported on staffing challenges resulting from elevated sickness rates and maternity leave, which had affected service provision.
- A ward service reset is currently in progress to ensure adequate coverage. Recruitment efforts and budget realignment are underway; however, full resolution is expected to take several months.

FB sought clarity regarding the nature of staffing challenges; PS clarified that the challenges are due to a mix of sickness, maternity leave, and the need for a service reset.
KB commended the enhanced governance clarity and inquired about engagement with divisional leads; PS noted that executive support from NA is facilitating increased engagement, with established escalation pathways available when necessary.

GM expressed concern regarding drug shortages and the implications of recent government pricing adjustments. PS responded that current shortages remain manageable, though the complexity of individual cases presents a greater challenge than the overall volume. There are plans to detail one shortage per quarterly report to enhance committee understanding.

NA acknowledged the ongoing improvements in QI application and data presentation, supporting the committee's work.
Resolved:- FB requested that divisions take steps to ensure consistent committee attendance and implement effective feedback mechanisms in support of the Chief Pharmacists work.
PS indicated that the DTC report is continually evolving and future iterations will include additional detail regarding the medical gas committee and drug shortages.

PS thanked NA for support and confirmed recommendations had been implemented.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Quarterly Report and **NOTED** the continued improvements and clarity in reporting.

25/26/226 Sunflower House Improvement Plan

LC presented the Sunflower House Improvement Plan for assurance and committee approval. The report detailed background detail, actions taken, and ongoing challenges following the closure of Sunflower House to direct admissions at the end of October 2025, the unit remained open for consultation. The closure was due to a combination of factors affecting safe and effective care delivery.

- Environmental challenges persist, causing significant stress for staff; the Chief Operating Officer/Deputy CEO and colleagues had recently visited the site to observe these issues.
- Weekly estate meetings are held to address infrastructure problems, with urgent mitigations and actions planned for the current and following week.
- NHS England provide ongoing support; meetings are held weekly with the team.
- An agreement was established to provisionally recommence admissions from early February 2026 on a case-by-case basis, contingent upon satisfactory progress with the action plan. If sufficient assurance is not provided, the Community & MH Divisional Director will escalate the matter to the Executive Team.
- CQC are fully briefed and had received the Sunflower House report, CQC will conduct an informal supportive visit in early February 2026.

FB affirmed the plan's clarity and suitability and inquired regarding future progress reporting. LC agreed to deliver verbal updates at the February SQAC meeting and would submit an additional progress report by exception at the April 2026 SQAC meeting.
FB noted that this issue also appears in the Divisional report, ensuring ongoing visibility.
FB confirmed that SQAC is assured that a robust plan is in place, with clear ownership and external oversight and confirmed that progress will be monitored and reported back to the committee as agreed.
Resolved: SQAC received, **NOTED** and **APPROVED** the Sunflower House Improvement Plan and received assurance from the report and welcomed a verbal update at the February SQAC meeting.

---- Effective -----

25/26/227 Southport Learning AR Review

NA presented the Southport Learning AR Review report and drew attention to a few key points from the report including:-

- NA referenced the Southport Learning AR review report in the pack which tracks progress on 39 actions, with 15 now complete (up from 6 last month), indicating good progress. All actions previously marked as "no" or "limited" progress had progressed, and delayed actions are expected to progress within the month. Several actions are due by the end of January 2026 with the Associate Director of Nursing & Governance and team relying on action owners to provide assurance evidence for sharing with the ICB.
- There is a notable rise in completed actions since the previous report.
- Remaining delayed actions are expected to progress soon.
- Assurance evidence is currently being gathered to address outstanding actions.

KB highlighted that some recommendations should be considered trust wide as a "second wave," such as record keeping, which would be a significant piece of work. KB sought clarity regarding timelines for switching to trust-wide actions and questioned how these would be addressed. NA responded that the focus would remain on current actions until the end of March 2026, after which time the team will consider broader trust-wide implementation. NA advised that some actions may not need to be trust-wide until an audit determines their relevance.

GM referred to any staff feedback regarding changes made to the electronic case records, specifically regarding information accessibility and alerts. LC confirmed positive staff feedback on Meditech improvements, with further enhancements going live week commencing 26.1.26. LC stated that staff feel listened to, and improvements allow for better record viewing and safeguarding indicators. LC also noted positive feedback from acute Trust colleagues on the new front screen, which improves visibility of key indicators such as Mental Health Act status and neurodevelopmental pathway involvement.

SQAC welcomed the progress and ongoing improvement and **NOTED** the positive staff engagement and feedback on digital record changes. SQAC **NOTED** the Trust-wide actions will be considered after the current phase, with further review planned for the next financial year.
Resolved: SQAC received and **NOTED** the Southport Learning AR Review report.

25/26/228 **Clinical Effectiveness & Outcomes Board Chairs Highlight report**

JR presented the Clinical Effectiveness & Outcomes Board Chairs Highlight report, summarising the meeting held on 9.1.26. The report focused on recent developments, audit participation, and areas requiring committee attention.

Highlights:

- NICE App Rollout: -The NICE app is now live and rolled out on InPhase, to enable more robust assurance reporting.
- NCEPOD Topic Proposal: - A topic proposal was submitted in collaboration with the Alder Centre to NCEPOD, focusing on physiotherapy-led support for physical postpartum recovery following baby loss which is a national issue. The NCEPOD CEO was optimistic about the proposal's prospects.
- The December Clinical Audit Master class received positive feedback, with an 86% positive response rate.

Challenge:-

- National Epilepsy 12 Audit (Cohort 7) – SQAC noted that the full submission for Cohort 7 had been completed, representing significant progress after previous difficulties, in contrast to the limited or absent data submission for Cohort 6. JR informed SQAC of challenges anticipated for Cohort 8, specifically due to an identified workforce gap at the outset of January 2026, which is expected to prevent timely data submission. This issue has not yet been documented on the risk register but has been escalated to the Division of Medicine, and a meeting is pending. Ongoing monitoring will be carried out by the Clinical Effectiveness Board.

FB acknowledged the previous notification about the workforce gap for cohort 8 and requested and welcomed a future update on the current status and actions taken to address this issue.

Resolved: SQAC received assurance regarding progress in audit participation, digital enablement, and proactive risk escalation, and acknowledged the update on cohort 8.
Resolved: SQAC received and **NOTED** the Clinical Effectiveness & Outcomes Board Chairs Highlight report

25/26/229 **Board Assurance Framework**

ES presented the Board Assurance Framework, emphasising the importance of reviewing overlapping risks and considering the impact of financial challenges on both operational and clinical risks. ES noted that the Risk Management Forum (RMF) is currently scrutinizing highly rated and operational risks, with their next meeting scheduled for 4 February 2026. The agenda will include a discussion on the effects of financial issues on risk, which will become a standing item for the RMF. ES proposed that, moving forward, a comprehensive report addressing these areas would be provided to SQAC in order to identify and mitigate any emerging control gaps.

- CQC Risk (1.1): ES reported the appointment of a new CQC inspection manager/operational manager and noted that a meeting with the new CQC team is scheduled in February 2026. ES assured SQAC that any emerging issues would be communicated to SQAC.

ES and FB discussed the benefit of clarifying potential overlaps among safety, quality, people, and finance risks, ensuring both committees have a clear understanding of their respective responsibilities for each risk area
FB praised the clarity regarding risk overlaps and the structured approach to risk management.

Resolved: SQAC were assured that the BAF is being actively managed, with clear oversight of risk overlaps and the integration of financial risk monitoring into regular review processes.
Resolved: SQAC received and **NOTED** the Board Assurance Framework

25/26/230 Board Assurance Framework Risk 1.4 Assurance Review

LC provided a comprehensive assurance review of BAF Risk 1.4, which addresses community mental health waiting times. The risk has been on the register since 2021, primarily due to post-COVID increases in demand and persistent staffing challenges. The current risk score is 15, with a target risk score of 9.

Current Status & Metrics:

- Significant improvements have been made in referral-to-assessment and referral-to-treatment times; however, challenges remain, especially with staff recruitment and retention.
- There are children waiting over 52 weeks for specific interventions, due to staff absences and delays in recruitment, particularly following staff movement to the new gender service. The Divisional Director for Community & MH meets with the team fortnightly to review these cases.
- The service is affected by closures of third-sector providers, which increases demand on services.
- New national standards are being introduced, including a 104-week wait metric. Currently, no children are waiting over 104 weeks, but there are data quality issues with outcome metrics for some records. Work is ongoing with NHS England to resolve this.
- Crisis care and eating disorder services are also monitored, with improvements noted in reduced admissions and enhanced support teams.
- Robust improvement plans are in place, with regular review and alignment of processes between Liverpool and Sefton localities.
- Digital enhancements have improved record visibility and reporting, supporting improved oversight of waiting times and safeguarding indicators.
- The risk score will not be reduced at this time due to ongoing challenges and new national metrics.

FB commended the clarity and comprehensiveness of the review, noting that it provided assurance on active risk management and the holistic approach taken by the teams.

Resolved:- SQAC were assured that Risk 1.4 is being actively managed, with regular review, robust controls, and ongoing improvement actions. The risk remains high due to persistent challenges, but transparency and proactive management are evident.
Resolved: SQAC received and **NOTED** the Board Assurance Framework Risk 1.4 Assurance Review

25/26/231 Review of Externally Sourced Service Provision – Interim Report

ES delivered the Review of Externally Sourced Service Provision, noting that the report was initiated due to prior concerns regarding IR(ME)R regulations and insufficient oversight of externally provided services (SLAs). The objective of this review is to consolidate information regarding all externally sourced services at corporate level, addressing the previous limitation where such data was retained only within individual divisions.

- The report identifies variation in SLAs, with some requiring service specifications and clearer KPIs. The next stage is to complete the mapping exercise by the end of March and develop a proportionate governance framework for ongoing monitoring.
- Governance Manager led the data gathering and analysis, and ES emphasised the need for proportionate oversight, recognising the diversity of SLAs and service types.

FB noted that the report should be shared across divisions to increase awareness of existing SLA content and identify gaps, facilitating ongoing enhancement and more effective monitoring. It was also recommended that the report be presented at divisional governance meetings to encourage the identification of any missing services and support further review of SLAs.
ES agreed with the approach and confirmed the next steps would include further engagement and framework development.

FB expressed thanks for the ongoing work undertaken to date and welcomed a further update once the mapping and framework are complete. The importance of divisional engagement and ongoing improvement of SLA oversight was **NOTED**.

Resolved: SQAC received and **NOTED** the Review of Externally Sourced Service Provision – Interim Report and welcomed an updated report at the March 2026 meeting.

---- Well Led ----

25/26/232 **Clinical Guideline extravasation & infiltration**
Resolved SQAC received, **NOTED** and RATIFIED Clinical Guidelines extravasation & infiltration

25/26/233 **Clinical Guideline for umbilical venous catheter care**
Resolved: SQAC received, **NOTED** and RATIFIED Clinical Guideline for umbilical venous catheter care.

25/26/234 **Clinical Guidelines taking blood cultures**
Resolved: SQAC received, **NOTED** and RATIFED Clinical Guidelines taking blood cultures

25/26/235 **Troubleshooting Broviac & PIC central venous access**
Resolved: SQAC received, **NOTED** and RATIFIED Troubleshooting Broviac & PIC central venous access.

25/26/236 **MRU hand hygiene SOP**
Resolved: SQAC received, **NOTED** and RATIFIED MRU hand hygiene SOP.

25/26/237 **Notifiable Diseases Policy – C50**
Resolved: SQAC received, **NOTED** and RATIFIED Notifiable Diseases Policy – C50.

25/26/238 **Pertussis (Whooping Cough) Policy – C60**
Resolved: SQAC received, **NOTED** and RATIFIED Pertussis (Whooping Cough) Policy – C60

25/26/239 **Screening and management of multi-drug resistant organisms (MDRO) Policy – C58**
Resolved: SQAC received, **NOTED** and RATIFIED Screening and management of multi-drug resistant organisms (MDRO) Policy – C58

24/26/240 **C76 - Records Keeping Standards Policy**
Resolved: SQAC received, **NOTED** and RATIFIED C76 - Records Keeping Standards Policy

25/26/241 **Safe Together and Always Right (STAR) Ward Accreditation Scheme – Standard Operating Procedure**
Resolved: SQAC received, **NOTED** and RATIFIED the Safe Together and Always Right (STAR) Ward Accreditation Scheme – Standard Operating Procedure

---- Any Other Business ----

25/26/242 **Any Other Business**
None received

---- Board Assurance ----

25/26/243 The key assurances and highlights report was presented to the Board meeting held on 4th December 2025

Date and Time of Next Meeting: 25th February at 9.30 – 11.30 am via Microsoft teams

Alder Hey Children's NHS Foundation Trust

MEETING OF THE GROWTH AND OPPORTUNTIES COMMITTEE

Confirmed Minutes of the meeting held on **Tuesday 16 December 2025 at 1:00pm. LT3**

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

25/26/014	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/015	**Declarations of Interest** MJ is Chief Solutions and Services Officer at Strasys Ltd, who have some involvement from time to time across the Cheshire and Merseyside healthcare system in an advisory capacity.
25/26/003	**Minutes and Action Log of the GO Committee Meeting on 7 October 2025**

	The minutes of the last meetings held on 7 October 2025 were approved. The action log was reviewed and updated.
25/26/017	**Top Opportunities and Challenges** The Committee received an update on the organisation's two major strategic opportunities: the development of the Paediatric Service Chain and the Children's Integrated Health Organisation (IHO). Both remain active priorities, with significant progress made since the previous meeting. The paediatric chain has now been firmly embedded as a system priority across Cheshire and Merseyside, expanding beyond an acute-focused model to a more holistic children's strategy that includes prevention, community-based services, commissioning, and neighbourhood-level provision. The IHO also continues to present a major national opportunity. Although not included in the initial national wave, the organisation retains a strong future pathway, supported by progress toward Advanced Foundation Trust status and strengthened relationships with regional partners, including the ICB. Work is underway towards a proposed shadow year in 2026–27, during which two to three service lines could operate under enhanced commissioning autonomy. A four-part children's strategy blueprint, developed collaboratively across Cheshire and Merseyside, has now been accepted into the wider system plan. This sets out a combined out-of-hospital model, the paediatric acute chain, a system-wide provider arrangement for children's services, and refreshed system partnership architecture. The Committee noted several key challenges associated with delivering these opportunities. These include the urgent need for robust data and baselining across all elements of children's care, significant workforce capacity and capability pressures, and the need to navigate challenging dynamics between the ICB and local authorities. Financial and commissioning resource constraints were also highlighted, alongside the importance of embedding research, innovation, evaluation, and health economics early in programme design. Despite these challenges, the Committee agreed that the opportunities remain strong and directionally sound, with growing system alignment and commitment across partners. **Resolved:** The committee noted the top opportunities and challenges.
25/26/018	**GO Metrics** The Committee received an update on the development of the GO Metrics, which have been refined through the GO Acceleration Team to create a simplified, meaningful set of measures that align with organisational priorities. The streamlined framework aims to provide a shared focus across teams, support baseline establishment, and enable clearer tracking of progress against the GO agenda. Overall, Themes 1 and 3 were considered strong, clear, and reflective of the organisation's ambitions. However, the Committee agreed that Theme 2 requires further refinement, as its current wording does not fully capture the breadth of aspiration or the complexity of the relationship between GO priorities and wider transformation programmes. Members highlighted the need for consistent measurement across both GO and Transformation activity to avoid duplication and ensure aligned outcomes.

	A key area discussed was the importance of defining what constitutes a "new model of care" and establishing measurable baselines. The Committee also emphasised that while quantitative measures are valuable, qualitative progress indicators—such as milestone achievements, the quality of models developed, and demonstrable improvements for children and families—are equally important and should be built into the framework. Several members noted that the current metrics under-represent research, innovation, and education, despite their centrality to organisational strategy and opportunities such as the paediatric chain and IHO work. It was agreed that these elements should be incorporated more explicitly into the revised metrics set. The Committee endorsed the need for additional work to refine Theme 2 and develop clearer definitions, supported by robust baseline data. Further alignment between GO and Transformation measurement approaches will now be taken forward, with research and innovation considerations to be more fully integrated into the framework before final approval. **Resolved:** The committee noted the GO Metrics and endorsed the additional work to refine them.
25/26/019	**Leading the Way for the Children's System** This was discussed during item 25/26/017.
25/26/020	**Research and Innovation** **POIZ Launch Plan** The Committee received an update on the Paediatric Innovation Zone (POIZ) launch, which will form part of the two-day 10-year Celebration Conference in March 2026. The launch was intentionally scheduled later in the programme lifecycle to allow the team to build capacity, establish programme structures and meet Combined Authority requirements. The event will include business engagement sessions, campus tours, workshops, and a formal launch led by the Metro Mayor, with keynote speakers already confirmed. Internal and external invitations will be issued, with green-fenced spaces reserved for organisational and partner representation. Internally, the programme team has progressed significantly, including appointing a Programme Manager, recruiting associate posts, strengthening clinical input, and supporting six businesses who will showcase their work at the launch. The innovation school's competition will also feed into the event, with children involved in demonstrations and award activities. The Committee emphasised the importance of positioning the launch as a system-wide endeavour rather than an Alder Hey-specific initiative and agreed that the full launch plan should return to Execs for further review and alignment. **Action:** **Bring the plan for the Paediatric Innovation Zone launch back through the Executive team and ensure inclusion of Cheshire and Merseyside partners if possible. (SL)**

	Institute of Child Health and Wellbeing next steps The Committee received a brief update on the Institute of Child Health & Wellbeing, which is now moving from strategic design into delivery planning. Key next steps include finalising the Institute's strategy and priority research themes, establishing its branding and visual identity, and confirming governance and funding arrangements across the three partner organisations. Work is underway to define hosting structures and ensure alignment with major organisational programmes such as the paediatric chain. The importance of building a strong academic workforce pipeline was highlighted, supported by exceptional recent recruitment into Academic Clinical Fellow posts. Engagement with wider Cheshire and Merseyside partners will form the next development phase, with the longer-term ambition of positioning the Institute as the leading paediatric research hub in the North. The Institute will continue to embed research, innovation, evaluation and health economics into major transformation programmes as operational planning progresses. **Grant Opportunity 2026** The Committee received an update on current and emerging grant opportunities. The main focus remains the Combined Authority–funded Paediatric Innovation Zone (POIZ), now in full implementation following the July 2025 grant agreement, enabling key programme appointments and progress against required economic and innovation metrics. Additional international and European funding opportunities are being explored through partnerships including the Barcelona innovation network and the Hartree Centre, with potential to access Horizon-aligned programmes and AI-focused grant streams. Research and academic grant income continues to underpin the work of the Institute of Child Health and Wellbeing, supported by strong recruitment into Academic Clinical Fellow posts. Further small-scale funding activity is linked to the Schools Innovation Competition and emerging opportunities through global partnerships such as Vietnam. These grant pathways collectively support ongoing innovation, research, and system transformation priorities. **Resolved:** The committee noted the updates provided.
25/26/021	**International and Private Patients** The Committee received an update on the development of the private patient's programme, which has progressed but remains constrained by limited dedicated resource. Diagnostics is the most advanced area, with strong insurer interest and the potential to utilise research radiographers to begin activity without impacting NHS capacity. The emerging private care offer focuses on diagnostics, day-case procedures, selected specialist services and a potential sports science Centre of Excellence. Strengthening commercial capability, contracting expertise, branding, and governance processes remains essential. The Committee supported moving quickly with early pilot activity rather than waiting for the full model to be built, emphasising the importance of demonstrating both income generation and benefits to NHS waiting lists. A business case for dedicated resource will be brought forward to enable the programme to scale at pace.

	Action: **Prepare and present the business case for private patients, keeping it small and reasonable, to the Executive team for consideration. (NA)** **Resolved:** The Committee received the updates on private patients.
252/26/022	**Programme Updates – Assurance** **<u>Research & Innovation</u>** The committee received updates on research and innovation activities, highlighting preparations for the Paediatric Innovation Zone launch, which will involve coordinated event logistics, stakeholder engagement, and participation from local businesses, schools, and international speakers. Recent international collaborations and conference attendances in Barcelona and San Diego were discussed, with an emphasis on learning from global best practices and hybrid public-private models. The team reinforced the importance of building partnerships across academic, clinical, and industry sectors, with innovation ambassadors and collaborative events cited as key networking strategies. The committee reviewed the financial landscape of research and innovation, highlighting improvements due to higher MRI scanner usage and opportunities to deploy research radiographers for private patient services. Despite ongoing deficits in the automation team budget, steps are being taken towards more proactive cost recovery. **Action:** **Produce a financial strategy paper for Research and Innovation for the next year, detailing funding sources, self-funding expectations, and the trust's financial position, and bring it to the next meeting. (SL)** **<u>Education</u>** The Committee received an update on Education, which continues to make strong progress across capacity-building and workforce development. The education programme is currently being refreshed and broadened, with a more diverse and inclusive offer aligned to organisational priorities and the wider Futures and GO transformation agenda. The recent launch of the Junior Research & Faculty initiative was highlighted positively, demonstrating growing engagement across clinical and academic teams. The Innovation Schools Competition is also underway and generating excellent feedback, helping to inspire future talent and strengthen community engagement. Overall, Education remains well-aligned with Research & Innovation and digital transformation workstreams, supporting the development of a skilled, research-aware and innovation-ready workforce. **<u>Global Health</u>** The Committee received a brief update on the Global portfolio, which continues to expand at pace, particularly through the strengthening Vietnam partnership and the launch of the international Observership Programme. A senior Vietnamese delegation will visit in March to support progression of the partnership and help secure local funding. The observership programme has now been fully formalised and is expected to generate a sustainable revenue

	stream, though capacity management will be important as demand grows. The Committee noted the absence of a middle-management layer within the Global function, which is limiting its ability to scale, and agreed this requires attention. New partnership categories have been defined to ensure clearer governance, and the refreshed Global KPIs were approved. Work continues on updating the Global Strategy to align with the organisation's financial and strategic context, with opportunities to better integrate international and commercial activity across the GO portfolio. **Resolved:** The Committee welcomed the progress being made in the areas and noted that the Global KPIs were approved.
26/26/023	**Strategic Partnerships** The Committee received an update on the rapidly expanding portfolio of strategic partnerships across the organisation. A comprehensive inventory has now been developed, mapping more than 50 partnerships and detailing their SROs, governance routes, scope, benefits and associated risks. While the list provides a strong foundation, it was acknowledged that further refinement will be required as partnerships evolve. The update highlighted that partnerships span several major themes, including Cheshire & Merseyside system collaborations such as the paediatric chain and IHO development; research and academic partnerships with multiple HEIs; digital and innovation collaborations including Blinx and regional FDP work; and an expanding global portfolio. This growing breadth has created variation in governance maturity and increased operational pressure on teams supporting these relationships. Resource constraints and inconsistent partnership oversight were identified as key risks. In particular, the organisation currently relies heavily on a small number of senior leaders, with limited programme and administrative support to manage the volume and complexity of the partnerships. The Committee agreed that stronger coordination and standardised governance are now essential to ensure alignment, reduce duplication, and maximise strategic benefit. Two governance options were presented: embedding oversight through existing committees or establishing a dedicated subcommittee of the GO Committee. The Committee expressed a clear preference for the creation of a Strategic Partnerships Subcommittee, which would bring together all SROs, undertake systematic reviews, and provide consistent assurance. A tiered approach to monitoring—distinguishing major strategic partnerships from lower-risk maintenance arrangements—was also supported. Partnerships will be incorporated into the revised GO Metrics under the partnerships and reputation theme. **Action:** **To establish a subcommittee or formal vehicle to govern strategic partnerships holistically, including regular review and risk stratification of partnerships. (AP**) **Resolved:** The Committee noted the Strategic Partnerships Update.

25/26/024	**Any Other Business** None raised.
25/26/025	**Review of the Meeting** The Chair highlighted that it is important to bring forward the plans for the POIZ launch through the executive team and, if possible, involve C&M partners. He looks forward to reviewing the business case related to private patients. Additionally, we anticipate the R&I financial strategy paper for next year, as it will be essential to our planning. It is also noted that the global KPIs, as outlined in the documentation, have been approved. Concerning strategic partnerships, there is a preference for a holistic approach with nuanced consideration. He thanked the committee for their participation.
	Date and Time of Next Meeting: 26 February 2026 at 1.30pm, Lecture Theatre 1, Alder Hey

BOARD OF DIRECTORS

Thursday, 5th March 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 ☐ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☐
Summary / supporting information	To provide a strategic update to the Board of the key people issues during January 2025.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care ☐ **Support** our people ☐ **Pioneering breakthroughs** **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes R No ☐

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

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

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

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 Janualry 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 and support, thriving teams and responsive interventions to support the organisation through change (thriving organisation).

New values

Since the new values were formally agreed by the Board in December 2025, the values working group is now focussed on the implementation plan with a focus on the development of a new values-in-action framework and toolkit. A task and finish group met on 5th February comprising representatives from HR, FTSU, EDI, SALS and OD to develop a draft framework based on the outputs of the consultation and engagement sessions held through 2025. The framework will be shared and agreed by the values working group on 3rd March before sharing with a wider reference group (clinical and non-clinical) before final agreement and launch.

Staff experience & support

The Staff Advice and Liaison Service continues to be busy with over 20,000 contacts to date since the service was formally launched in January 2020. In keeping with previous trends, the winter period has seen a rising number of people seeking help with January being the busiest month to date with 102 new referrals and 412 contacts in total.

Approximately 20% of staff accessing the service are on the sickness pathway which is higher than the 16% average and reflective of the higher rates of sickness in the organisation. In response, SALS have joined HR colleagues in a Sickness Absence Task and Finish Group to coordinate a response. Analysis of absence data has revealed patterns in teams where there are high volumes of stress-related absences in specific areas including many of the wards and Domestics. An outreach programme for leaders has been developed, including a warm invitation letter to SALS for those off sick and a ‘Stress Consultation Pathway’ to empower managers by sharing an understanding of what helps people stay and get well. SALS also offered a trust-wide session focused on coping with stress that has been viewed by over 300 hundred staff and widely shared. A new carer support group in partnership with the EDI lead and HR has also been established.

Over the last few months, there have been higher than average rates of access from the Divisions of Community and Surgery, connected to the impact of ongoing investigations, incidents and the Inquiry. The top 3 staff groups remain the same Nursing, Admin and Clerical, and Additional Clinical Services (HCAs). With workplace stress being a prevalent theme, specific workplace stressors include workplace incidents, impact of child death, incivility, and team culture. Additional stressors have included ward staff being moved and flexible working

requests being denied. Approximately 25% of contacts relate to staff seeking support for their mental health. This includes staff seeking support for post-traumatic stress, grief, anxiety, and depression including individuals presenting in a mental health crisis over the last few months.

Reflective of the rise in concerns about the cost of living, SALS have seen an increase in the number of staff signposted to the Citizens Advice Bureau. The team are also beginning to see and hear more about concerns relating to the organisation-wide change and are planning to respond with help and support for coping with uncertainty and change.

Thriving Teams

Our 2025-26 Staff Survey team level data has been utilised to segment all teams we received data for into 3 categories based on their average People Promise score: Thriving (upper quartile), Functioning (middle 50%) and Struggling (lower quartile). This information has already been shared with Execs, People Committee and Divisional Leads and meetings with Divisions Leads are currently being arranged to discuss the results and next steps. Alongside this, we are working with Digital colleagues to develop a Thriving Teams Index that brings the above data together with wider staffing and safety culture indicators. The Index will enable more regular assessment of team effectiveness and will be supported by a Thriving Teams toolkit to help leaders address priority areas within their teams. Our aim is to have a static prototype available for teams in Q1 2026–27.

In the meantime, we are collaborating with BI to produce this year's Big Conversation packs, which will incorporate elements of the Thriving Teams Index above to provide teams with richer data than ever before. The packs will also support discussions on the new Trust values, create space to reflect on the HWWWITF programme, and ensure that outcomes and actions are captured consistently.

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.

We have developed a new Leadership Competency Framework, aligned to the Trust's refreshed values and the national NHS Leadership and Management Framework which will underpin future leadership development, and expectations. All senior leaders in Wave 1 have been offered coaching and emotional support, and we are now designing a programme of team development for triumvirates and a new leader induction offer, both due to launch in April 2026.

We are also finalising a new intranet-based Change Hub, scheduled to go live by the end of February. The Hub will support staff to understand change and the impact it has on them as an individual, as well as support leaders to lead through change. It will also offer easy access to wellbeing resources and signposting to our internal Development Hub, and Careers Advice & Guidance intranet pages.

1. Equality, Diversity, and Inclusion

We continue to make tangible progress in embedding Equality, Diversity, and Inclusion (EDI) across the organisation so that staff feel safe, supported and empowered to thrive, strengthening our ability to deliver exceptional care for children and young people.

The Gender Pay Gap

We are pleased to present to the Trust Board this year's Gender Pay Gap report highlighting that the primary driver is the distribution of males and females within senior Medical and Dental

roles, and confirms the progress made to date alongside continued action to further narrow the gap. Alongside delivering the core recommendations, the Trust has continued to support NHS High Impact Action 3 to eliminate pay gaps and remains committed to implementing further actions that will reduce the gender pay gap and strengthening our commitment to a fair and equitable workplace.

Grow to Lead Development Programme
The expression of interest for our internationally recruited staff development programme, 'Grow to Lead', has now been circulated. The programme, delivered in collaboration with The Clatterbridge Cancer Centre, will begin in April. Its aim is to support our internationally recruited staff to feel valued and empowered as they continue to develop and grow in their roles.

NW BAME Assembly Anti-Racism Framework
We will be applying for the NW BAME Assembly Anti-Racism Bronze status in March 26 following a pre-submission process that helped us confirm we are on the right track for a successful application. The pre-submission stage also enabled us to gather evidence of our anti-racism journey and receive guidance from the BAME assembly ahead of our full submission in March. If we are successful, it will be a significant achievement demonstrating that our anti-racism journey is well underway, and we remain committed to progressing towards silver status and embedding an actively anti-racist culture across Alder Hey.

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% 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.

Widening Participation (WP)
The remit of the WP team continues to grow, with positive feedback being received from partners including schools and educational establishments we engage with. Provision has grown to include primary schools and SEN provision, as well as continuing support to secondary schools; and partners who support young people who are classed as disadvantaged e.g. care experienced and unable to attend mainstream school. Working with Elevate EBP, we have reviewed and refreshed our approach to 'experience of work' and have introduced a series of Industry Days, aimed at groups of young people from a selection of schools for years 8-9, to provide guidance, advice and practical opportunities to understand about the range of roles available in the NHS. Our total social value across years 1 and 2 now exceeds £406,000.

Apprenticeships
The matrix standard is an international standard for information, advice, and guidance (IAG) services. The matrix standard is owned by the Department for Education and ensures the high-quality delivery of IAG. It is relevant to all sectors and is a means of demonstrating quality. To maintain matrix accreditation, we, as an organisation and the apprenticeship information, advice and guidance services are reviewed every 3 years. The review involves consideration

of a raft of information (desk top review) as well as interviews with learners, managers, training providers. The Trust were successful in retaining this important accreditation following an assessment in February 26.

Undergraduate Medical Education
As part of the regular review of undergraduate medical education (UGME), we underwent a Quality Review by Edge Hill University in respect of our placement activity for medical students. The review covered a number of standards and areas as required by the GMC and National Education Contract. The feedback forms the review was overwhelmingly positive - which is testament to the focus we have embedded on student experience and continuous improvement. We are now working with EHU to increase placement opportunities to medical students earlier in their course (focusing on aspects such as public health and community) as well as looking at the implications of student number expansion over the next few years.

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.

PDR Update
The PDR process automation project has now gone live. It is anticipated this will reduce the admin burden within individual teams and increase reporting compliance. From an activity perspective as of 16 February 2026, 87.78% of B7+ colleagues are compliant, just short of the 90% KPI Trust target. When focusing on colleagues at B6 and below, compliance reduces to 70.12%. For the latter colleagues, eight areas have 100% compliance with another three achieving over 90% compliance in line with the KPI. Eight areas have compliance between 60.61% and 89.47%, equating to 729 people who require a PDR discussion between now and 31 March 2026 and for it to be recorded in ESR. The L&D team continues to support through training, updated reports, monitoring, and advice and guidance.

Training Needs Analysis (TNA)
In March, the L&D team will commence 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 in demand. 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 current sickness position (in-month) as of January 2026 is 6.69%, which is a reduction from the previous months position of 7.36%. Sickness rates are significantly higher than the Trust target of 4.5% with a split of both long term and short-term sickness absence (LTS at 4.22% with a target of 2.5%, and STS at 2.461% with a target of 2%). Alder Hey is not an outlier; these higher rates of sickness absence are being experienced by our colleagues in other Trusts across Cheshire and Mersey. A Northwest Chief People Officer and Deputy CPO meeting was held in February 2026, dedicated to the review and approach of addressing high levels of sickness absence across the region.

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.

Pay award

On 12th February 2026 the government announced the 2026/27 pay award for staff under the remit of the NHS Pay Review Body (NHS PRB). Staff on Agenda for Change NHS terms and conditions will receive a **3.3%** consolidated uplift. The pay award will be paid in April salaries, in line with ESR lead times.

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

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.

Recommendations & Board Actions

The board are asked to note the content of the report and support the actions being taken by the people services teams to support colleagues and mitigate the risks.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th March 2026

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

Does this relate to a risk? Yes R No ☑

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

Risk Number	Risk Description	Score

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

Alder Hey Children's
NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust Gender Pay Gap 2026 (reporting 2025)

Introduction

Alder Hey Children's NHS Foundation Trust is one of Europe's largest and busiest children's hospitals, providing care for everything from common childhood illnesses to highly complex and specialist conditions. Each year, Alder Hey supports more than 450,000 children, young people, and their families. Our Trust employs over 4,000 staff working across hospital and community settings. We are committed to reflecting the rich diversity of the children and young people we serve and to ensuring that our workforce feels supported, valued, and included. Our People Plan sets out how we will support and develop all our people. Alder Hey is dedicated to building a diverse and inclusive workforce that reflects our local communities and the families who come through our doors, while celebrating the creativity, innovation, and talent of our staff.

Background

Gender pay gap reporting is a vital mechanism for identifying and addressing inequality within the workforce. Since 31 March 2017, organisations with more than 250 employees have been legally required to publish their gender pay gap annually. This requirement supports transparency and accountability and enables organisations to better understand how systemic factors may influence pay outcomes. This report presents the gender pay gap data for Alder Hey Children's NHS Foundation Trust, in line with statutory requirements. It also provides background to support meaningful interpretation of the data and to inform our future actions aimed at reducing gender-based inequality. This work sits within the Trust's wider commitment to equality, diversity, and inclusion, recognising that fair pay and equitable access to opportunity are fundamental to an inclusive workplace.

It is important to distinguish between the gender pay gap and equal pay. Equal pay relates to differences in pay between males and females performing the same or equivalent roles and is unlawful. The gender pay gap, by contrast, reflects the difference in average pay between all males and all females employed by the Trust, regardless of role, grade, or working pattern. Gender pay gaps are often driven by organisational factors such as occupational segregation, part-time working patterns, and under-representation of females in senior or higher-paid roles. An organisation may therefore have clear equal pay arrangements while still experiencing a gender pay gap. Throughout this report, the terms 'males' and 'females' are used rather than 'men' and 'women', reflecting the statutory reporting methodology, which requires pay gap calculations to be based on sex. The Trust recognises and respects gender identity and is committed to creating an inclusive environment for all colleagues, including trans and non-binary staff. We also acknowledge that gender does not operate in isolation and that experiences of pay and progression may also be influenced by the intersection of gender with other protected characteristics.

Reducing the gender pay gap forms part of our broader approach to advancing equity, tackling discrimination, and improving equality of opportunity across our workforce. We are committed to using this data alongside other workforce

intelligence to drive sustained improvement and to ensure all colleagues are supported to thrive and progress at Alder Hey Children's NHS Foundation Trust.

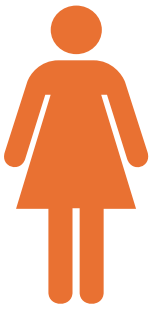
Collecting our data

Using snapshot data from our Electronic Staff Record System (ESR) this report looks at the following calculations to meet the requirements of the legislation:

- Mean gender pay gap in hourly pay
- Median gender pay gap in hourly pay
- Mean bonus gender pay gap
- Median bonus gender pay gap
- Proportion of males and females receiving bonus payment
- Proportion of males and females in each pay quartile

The snapshot date for public sector organisations is **31st March 2025,** this report therefore reflects our pay profile for the preceding 12 months from this date

17.69%



82.31%

As of 31 March 2025, 82.31% of the workforce identified as female and 17.69% as male. This distribution is broadly in line with previous years and reflects the national picture across NHS Trusts, where females continue to make up a higher proportion of the workforce than males

Pay Gap Summary

Difference between mean and median

We look at both the mean (average) and median (middle) for pay gap reporting. The mean difference is the difference in average hourly pay, adding all pay rates together and dividing by the total number of people. The median difference is the difference in hourly pay between the middle paid (the person at the mid-point if you were to line all

employees up from low to high pay) male employee and middle paid female employee.

Mean pay gap

This figure shows the difference in average hourly earnings between male and female employees. The data indicates that, on average, female employees earn 25% less per hour than male employees. This disparity mirrors wider workforce trends across the NHS, where women are disproportionately represented in lower pay bands, while higher-graded Medical and Dental roles are more commonly held by men. However, this pattern is not reflected at Alder Hey, where women make up 53% of our Medical and Dental workforce. This difference does not indicate unequal pay for the same work but highlights a difference in gender profile of senior and higher-paid medical roles. Addressing this disparity requires focus on progression, leadership development, inclusive talent management, and removing structural barriers to career advancement.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	29.2822	22.9937
Female	21.9237	19.0948
Difference	7.3585	3.8989
Pay Gap %	25.1296	16.9565

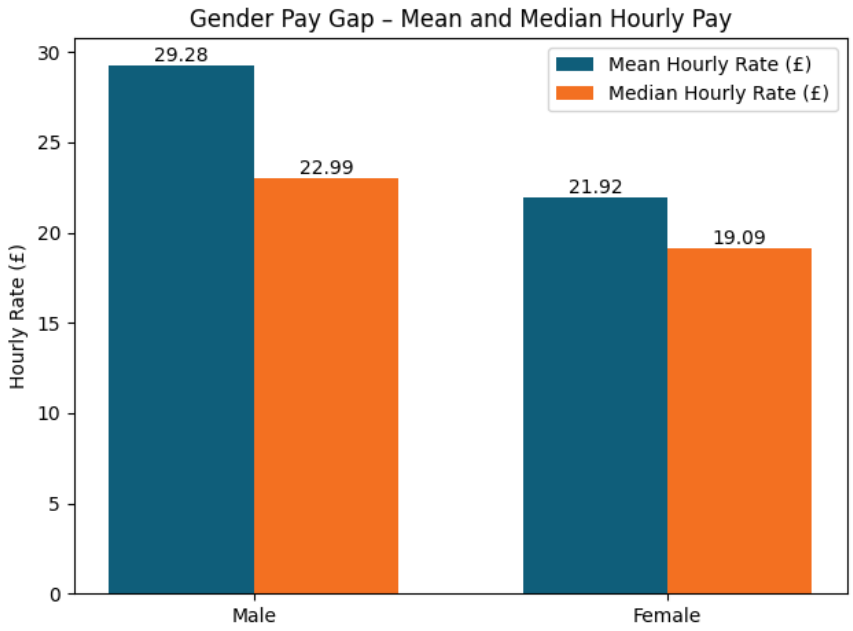


Chart1: Gender Pay Gap Mean and Median Comparison

Graph 1 shows that Males earn higher average and median hourly rates than females. The gender pay gap is 25.1% on mean pay and 17.0% on median pay.

Median Gender Pay Gap

This figure shows the difference between the median hourly earnings of male and female employees. The data indicates that female employees earn 17% less per hour than male employees, representing a 1% reduction compared to 2024. This reduction suggests modest progress in narrowing the gender pay gap. However, the gap continues to reflect organisational factors within the workforce, including differences in role distribution and representation at senior and higher-paid levels. Continued focus on equitable progression, access to development opportunities, and inclusive workforce planning remains essential to driving improvement.

Proportion of Males and Females in each salary Quartile Band

Quartiles are calculated by ranking all our employees from highest to lowest paid, dividing this into four equal parts (quartiles) and working out the percentage of males and females in each of the four quartiles. The chart below shows the proportion of males and females in each pay quartile; the lower quartile includes the lowest paid staff per hour, and the upper quartile includes the highest paid staff per hour. There are a higher percentage of males in the upper pay quartile compared to the percentage in each of the lower pay quartiles.

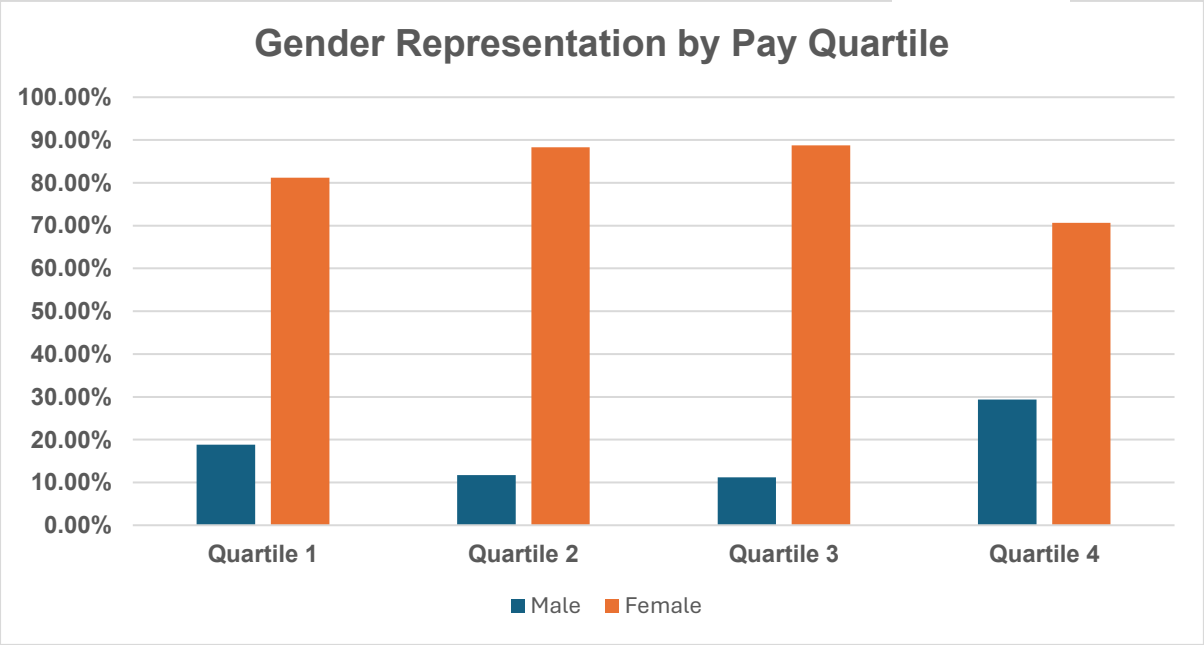
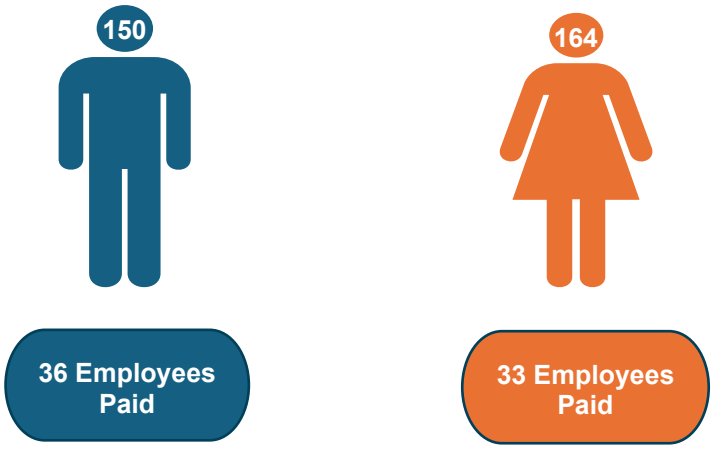


Chart 2: Gender Representation by Pay Quartile

Gender Pay Gap Bonus Pay

Bonus pay is included within basic pay for the purposes of calculating mean and median gender pay gap figures. Bonus pay was previously awarded through the **Local Clinical Excellence Awards (LCEAs)** for eligible Consultant Medical and Dental staff. These awards recognised exceptional contributions to high-quality patient care beyond the standard expectations of the role. The contractual entitlement to an annual LCEA round **ceased on 1 April 2024**, following national changes to consultant contractual arrangements. To ensure fairness and continuity while new national arrangements were being developed, an interim approach was used in which available LCEA funding was distributed equally among eligible staff, and no new competitive awards were made during this period. In 2025, 150 male and 164 female staff met the eligibility criteria; however, payments were made only to those who held existing awards under the previous scheme, resulting in payments to 36 males and 33 females. This reflects legacy award holdings.

Separately, the **national Clinical Excellence Awards (NCEAs)** had already been replaced in 2022 by the **National Clinical Impact Awards (NCIAs)**, a new national framework designed to improve transparency, equity and consistency. Updates to the national awards process and payment rules were introduced for the **2025 awards round**.



Mean Bonus Gender Pay Gap

The data tells us that on average bonus pay, female employees earn 20.02% less than male employees.

Median Bonus Gender Pay Gap

The data tells us that on median bonus pay, there is no difference between female and male pay. This data below compares the number of Medical and Dental staff receiving bonus payments with the total Medical and Dental workforce.

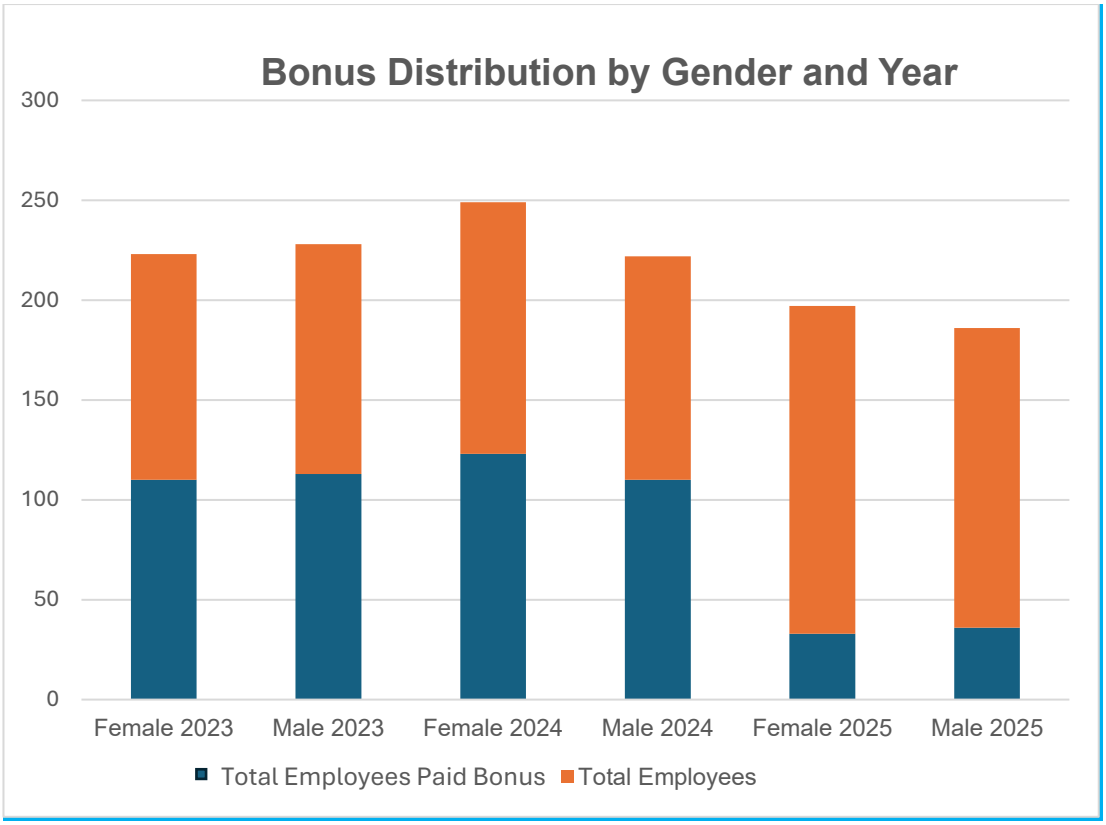


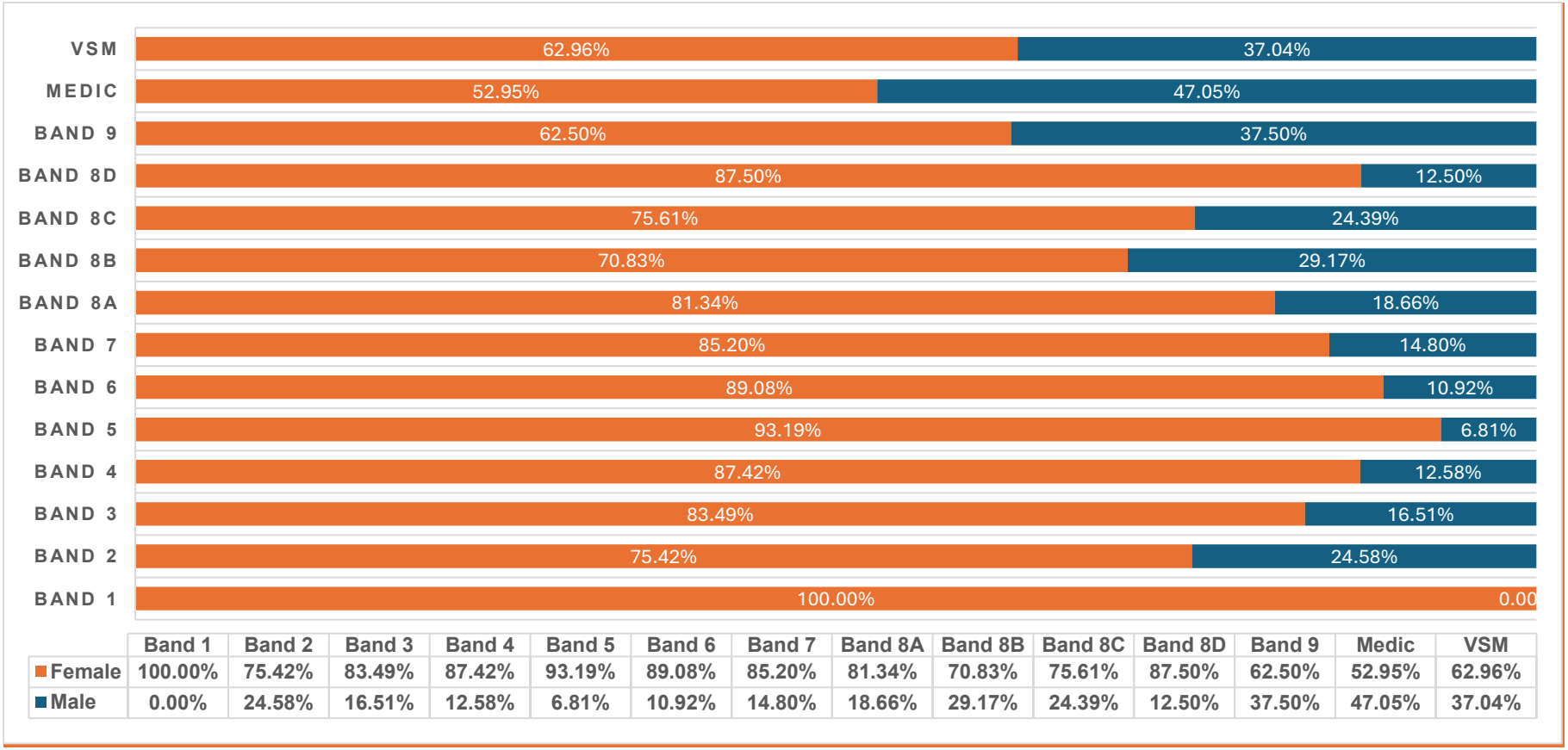
Chart 3: Bonus Distribution by Gender and Year

In addition, from April 2025 the national transition from CEAs to Clinical Impact Awards introduced a timing delay, whereby awards are granted from 1 April in the year following application. As a result, awards applied for in 2025 will not be reflected in bonus pay data until April 2026. The apparent reduction in bonuses in 2025 therefore reflects changes to award mechanisms and payment timing rather than a reduction in access to awards or recognition for female doctors.

The Trust will continue to monitor the impact of the new national award arrangements on gender pay gap outcomes, including differential effects by sex, grade, and specialty, to ensure that future award processes support fairness, transparency, and equity.

Understanding our results

Alder Hey staff are employed on national contractual terms and conditions; Agenda for Change Bands 1-9, Medical and Dental, and Very Senior Managers (VSM). The chart below shows the gender differences between grades and staff groups, with the biggest variation to this being within AfC Band 8d and 9, and medical staff.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medic	VSM
Female	100.00%	75.42%	83.49%	87.42%	93.19%	89.08%	85.20%	81.34%	70.83%	75.61%	87.50%	62.50%	52.95%	62.96%
Male	0.00%	24.58%	16.51%	12.58%	6.81%	10.92%	14.80%	18.66%	29.17%	24.39%	12.50%	37.50%	47.05%	37.04%

Chart 4: Gender Differences Between Grades & Staff Groups

AFC BREAKDOWN

An analysis of pay for Agenda for Change (AfC) staff only shows a mean gender pay gap of 1.33%. A mean gap of 1.33% indicates that on average, female AfC staff earn slightly less than male AfC staff. This is usually due to more men occupying higher paid roles within the AfC pay scale, even if the number of women overall is greater, and even a small number of higher paid male staff can produce an increase. In contrast, the median gender pay gap is -5.18%, meaning that at the midpoint of the pay distribution, female AfC employees earn 5.18% more than male AfC staff. This shows that women are more heavily represented within the mid-range bands. Female staff are better represented and are earning slightly more, which pulls the median in their favour.

The small mean gender pay gap of 1.33% reflects higher concentration of men in senior AfC roles, which increases the male average hourly rate. In contrast, the median pay gap of -5.18% indicates that females are well represented across the middle of the AfC pay structure, resulting in a slightly higher midpoint hourly rate for female staff. This variance shows factors, particularly representation in the highest AfC bands influence the mean gap, rather than unequal pay for equivalent work.

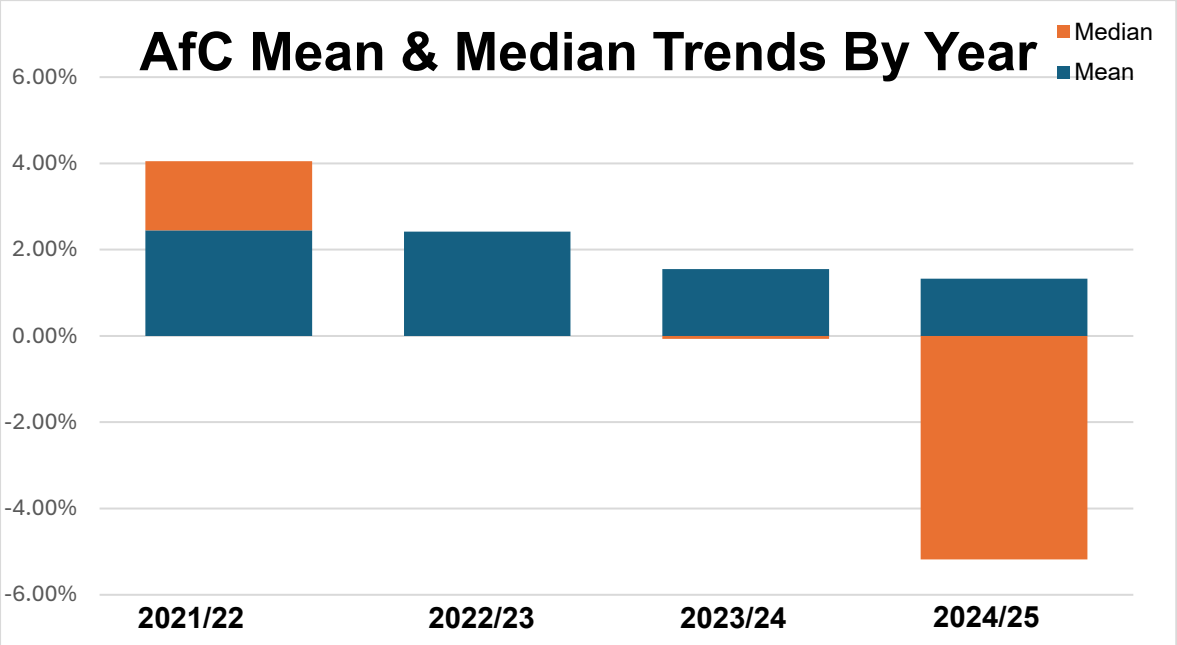


Chart 5: AfC Average & Median Trends by Year

Medical and Dental breakdown

Within the Medical and Dental workforce, females make up 52.95% of staff, with males representing 47.05%. The Medical and Dental gender pay gap has reduced steadily over time, with both the average (mean) and median gaps narrowing across the four reporting years. The mean gap fell from 8.77% in 2021/22 to 2.04% in 2024/25**,** while the median gap reduced from 2.94% to near parity at 0.15%**.** This indicates significant progress towards pay equality, particularly at the midpoint of pay, although a small average gap remains, reflecting continued differences in the distribution of men and women in higher-paid roles. This reflects long-standing

workforce composition and progression patterns, rather than differences in pay for the same role or individual performance. The disparity in length of service between male and female medical staff is reducing over time. As this balance continues to improve, it is expected to have a positive impact on narrowing the gender pay gap within this staff group.

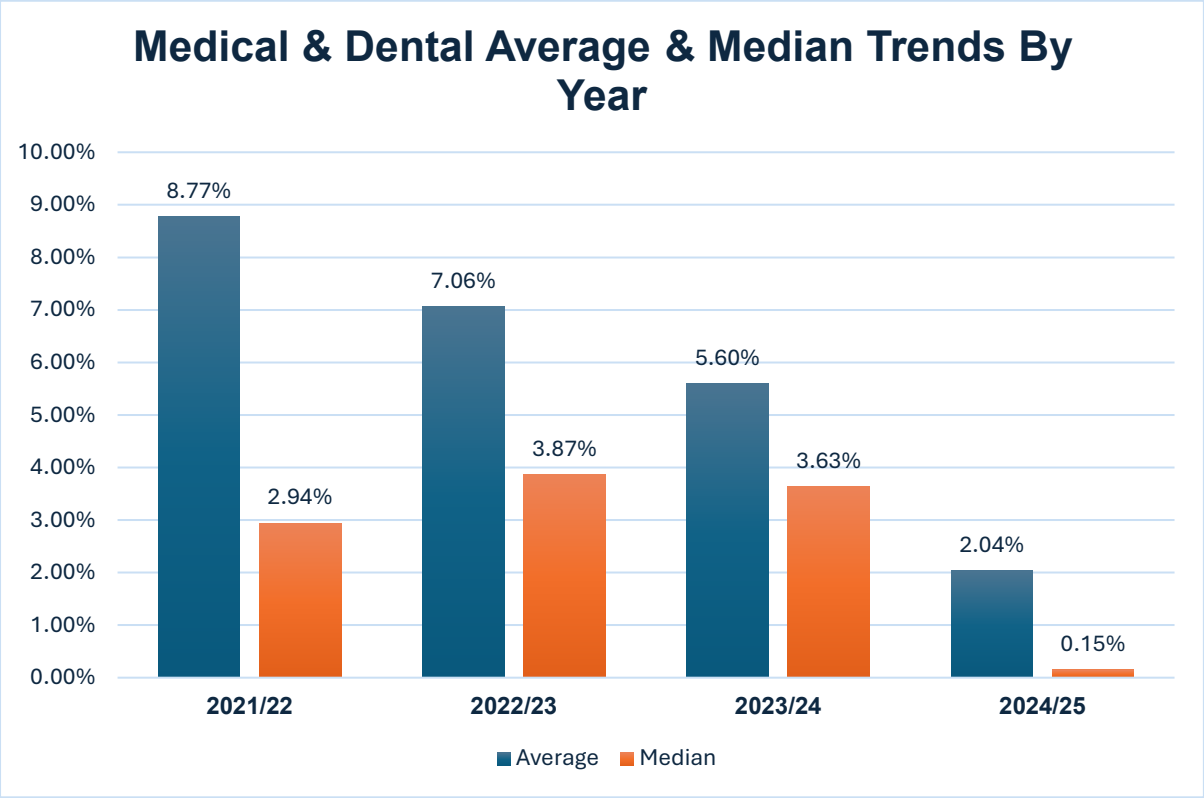


Chart 6: Medical & Dental Average & Median Trends by Year

Conclusion

This report presents the Trust's gender pay gap data in line with Government reporting requirements, ahead of the statutory submission deadline of 31 March 2025.

- **Mean gender pay gap:** 25%
- **Median gender pay gap:** 17%

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 disproportionately 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. However, recent recruitment trends show an increasing number of female consultants, which is expected to positively reduce the gap. Several factors contribute to the remaining gap, including differences in role distribution, length of service, pension arrangements, and patterns of flexible or part-time working. To address these issues, we are taking targeted action to improve

gender balance in senior clinical roles, ensuring equitable access to progression opportunities for all staff, and strengthening our leadership development pathways. These steps will support long-term sustainable progress in narrowing the gender pay gap.

Recommendations

Alder Hey Children's NHS Foundation Trust is committed to fostering an equitable and inclusive workforce. Actions to reduce the gender pay gap will be embedded within the Trust's Workforce Equality Objectives, incorporated into the People Plan, and monitored through the People Committee.

The key objectives include:

1. **Promoting a flexible working culture** (High Impact Action 1)
   Actively promoting flexible working for all staff and supporting those returning to work following extended periods of absence, recognising the role flexibility plays in supporting work-life balance and equality.

2. **Driving behavioural and cultural change** (High Impact Actions 1 and 6)
   Addressing unconscious bias, promoting gender equality in leadership, and challenging practices and behaviours that may disadvantage females.

3. **Embedding fair and inclusive recruitment and talent management** (High Impact Action 2)
   Strengthening recruitment, progression, and talent management approaches to address under-representation and ensure equity of opportunity across all staff groups.

Actions implemented

In addition to the core recommendations, the Trust has continued to support delivery of NHS High Impact Action 3 to eliminate pay gaps. In past 12. Months we have introduced the following initiatives:

- Development of dedicated Carers and Endometriosis support groups
- Continued delivery of the Trust's commitment to the Sexual Safety Charter
- Inclusive recruitment and progression training for managers to address unconscious bias

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**Chair's Report from ARC meeting, 12th February 2026**
Report of:	**ARC Chair**
Paper Prepared by:	**ARC Chair**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Minutes from the meeting on 10th December 2025
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☑
Resource Implications:	None

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

Risk Number	Risk Description	Score

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

1. Introduction

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

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

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

- Presentation on risk management processes within Medicine
- Update on the Roll Out of Risk Appetite and Tolerances
- Board Assurance Framework (ARC deep dive of Futures risk 4.1)
- Risk Management Forum Update including Chair's Report and Minutes from most recent meeting
- Corporate Risk Register
- Trust Risk Management Report
- Risk Horizon Scanning Discussion
- Draft Internal Audit Plan for 26/7
- Internal Audit Progress Report, including the outcomes of audits of Financial Measures – Grip & Control (Substantial) and Balance Sheet Control Accounts Processes (Moderate)
- Follow Up of Previously Agreed Internal Audit Recommendations
- Anti-Fraud Services Progress Report
- Recommendations from the National Proactive Exercise on Contract Management and the Local Proactive Exercise on Agency / Bank Staffing – ID validation and vetting (Fraud reviews) and their implementation status
- Update on the challenges in producing information on clinical and non-clinical claims
- Q3 Assurance Report on Compliance with the Data Protection and Freedom of Information Acts
- Accounting Policies Update
- External Communications Policy (Approved)
- ARC Terms of Reference and Workplan (Approved)
- Outcome of the effectiveness reviews of Internal Audit, External Audit and the Anti-Fraud Service

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

The Committee noted that the delivery of the Internal Audit plan is behind schedule for this point in the year. Assurance was sought (and received) from MIAA regarding its completion by year-end. MIAA advised that all Trusts across C&M are in the same position, reflecting the response to financial challenges within the region.

4. Positive highlights of note / areas of significant discussion

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

- The risk management presentation by Medicine Division allowed ARC to seek further information and ask questions of the Divisions risk management processes and oversight to obtain assurance as to their effectiveness
- ARC received an analysis of the Corporate Risk Register which highlighted risks which had external dependencies, those with a robust action plan and those without which will enable future discussions to be focussed effectively
- ARC received the Draft Internal Audit Plan for 26/7 and details of how it was drawn up (understood who was consulted, information reviewed, mandated audits) and how the proposed audits were identified and prioritised. ARC considered each of the proposed audits and approved for the Final Plan to be presented to its April meeting subject to resolving the funding source for an audit of the Governance of the Liverpool Neonatal Partnership
- The 25/6 Internal Audit Plan (see Appendix 1) included proportionally more finance related audits than is usual given the financial challenges within C&M and the requirements of the ICB. In 26/7 the Plan is less finance focussed and includes audits of areas of emerging or increased risk such as Governance of POIZ, PFI Contract Management, Sickness Management and Specialist Mental Health Services Waiting List Management
- Also included in the 26/7 Internal Audit Plan is an audit of AI Governance which MIAA are undertaking across all the C&M Trusts which should enable sharing of good practice
- Following investigations by the Anti-Fraud Service into referrals relating to an incidence of alleged timesheet fraud and one of theft of medical items, ARC commissioned reports from management of a review of the internal controls in both areas and of changes made to reduce the opportunity for future instances.
- The outcome of a detailed effectiveness review of the Internal Audit Service and light touch reviews of External Audit, the Anti-Fraud Service and of ARC itself was received which confirmed no significant weaknesses and highlighted some minor enhancements to ARC's operation.
- Finance presented a detailed Accounting Policies paper which highlighted any areas of significant change since the prior audit, or those where accounting judgements are open to interpretation and therefore may require increased discussion with, and review by External Audit. ARC reviewed each of the items presented to understand their potential impact on the Trust's Control Total, Financial Statements and the external audit process.

5. Issues for other committees

SQAC and the Clinical Effectiveness and Outcomes Board (CEOB) are asked to consider whether a regular, formal effectiveness review of Clinical Audit effectiveness should be undertaken to provide an evidence base to inform the assurance provided by SQAC to ARC on the delivery of clinical audit.

6. Recommendations

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

Appendix 1 – 2025/26 Internal Audit Plan

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

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

Audit	Assurance	May be of interest to…
Cyber Assessment Framework Part 2	Limited	FTPC
Clinical Governance	Substantial	SQAC

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

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Wednesday 10th December 2025 via Teams**

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr A Bateman	Chief Operating Officer & Deputy Chief Executive	(AB)
	Ms. E. Kirkpatrick	Assoc. Director of Finance - Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRo)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Item 25/26/101	Ms. C. Cortez-James	Risk and Governance Lead, Division of Surgery	(CCJ)
Apologies:	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)

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

25/26/97 Introductions and Apologies

The Chair welcomed everyone to the meeting, noted the apologies that had been received, and outlined the agenda, emphasising that risk will be the main topic of discussion during the meeting.

The Chair noted that December's meeting is routine from a reporting perspective and recommended that policies, procedures, etc. be submitted during this point in the annual cycle.

25/26/98 Declarations of Interest

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

25/26/99 Minutes from the Meeting held on 18th September 2025

Resolved:

The minutes from the meeting held on the 18.9.25 were agreed as an accurate record of the meeting.

25/26/100 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action *25/26/44.1:* *E&Y External Audit Year End Report on the Trust's Accounts (Schedule a Meeting with E&Y/Finance to discuss the additional audit fees in further detail)* – A further discussion is required to reach an agreed position of which will be presented to the Council of Governors (CoG) on the 16.12.25. **ACTION TO REMAIN OPEN**

Action 25/26/51: *Clinical Audit Annual Report for 2024/25 (Develop a process for monitoring and gaining assurance on the completion and embedding of actions from Trust-wide clinical audits)* – This area of work is currently being reviewed as part of the development of the InPhase Clinical Audit Module and has also been incorporated on the Clinical Audit Work Plan for 2026. It was reported that there have been delays in progressing this action due to limited capacity within the Clinical Audit Team. It was confirmed that this action will form part of the MIAA Oversight Action Plan. **ACTION CLOSED**

Action 25/26/61.1: *Rollout of Risk Appetite within CAMHD (Following rollout of Risk Appetite in Divisions and Services, the Governance Team will meet with Division/Service to discuss queries identified during the rollout and to agree actions to resolve them; where this results in a new process these will be added to the Risk Appetite Principles document, included as part of future rollout, and communicated to teams who have rolled out previously)* - It was reported that the rollout of risk appetite is currently paused. The Community and Mental Health (C&MH) Division have finalised their risk appetite, and all feedback and learnings have been included in the updated Risk Management Policy and the draft Risk Appetite Principles document. Collaboration has taken place with the Division of Medicine (DoM) and Corporate Services to determine their risk appetite, which is subject to review once the Trust Board has approved risk appetite tolerances for 2026. **ACTION TO REMAIN OPEN**

Action 25/26/61.2: *Rollout of Risk Appetite within CAMHD (how we implement the lessons learnt from C&MHD experience) – It was confirmed that narrative has been incorporated within the updated Risk Management Policy (page 13).* **ACTION CLOSED**

Action 25/26/62.2: *Review of BAF Risks (FPTC) – Undertake a piece of work to ensure that the 'Top 5 Risks' presented at FTPC are aligned with the strategic risks captured in the BAF* – The top areas of risk in the BAF have been updated, including the Campus and the finance risk. All FTPC top 5 risks are now reflected in the BAF, which will continue to be regularly reviewed and updated. Updates will appear in the next iteration of the BAF. **ACTION CLOSED**

Action 25/26/86.1: *Internal Audit Progress Report (Arrange for the Cyber Improvement Plan to be submitted to FTPC in October 2025 and included on the Workplan at appropriate intervals)* – The Cyber Improvement Plan is to be presented to Finance, Transformation and Performance Committee (FTPC) during January's meeting and will be included in the FTPC work plan for future reference. Discussions are ongoing with the Chair of FTPC, John Kelly, about where and what cyber-related information is reported. It is expected that this matter will be resolved by January. **ACTION TO REMAIN OPEN**

25/26/101 Update on the Risk Management Process within the Division of Surgery

The Committee received a detailed presentation on the Division of Surgery's approach to risk management. It was reported that the Division operates two weekly "rapid review" meetings focused on assessing new risks, reviewing high-risk incidents and ensuring timely updates to

existing risks. A further weekly Wednesday risk review meeting brings together senior Divisional staff, governance leads, risk owners and managers to examine risks due for review and determine whether they should be escalated, downgraded or amended. It was confirmed that governance support is provided directly to specialties, including attendance at monthly meetings to identify new or emerging risks and advise on additions to the risk register.

It was explained how new risks enter a holding area within the InPhase system when first submitted. They are discussed at rapid review meetings and are only transferred onto the live risk register once sufficient information, controls and actions have been provided. Risks are sometimes returned for further detail if insufficiently described. The Division also maintains oversight of its departmental risk profile and ensures that weekly reviews keep the register up to date.

The Chair asked for more information about how emerging risks discussed in governance meetings with specialties are escalated into Divisional processes. It was reported that specialties present new and emerging risks to Divisional governance forums, such as Divisional Integrated Governance (DIG) meetings. This helps prompt discussions and, when appropriate, the inclusion of these risks in the risk register.

A question was raised about how the risk management processes described support learning and reduction of serious incidents, specifically noting three incidents relating to retained surgical items. The Committee was advised that the risk management process has been implemented at Theatre Safety Board level where risk identification is a standing item on the agenda. It was clarified that the three cases arose in different teams and specialties, and that a subject-matter expert with human-factors expertise has been commissioned to undertake a Trust-wide review across theatres.

The Chair requested that the Division ensure risk descriptions are clearly articulated when an increase in score from 12 to 15 brings the matter to Assurance Committee level, so that Non-Executive Directors who may not be close to the operational detail can understand them. The Committee was advised that this issue is a recurring topic at the RMF, where unclear descriptions are regularly challenged and risk owners are asked to provide revisions. It was also noted that the implementation of risk appetite and tolerance should support teams in the Division determine consistent target scores.

The Chair offered thanks for the comprehensive overview, observed a clear increase in risk awareness within the Division, and emphasised the need to maintain this progress. The Chair welcomed the structured approach and the mechanisms in place to ensure new risks are captured consistently.

Resolved:
ARC noted the update on the Risk Management Process within the Division of Surgery.

25/26/102 Update on Risk Appetite and Tolerance Rollout

The Committee received an update on the status of the rollout of risk appetite and tolerance. It was reported that while strong progress has been made, including successful piloting in the C&MH Division, a decision had been made to pause the formal rollout due to significant shifts in the Trust's operating environment and competing organisational priorities. In particular, the Medium-Term Plan, the Advanced Foundation Trust (AFT) application and wider system pressures meant it would not be appropriate to embed a formal appetite

statement at this time, as it would likely require rapid revision. It was confirmed that discussions on risk appetite and tolerance continue informally enabling the organisation to maintain familiarity with the approach.

The Chair queried whether the pause reflected capacity constraints, changing risks, or both. It was confirmed that the pause was driven by both factors. The Chair also questioned as to whether the rollout would require a significant redesign when implementation resumes; the Committee was advised that only refinement, not redevelopment, will be required.

Following discussion, the Committee agreed with the approach pointing out that it wouldn't be sensible to set a Board-level risk appetite statement at this point in time. It was confirmed that the Trust aims to revisit this work early in the new financial year, once there is more clarity on the organisation's AFT application and Medium Term Plan.

Resolved:
ARC noted the update on the rollout of risk appetite and tolerance.

25/26/103 Board Assurance Framework (BAF) Report

The Committee received the Board Assurance Framework (BAF) Report for October. It was pointed out that the Trust's strategic risk profile has experienced substantial changes driven by external pressures. Attention was drawn to emerging risks including issues relating to the PFI, and emphasis was placed on the importance of understanding how financial decisions, workforce constraints and operational pressures interconnect across the organisation.

It was reported that a number of the organisation's top risks have been refreshed following detailed reviews of the BAF and alignment with Divisional risk registers. The challenge of balancing transparency with commercial sensitivity when drafting the PFI risk was also noted.

The Chair reflected that financial, people, operational and quality risks are deeply interconnected and could no longer be viewed in isolation and asked whether the reductions shown in impact scores between current and target ratings on several BAF risks were justified, noting that controls normally influence likelihood, not impact. The Chair also questioned whether the rapid pace of change across the organisation was being sufficiently captured in the BAF, and whether updates are sufficiently aligned with ongoing developments.

Concerns were raised regarding the impact of industrial action, particularly its effect on morale and the financial strain on the Trust, and it was queried as to whether this risk is adequately reflected in the BAF. It was noted that the upcoming period of industrial action, combined with winter pressures, is expected to be the most challenging to date and carried increased operational and safety risks.

The Chair proposed that the organisation may require a consolidated BAF risk to reflect the combined effects of financial constraints, workforce challenges, cultural impacts, industrial action, and major transformation programmes. The Committee agreed that this required further consideration.

25/26/103.1 Action: ES

Focus on People Committee risks (2.1, 2.2 and 2.3)

The Committee received an update focused on risks overseen by the People Committee. The Chair of the People Committee, Jo Revill, reported that the organisation has seen significant shifts in people-related risks over recent months, driven by the challenging financial environment, sustained pressures across the NHS, and a noticeable decline in morale within certain staff groups. It was reported that Divisions have been actively reviewing their workforce risks, with particular attention to mandatory training compliance, where collective work is now underway to improve performance across the Trust.

The Chair observed that people risks could no longer be seen as isolated issues and asked whether the People Committee is routinely considering the cross-cutting effects of financial controls, workforce shortages, culture and patient safety. It was confirmed that these interdependencies are now a core part of People Committee discussions.

Resolved:
ARC noted the BAF report for October 2025 and the review of the BAF risks allocated to the People Committee.

25/26/104 Risk Management Forum Update; including Chair's Highlight Report and Corporate Risk Register

The Committee received an update on December's RMF and the Extraordinary RMF that took place on the 5.11.25; which was held to examine the impact of recent financial decisions, strengthen the triangulation between financial controls, workforce pressures and operational risks, and encourage Divisions to highlight under-reported or emerging risks. The session was noted to have been well attended and to have enabled open and constructive discussion.

AB summarised the outcomes of the Extraordinary RMF, highlighting three principal outputs:

- Clearer identification of the risk implications of recent financial controls.
- Enhanced insight into workforce availability, sickness and maternity leave data.
- Identification of high-risk areas requiring further mitigation.

It was reported that the Divisions found the new workforce analytics particularly valuable and had been asked to review them further to ensure the risk register accurately reflected current pressures. It was also confirmed that some risks previously assessed as high had subsequently reduced in severity, while others, especially related to recruitment, absence rates, and medical rota fill, had increased.

The Chair of the RMF advised that it has been agreed to dedicate time at future meetings to continue this deeper examination of cross-cutting risks due to their increasing significance. Attention was also drawn to the importance of full Divisional representation at RMF meetings to maintain a comprehensive organisational risk picture.

The issue of articulating aggregated, system-level risks was highlighted, and it was queried as to whether a more sophisticated risk-aggregation model existed. The Chair noted that established models from other industries have been reviewed; however, a suitable framework has yet to be identified. Efforts will continue to identify an approach that can be tailored for application within the NHS.

A question was raised about whether there should be a more formal mechanism to ensure that insights from the RMF are consistently fed into People Committee discussions. It was reported that Divisional and Corporate leads are expected to feed relevant risks through the risk register process. It was also pointed out that the RMF has recently taken steps to strengthen cross-committee alignment and will continue to refine this.

The Chair asked as to whether NED attendance at the RMF risked inhibiting discussion. It was confirmed that Fiona Beveridge's recent attendance had not inhibited openness, and that the RMF are comfortable with NED attendance from an observational perspective.

Corporate Risk Register (CRR)

The Committee received the CRR for the reporting period from the 1.10.25 to the 31.10.25.

Resolved:
ARC noted the RMF update, the CRR for the reporting period; 1.10.25 to the 31.10.25, and the approved minutes from the RMF held on the 5.9.25.

25/26/105 Risk Management Training Options

The Committee received a report on the proposed options for the suggested roll out of risk management training across the Trust, for discussion purposes and agreement. The following points were highlighted:

- In March 2025, the Education Governance Committee (ECG) considered the request for risk management training to be made a mandatory requirement. The decision made by the EGC was that risk management training should be treated as essential linked to role requirements. The Central Governance and Risk Team were asked to consider this, with the Learning and Development Team providing guidance on how this can be actioned
- Based on discussions, a blended approach was proposed as the preferred, realistic model; E-Learning package plus a monthly one-hour drop-in session led by the Central Governance and Risk Team. Although this option does not align to the NHSE (2024) Statutory and Mandatory Training Programme, it was emphasised that risk management capability remains essential across the Trust.
- It was reported that the Trust cannot make this training mandatory within ESR, as it does not qualify under NHSE mandatory categories.
- The Committee was advised that the Divisions already undertake local risk management sessions and have found them beneficial.

The Chair queried as to whether the E-Learning module will be Trust specific. It was reported that the module is a generic package, intended only to provide baseline knowledge. Trust-specific practice and contextual learning will be covered through drop-in and Divisional sessions.

A question was raised about how uptake/compliance will be monitored. It was reported that staff will be encouraged to self-record training completion in ESR, but the Trust cannot enforce compliance. Nevertheless, local Divisional engagement will continue, with a focus on practical support.

Resolved:
ARC supported Option 3: Blended Approach for the roll out of risk management training across the Trust.

25/26/106 Risk Management Policy

The Committee received the updated Risk Management Policy which has undergone a substantial rewrite to remove outdated references, clarify structures, processes and responsibilities for risk management, and align the policy with current Trust practices and governance pathways.

It was reported that a correction was required within the document as it incorrectly stated that risk categories were based on the cause of a risk. It was confirmed that this would be amended to reflect the correct principle that categorisation must be determined by the consequence of the risk.

Following discussion, the Committee confirmed its agreement with the amendment to the policy, and it was noted that the Chair had provided a number of minor comments, all of which have been addressed.

Resolved:
ARC approved the revised Risk Management Policy subject to the amendment.

25/26/107 Trust Risk Management Report

The Trust Risk Management Report was submitted to provide the Committee with key movements and areas of focus within the Trust's risk profile as at the 31.10.25.
It was reported that the Trust had seen improvements in the updating of action plans following targeted engagement with the IM&T/Digital team. A series of face-to-face sessions with the entire team over recent months has resulted in more timely updating and rationalisation of actions, as well as work to improve incident management processes. It was noted that a number of long-standing high-moderate risks have remained static and unchanged since February and therefore will be a priority for focus in the new year.

It was also confirmed that progress is being made in the C&MH Division, following previous delays caused by capacity pressures, including an inspection by CQC, and the Public Inquiry. Overdue actions are reducing and the position is beginning to stabilise.

The Chair drew attention to the remaining risks without action plans for extended periods and sought assurance that they would be followed up outside of the meeting. It was agreed to action this request whilst noting that in most cases delays arose from capacity issues rather than governance gaps.

25/26/107.1 Action: JRO

The Chair reflected that the Trust's current environment will naturally drive an uptick in risk scores and new risks being added and asked whether the organisation's risk management processes are equipped to manage this likely escalation. It was noted that outputs from recent RMF sessions and Divisional reviews are pointing towards risks needing to evolve. It was confirmed that the processes in place; weekly Divisional reviews, RMF oversight and strengthened governance involvement, are sufficient to support this but it was acknowledged that the volume of work will increase.

The Chair offered thanks for the update and noted that, despite operational pressures, the Committee requires assurance that oversight of high-moderate risks remains strong.

Resolved:
ARC received and noted the Trust Risk Management Report as at the 31.10.25.

25/26/108 Horizon Scanning

The Chair felt that the organisation is currently experiencing what is described as a "perfect storm" of pressures, including significant financial challenges, the organisational impact of the Southport Public Inquiry, declining morale due to sustained pressure, reduced organisational capacity due to programmes such as the AFT application, Paediatric Chain, Vision 2030, and a decline in performance/increase in incidents as staff face continued operational strain. It was noted that while these pressures are reflected across a number of BAF risks, their cumulative and interconnected nature may warrant consideration of a broader overarching risk to capture the combined effect.

GM emphasised the strategic importance of maintaining the Trust's Segment 1 status, noting that it provides valuable flexibility and autonomy in responding to pressures and that any deterioration in this position could create additional risk for the Trust therefore maintaining this status is critical to organisational resilience and future planning.

The Chair asked that the Committee's observations be included in discussions with Executive risk owners as part of upcoming BAF reviews to ensure these cross-cutting issues are fully explored.

25/26/108.1 Action: JP

Resolved:
ARC noted the discussion and the importance of continued Executive focus on emerging cross-risk dependencies.

25/26/109 Internal Audit Progress Report

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

- There have been two final reports issued:
  - Clinical Audit – Moderate Assurance
  - Divisional Clinical Governance – Substantial Assurance
- Six reviews are in progress with completion expected by April 2026 to inform the Head of Internal Audit Opinion.
- It was confirmed that the placeholder in the plan will be used to review the governance of the Financial Improvement Plan (FIP), following agreement with Executive Directors and NEDs. It was felt that this area will benefit from a review to provide assurance and to support the organisation's financial controls and decision-making processes. MIAA will liaise directly with the Senior Responsible Officer (SRO) of the FIP, Adam Bateman, to scope and schedule the audit work.

The Chair enquired about the amount of reports anticipated for submission at February's meeting. It was estimated that three to five reports will be presented, depending on fieldwork

progress. It was noted that sufficient time will be needed on February's agenda to discuss this area of work in full.

For noting
ARC approved the use of the placeholder in the Internal Audit Plan for reviewing the governance of the FIP.

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

25/26/110 Trust Wide Clinical Audit Programme Mid-Year Progress Report

The Committee received an update on the Trust wide Clinical Audit Programme activity for the reporting period; 1.4.25 to the 30.9.25. The following points were highlighted:

- At the time of reporting a total of 21 nationally mandated audits were included on the Trusts Clinical Audit Plan for 2025-2026. It was confirmed that there were no delays or issues reported.
- Two national benchmarking reports were published during the reporting period for two national mandated audits; National Paediatric Diabetes Audit and Paediatric Intensive Care Audit. Both reports demonstrate that the Trust performed in accordance with national standards.
- A previous issue with renal audit submissions has been fully resolved with the support of the Digital Team who addressed a range of issues relating to IT challenges and transfer of data from Meditech to the regional Nephrology system (CyberRen) and the Renal Registry.
- At the time of reporting there were 27 identified local Trust priority audits;
  - 4 were completed
  - 1 was delayed (Trust wide audit of the Consent Audit). This is to be escalated at the Clinical Effectiveness and Outcomes Board (CEOB) in September for registration to be completed.
  - 3 audits were cancelled by the Divisions after they were subsequently determined to have been incorrectly classified as Trust-level priorities.
- At the time of reporting 127 projects have been registered within this reporting period, showing a healthy level of activity.
- The Clinical Audit Policy has undergone a full rewrite and will go to the Safety and Quality Assurance Committee (SQAC) for approval in due course.

The Chair referred to the three audits that were incorrectly classified as Trust level priority audits and requested confirmation that they had been reviewed appropriately before being cancelled. It was clarified that these audits were Divisional, not Corporate, and their prior inclusion was an error. Processes have since been improved to ensure only audits with Trust-wide significance are included going forward.

A question was raised about how the work of the Southport Public Inquiry will feed into future audit priorities and the Clinical Audit Plan. It was reported that a number of audit activities have been identified within the Learning Review Action Plan and will be elevated to Trust priority status. Upon approval by SQAC in December, they will be formally incorporated in the Trust Priority Audit List.

The Chair asked about the status of the delayed Consent Audit. The Committee was advised that the Divisions are working towards a standardised consent process, and the delay reflected the need for a consistent approach across Divisions before the audit could proceed. The Chair sought assurance that no nationally mandated audits were at risk especially in terms of timeliness of data submission. It was confirmed that all audits are progressing appropriately with no late submissions or risks flagged.

Resolved:
ARC noted the Trust Wide Clinical Audit Programme Mid-Year Progress Report.

25/26/111 Oversight of External Visits, Inspections and Accreditations – Update

The Committee received a verbal update on the revised External Visits, Inspections and Accreditations Policy. Attention was drawn to the policy's critical role in strengthening organisational assurance by ensuring that all external inspections, accreditations and reviews are properly logged and overseen. It was noted that full compliance depends on Divisions consistently submitting accurate information through their established governance routes. Work is ongoing via Divisional governance meetings to reinforce understanding of the updated requirements and embed reporting discipline.

It was reported that a review concerning the governance of external visitors, such as students and work-placement observers remains paused due to a highly sensitive internal investigation. This pause is necessary, but it was agreed to liaise with the Chief People Officer to discuss potential interim steps to prevent any gaps in governance. Once feasible, a full review will proceed, with the expectation that the People Committee will consider the operational framework before returning to ARC for assurance purposes.

25/26/111.1 Action: ES

The Chair drew attention to the outstanding legacy action on the log and inquired about its status. It was agreed that the action should remain open until the internal investigation concludes and the relevant work can resume.

Resolved:
ARC noted the update on the revised Oversight of External Visits, Inspections and Accreditations Policy.

25/26/112 Light Touch Review of Effectiveness of the Counter Fraud Service and External Audit/Full Review of Internal Audit

The Committee was provided with suggested questionnaires for a 'light touch' single question review of Counter Fraud Service and External Audit along with a questionnaire for a full review of MIAA.

The Chair explained that these assessments form a routine part of the Committee's annual assurance cycle and enable members to provide structured feedback on the performance, quality and responsiveness of the Trust's assurance providers. It was noted that the Counter Fraud Service and External Audit questionnaires each consisted of a single question inviting member comments, while the Internal Audit questionnaire provided a more detailed framework for evaluating the robustness of planning, fieldwork, independence, reporting and engagement with management.

The Chair confirmed that the completed questionnaires will be collated and presented to the February meeting for formal consideration. Members were asked to submit their responses by mid-January to support timely reporting. No issues or concerns were raised during discussion, and the Committee was satisfied that the approach remains effective and proportionate in supporting oversight of the Trust's assurance providers.

25/26/112.1 Action: All

Resolved:
ARC approved the proposed questionnaires and agreed to complete the questionnaires in line with the proposed timings.

25/26/113 CIO Quarterly Update

Freedom of Information (FoI) Assurance Report for Q1/Q2

The Committee received the Freedom of Information (FoI) assurance report for Q1 and Q2, noting performance in the high-80% range against the Trust's internal 95% target. It was confirmed that there have been no ICO complaints received during the reporting period and that the team has assumed responsibility for FoI requests relating to the Gender Service, previously managed externally.

The Chair sought assurance on whether any issues had emerged from the ICO voluntary audit or the integration of Gender Service FOIs back into the IG Team. It was confirmed that the ICO audit had been satisfactory, with some findings indicating that the Trust has demonstrated practices not commonly seen elsewhere. The transition of Gender Service FOIs had also been managed without issues.

Resolved:
ARC noted the FoI Assurance Report for Q1/Q2.

25/26/114 Review and Update of Corporate Governance Manual

The Committee was advised that the Corporate Governance Manual has been reviewed by relevant Executive leads, Internal Audit, and Procurement to make sure that the manual remains fit for purpose. In light of this a number of proposed changes to job titles, committee references, and Internal Audit Standards have been proposed.

It was reported that a survey of users of the Corporate Governance Manual has been conducted to garner feedback on whether the changes made to the manual in January 2025 had been useful and remain fit for purpose. The overwhelming feedback, primarily from requisitioners, was that they were unaware of the updates to the Corporate Governance Manual. This has identified a training/communications requirement across the Trust, which Finance and Procurement will look to rectify via attendance at Divisional meetings, budget and requisitioner training and Trust wide communications.

It was noted that the survey response was low and quite stark, particularly when requisitioners and managers stated that they didn't know where the manual was located or that it existed. The Committee was advised that although responses were limited the insight was useful and will be used to shape improved communications.

A question was raised about whether the manual will be reviewed again in six months. It was confirmed that a review will take place to ensure the manual remains aligned with enhanced

controls and emerging financial governance arrangements. The Committee was advised that the Trust's AFT application may lead to significant constitutional changes in the Corporate Governance Manual, or a substantial review if national documentation is updated through the AFT process.

Resolved:
ARC:

- Approved the proposed changes to the Corporate Governance Manual, and the action plan for ensuring strong communication/training around the content of the manual.
- Noted that a further update may be required in Q1 2026/27 dependent on whether any of the enhanced controls that are currently in place continue on a more permanent basis.

25/26/115 Tenders and Waivers Activity Report for Q1 and Q2

The Committee was provided with an update on waiver and waiver exemption activity across the Trust for Q1 and Q2 of the 2025/26 financial year. The following points were highlighted:

- There was a total of thirty-six waivers signed off in Q1 and Q2, totalling approximately £2.5m. This includes 14 tender waivers exceeding £50k and 22 quotation waivers ranging between £20k and £49,999k.
- It was reported that approximately half of the waivers were retrospective, with purchase orders issued after the commencement of work. Nevertheless, overall trends remain encouraging, as both the number of waivers and waiver exemptions have steadily decreased each year.

The Chair pointed out that although waivers are declining a significant proportion remain retrospective and queried as to whether this indicates ongoing process issues. It was reported that in a number of cases activity had begun before the purchase order (PO) was finalised. A commitment was made to contact Divisional ACOOs to ensure awareness and improve future compliance.

25/26/115.1 Action: EK

The Chair also queried as to whether the decline in waivers reflects a genuine trend rather than a short-term fluctuation. It was confirmed that it is a genuine trend and reflects the increasing maturity of the 'No PO, No Pay' Policy. Further improvement/compliance is anticipated over time.

It was observed that all waivers including retrospective ones were supported by Health Liverpool Partnership (HPL) which it was felt is reassuring.

Resolved:
ARC received and noted the Tenders and Waivers Activity Report for Q1/Q2.

25/26/116 Any Other Business

There was none to discuss.

25/26/117 Meeting Review

It was agreed that the meeting was productive, with a particularly robust and wide-ranging discussion on risk. The latter part of the agenda was noted to be straightforward and no private meeting was needed.

Date and Time of the Next Meeting: Thursday, 16th April, 2:00pm-5:00pm, LT1, Institute in the Park

BOARD OF DIRECTORS

Thursday, 5th March 2025

Paper Title:	**Chair's Report from the Finance, Transformation & Performance Committee meeting held on 23rd February 2026**
Report of:	**John Kelly Committee Chair**
Paper Prepared by:	Julie Tsao, Executive Assistant

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☑ ☐
Action/Decision Required:	To note To approve	☑ ☑
Summary / supporting information:	Finance, Transformation & Performance Committee minutes from the meeting that took place on 28th October 2024.	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs **Strong Foundations**	☑ ☐ ☐ ☐ ☐ ☐
Resource Implications:	None	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks	1.2, 1.3, 1.4, 3.1, 3.2, 3.4, 3.6, 4.2					
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Introduction

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

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

- Top Five Risks update
- M10 Financial update including forecast for year end.
- M10 Integrated Performance Report
- National Cost Collection 2024/25
- Medium Term Plan
- Digital Futures Strategy
- Transformation update
- Liverpool Neonatal Partnership
- Board Assurance Framework
- Corporate Divisional update
- Treasury Management Policy

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

- None.

4. Positive highlights of note

- Approval given to Treasury Management Policy

5. Issues for other committees

- None

6. Recommendations

The Board is asked to note the Chair's Highlight report for the Finance, Transformation & Performance Committee meeting that took place on 23rd February 2026.

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Wednesday 21st January 2026 2025 at 3pm**

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)
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance:			
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mr. G. Wadeson	Associate Director of Finance	(GW)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	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:			
149.	Mrs J Holloran	Deputy Development & Estates Director	(JH)
152.	Mrs C Lee	Associate Chief Operating Officer Surgery	(CL)
152.	Mr G Montgomery	Accountant, Surgery	
153.	Miss N Pickard	Associate Chief Operating Officer Medicine	(NP)
155.	Mrs E Matthews	Head of Service Development & Performance	(EM)
158.	Paul Sanderson	Chief Pharmacist	(PS)
Observing:	Christian Laidlaw	Deputy Director System Assurance and Regulation Team, NHS England	(CLW)
	Liam McDonald	Management System Assurance and Regulation Team, NHS England	(LMc)
	Rahul Sharma	NHS England	(SH)
Apologies:			
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr A McColl	Deputy Director of Finance	(AMc)

25/26/145	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/146	**Minutes of the Last Meeting** The minutes of the last meeting held on 11th December 2025 were approved.
25/26/147	**Matter Arising and Action Log** FTPC went through the discussed outstanding actions: **Pharmacy Outsourcing** EK explained the pharmacy outsourcing process was delayed as another provider had expressed an interest. The operational side appears competitive, as financial details were lacking, further clarification was requested.

	Cash Policy and Working Day Requirements To be presented at February FTPC. **Action: EK** **Capital Prioritisation** Capital based scenarios on cash assumptions was due to take place on 27th January 2026.
25/26/148	**Declarations of Interest** The following declarations were made: • Non-Executive Director, Mark Jennings, declared that he is the Chief Solutions and Services Officer for Strasys.
25/26/149	**Top 5 Risks** The committee received an overview of the top 5 risks for the month. **1. Trust Financial Performance** M9 position reported a £0.3m deficit in month and a £0.1m surplus year to date. RL noted this was slightly ahead of plan mainly in relation to industrial action funding. Discussions with ICB, PWC and NHSE are ongoing in relation to closing the gap between £5m and £7.2m. RL noted the current position to achieve the £7.2m: • Income assumptions with ICB. • A meeting is taking place tomorrow morning with NHSE. • Internally the main focus remains on recurrency IP as the current gap is £11m. To reduce this to £5m a number of schemes are being worked through in February and March. One of them is in relation to the recurrent bed closures. An update was received on the review of current vacancies. The Chair asked if a deadline had been agreed for the target operating model. AB advised senior leaders briefings are scheduled to take place next week. DJW asked for details on how this would be communicated. MS noted a meeting was taking place with NA, AB and transformation leads to agree. **2. System Financial Performance** SFP plans had been met for M9. RL noted gaps within the best and worst case Year End position and ongoing meetings to resolve with PWC. **3. Campus & Capital Programme** RL and JH provided the highlights below: • PFI continues to get valuations and progress reports in terms of spend for the year end. • A number of delays are being managed in relation to NICU building. • National funding has now been granted for solar panels and a building management system. • Possibilities for Northeast plot include a health and well-being hub, proposals are due to be presented at a future Trust Board. **4. Transforming Alder Hey (ways of working, futures, AI & Digital)** NP noted work continues on the transformation programme. The next phase is scoping out the programmes of work over the next three years.

	5. Operational performance (productivity, access, targets, benchmarking) AB shared a summary of the National Oversight Framework. ED is expected to sustain performance at 85% in December and continue into January. The target for RTT is to get to 63% by March, currently at 62%. Alder Hey was the first Children's Trust to use the federated data platform scheduling for outpatients and theatre. MS outlined ongoing efforts to reduce sickness absence, with a dedicated team and a deep dive scheduled for the People Committee. The workforce plan includes reductions in temporary spend and improvements in job planning.
25/26/150	**M9 Finance Overview Report** Divisional performance was £100K favourable to plan in month. This is partly due to the industrial action funding, and a net under performance on ERF. EK provided an update on the coding recovery plan. KW referred to future service model plans for the coding team to account AI coding in terms of benchmarking with other children's hospitals due to be approved tomorrow. EK noted a number of bids that are due to be presented for approval. **Month 9 Debt Write Off** Approval was requested of £35K. There are three salary overpayments and one cycle scheme related to a member of staff. As there have been no responses the CCI have recommended to close these cases. The final debt is in relation to an innovation company that went into liquidation and reopened under a different name. Services have been received, this is in relation to an old invoice. KW discussed proposals to partner with a number of companies and queried the process. RL referred to a pre check company process and agreed to share with KW. **Resolved:** FTPC noted the M9 Finance report and APPROVED M9 Debt Write off.
25/26/151	**M9 Integrated Performance Report** Capacity, demand and emergency care has remained quite consistent even in December's peak month of pressure. Enhanced support is in place for the department to manage the second peak in the weeks ahead. A Clinical Lead has been appointed for Surgery, they've introduced a system in ophthalmology that's delivered brilliant results in reducing overdue follow up. The system is due to be shared with other services. Was Not Brought Rate is not at the 8% target. As the eye screening service has the highest number of WNB this service will now be provided from ophthalmologists services rather than the Trust. It is hoped the change will be easier for families to attend services closer to home. Neurodevelopmental pathways had a deep dive at Safety and Quality Assurance Committee this morning. Details were presented on a single integrated service which will bring some improvements in terms of time to diagnosis. Further detail on supporting this service was awaited nationally.

	MJ noted delays to the new NICU and asked that as the ED building is underneath NICU build are there concerns that this would impact ED targets. AB said feedback from the national team is that the four-hour standard for children young people is from September 2026. the new facility is due to be available from November 2026. Possible alternatives include a bid to create a virtual urgent care service. **Resolved:** FTPC noted the M9 Integrated Performance Report.
25/26/152	**Surgery Division** CL gave a presentation highlighting the bridge from month 6 forecast to the revised forecast at month 9. From the Recovery Financial perspective, increased income position following some focused actions around a number of schemes, particularly some around spinal activity and depth of coding improvement in specialties. From a drugs and devices income expenditure perspective, overall net improvement of £92K. Workforce control schemes have developed particularly some of our workforce schemes from the CIP programme come to fruition. £198K improvement specifically related to the control panel. Actions going forward include reducing risk of cancellations. A business case for national funding programme for the inventory management system has been submitted. Positive feedback has been received and approval is awaited. In relation to the Chair's query on weekend work dental services have continued. Support is to be provided to Manchester Children's Trust on spinal services on a Saturday. This has been approved by commissioners and referrals are awaited. An update on productivity was received, noting improvement in terms of the planned and actually utilised. This data is now being used at theatre performance meetings and has led to additional day cases in theatre. **Resolved:** FTPC noted the Surgery Division quarterly update.
25/26/153	**Medicine Division** NP noted a number of bullet points had not been included under risks in the pack distributed. The correct slides have been saved for auditing purposes and would be presented today. The forecast position is £5.2m overspent at the end of the financial year. This has now been reduced to £3.5m, noting a number of actions will need to be completed in Q4 for this to be achieved including recruitment and workforce controls, ERF income drive and increase in general paediatric capacity. The PAU staffing model for general paediatrics, has been delayed in line with the NICU build delay, with a view to recovering their ERF position this month. **Resolved:**

	FTPC noted the Medicine Division quarterly update.
25/26/154	**Community Division** **Resolved:** FTPC received the presentation slides for quarterly Community Divisional update.
25/26/155	**Medium Term Plan** A detailed update was provided on the development of the three-year medium term plan, addressing feedback from the region, uncertainties in commissioner offers, workforce reductions, and the alignment of strategic ambitions with system transformation. Regional feedback was received highlighting the need to reconcile the financial plan with workforce reductions and to provide assurance on CIP delivery. The plan currently projects a small surplus in year one, with larger surpluses and workforce reductions in years two and three. MS and GW outlined plans for workforce reductions and activity growth, noting that assumptions for future years are based on current resources and subject to change once commissioner offers are received. The plan includes a focus on sustainable workforce models and productivity improvements. KW and DJ described the alignment of the transformation programme with the medium term plan, including the establishment of a new transformation board and the pursuit of system-level opportunities such as the paediatric chain model. The narrative will reflect strategic ambitions not fully captured in the financial plan. AB and EM summarised key risks, including the challenge of delivering performance improvements with a contracting workforce, the need to close the CIP gap, and the impact of fixed contracts. Focus will continue to refine the plan as more information becomes available, with additional meetings scheduled before final submission. Following discussions RL agreed to arrange an Extraordinary FTPC/Trust Board after February Trust Board if needed. **Resolved:** FTPC noted the current position of the MTP and an additional FTPC/Trust Board maybe required.
25/26/156	**Board Assurance Framework** ES highlighted increased PFI risk and ongoing contract discussions with Project Co, with mitigation plans in place and further meetings scheduled. ES observed improved alignment of strategic risks across committees, particularly regarding ADHD waiting times and workforce risks, and suggested further integration for board reporting. **Resolved:** FTPC received and noted risks within the BAF.
25/26/157	**PFI** Discussions continue with Project Co and funders. A NED assurance group has been established to oversee progress. **Resolved:** FTPC received and noted the PFI position.

25/26/158	**Pharmacy Cabinet Omnicell Business Case** PS presented the above BC for approval noting the electronic drug storage cabinets supplied by Omnicell need to be replaced as they were installed in 2016 before Alder Hey moved to the current site and have reached the end of their 10-year life cycle. The current supplier, Omnicell have agreed to extend the maintenance contract on the cabinets by 12 months until October 2026. The purpose of this business case is to secure funds for sixteen new cabinets. PS referred to the financial detail in the business case. EK noted that this would be included in 26/27 financial plan. **Resolved:** FTPC APPROVED the Pharmacy Cabinet Omnicell Business Case.
25/26/143	**Any Other Business** No further business was discussed
25/26/145	**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 23rd February at 1pm, via Teams.

M10 top 5 risks	Initial Risk	Initial RAG	Latest Position	RAG M10
Trust Financial performance	Challenging 25/26 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time. Plan assumes delivery of £22.7m recurrent savings. Highest level set in any one year. Delivery contingent on both BAU and transformation savings	High	Month 10 position reported £1.1m surplus in month and £1.2m surplus YTD which is behind plan (£0.2m) largely due to PBR/ERF underperformance and pay pressures in month. ICB forecast (SW) at M10 reported likely forecast of £5m surplus position for the year and a best-case forecast of £7.2m surplus, in line with M9. A number of income assumptions in the 25/26 forecast are currently in discussion with the ICB and present a risk to overall delivery of plan if not confirmed. Ongoing discussions with PWC/NHSE re the ongoing FPRM and risk rating for AH but forecast of £7.2m committed to for M10 (no forecast change initiated). PBR/ERF in month performance is estimated below plan by £0.2m in-month in addition to a backdated loss of £0.1m. YTD PBR overperformance is £0.6m within divisional positions. CIP is ahead of plan in M10 (£1.9m) and on plan YTD largely due to non recurrent savings identified in M10. Total savings of £22m have been transacted (green) , forecasting to deliver £22.5m following the risk-based methodology adopted by region. There is a £10.2m gap (fully developed/amber/red/black) on recurrent plan as at M10 however actions are underway to take recurrent opportunity CIP ideas through FIP for approval to post, with intention to reduce the carry forward CIP to £5m.	High
System financial performance	Challenging 25/26 plan for C&M System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	Key data shared on M10 indicates achievement of the M10 and YTD plan, however the system has not received deficit support funding for Q4 which places significant cash risk in the system for those provider with DSF in the plan. PWC remains in the system with FPRM meetings taking place in January, Year end forecast remains signficantly away from the £178m deficit plan.	High
Campus and Capital Programme	Limited CDEL allocation in 25/26 Complex campus programme across multi sites, with several key buildings opening in year (Neo/Alderpark).	High	Capital – Currently the core capital forecast to be underspent (£0.4m). With range from £0.8m under spend to £1.8m overspend in best and worst case scenario. However funding assumes £3.4m of other funding not yet confirmed. ICB have confirmed an additional £2m CDEL cover available if required, and conversation ongoing with NHSE re any other national CDEL cover available. CDEL position for the trust believe to be management through phasing of charitable funding. Capital prioritisation initial panel has taken place with £10.4m of funding confirmed to proceed (committed and high risk), and a further £11m subject to further discussion. Subsequently £4.2m of capital has been approved in the National Strategic Funding process (diagnostics and UEC) – subject to approval of relevant business cases. 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. Campus – Ongoing review of delayed schemes: NICU, Elective Surgical Hub and CT Scanners. Equipment procurement to commence for long lead items, and where suppliers can store at nil cost. Opportunities for beneficial access (NICU) to be progressed with contractor. Cost pressures highlighted on 4-year plan as priority for '26/'27 including further Estates Safety Fund bidding. Demolition, infrastructure, car park and site completion works currently being managed within approved budgets.	High
Transforming Alder Hey	Transforming Alder Hey (ways of working, futures, AI & Digital)	High	Transformational work continues in line with the now-approved **2026/27 Transformation Plan**, alongside the ongoing development of a new operating model that will define the future shape of Alder Hey. 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.	High
Operational performance	National focus on productivity and benchmarking to drive down costs. Efficiency programme contingent on driving up productivity in order to reduce costs.	Medium	The trust's performance regarding patients waiting over 52 weeks continues to be a challenge. A proposal has been submitted and approved that includes strategies for increasing productivity and determining an optimal level of substantive recruitment to meet the standard and achieve CIP.	Medium

BOARD OF DIRECTORS

Thursday, 5th March 2026

Paper Title:	**Board Assurance Framework Report (January 2026)**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Implications:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Does this relate to a risk? Yes ☑ No ☐
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 January 2026	As detailed in the report

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

Board Assurance Framework 2025/26

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 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 February 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
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	**4x4**	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x4	2x3
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Alder Hey Campus	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 January 2026 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  The risk has been reviewed, and controls remain appropriate and in place. The gaps in assurance are monitored regularly at SQAC and through Trust Board. The risk continues to be influenced by the current financial challenges and SQAC are well sighted on the safety and quality risks, along with controls, associated with this.

- ***Children and young people not having timely and safe access to elective, urgent and follow up care (AB).***
  January performance against 2025/26 targets
  - Acute (78%) - ED performance remained above target at 86%
  - RTT (63% by March 2026) - 62% in month
  - Pts >52 weeks (1% by March 2026) - Currently 2% with the majority under dentistry
  - DMO1 (95%) - Performance dropped from compliant to 90%. This is primarily due to reduced capacity in Gastro.

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Settlement
  The Trust is awaiting confirmation from the Project Co Directors on the next steps following approval of the settlement.

  Water Safety Group meetings continue alongside operational forums to monitor and manage out-of-range water temperatures. A report from the SPV Board has been received and is currently under review. Further action in relation to the dosing system is being pursued, and step-in may be required.

  Tap Filters

  A formal notification regarding tap filters has been issued to Project Co. No response has been received to date.

  Chillers

  Ongoing performance issues with the chillers remain unresolved. A project plan outlining the proposed approach to full reinstatement has been received; however, no timelines have been provided.

  Combined Heat and Power (CHP)

  The CHP unit has been out of operation for approximately one year. The Trust continues to await an update from Project Co on the status of the unit and the proposed next steps.

  Summary

  A formal notification addressing all of the above matters has been issued to Project Co. No responses have been received at the time of this update.

- ***Increased waiting times for Specialist Mental Health community services. (LC).***
  BAF risk review. Presented to SQAC in January 2026. Paper presented to executive team on 10/02/2026 for approval of changes to reporting metrics as per NHS England guidance.

- ***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 position is closely monitored and is also addressed through the medium-term planning round, and reported to both FTP Committee and People Committee. Target Operating Model, will also address the Trust workforce plan and consultation has commenced. 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. Staff availability due to sickness continues to present a risk due to high levels of sickness absence (which is being experienced across C&M, not unique to Alderhey) dedicated and bespoke interventions are in place to support this reduction, including a sickness team.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed and all actions updated with specific focus on those actions addressing factors relevant to organisational restructure in the context of delivery of Vision 2030. Staff Survey control updated to reflect latest data.

- ***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 park. This, with the final works in this area, will complete the 9.4 hectares of the park. Hand back to LCC scheduled 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 Trust is implementing a new operating model to support delivery of Vision 2030. The operating model underpins the next phase of the Transformation Programme and is being delivered alongside business-as-usual pressures, creating a managed risk around organisational capacity.

  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.

  There remains a risk that in-year financial savings are not fully realised against CIP targets. Mitigations include prioritising activity with the greatest in-year and recurrent savings, strengthened governance and benefit tracking, and monthly Transformation Programme Board reviews to enable active reprioritisation.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  A review of the risk score has resulted in a static score of 20 this month. A detailed forecast has been undertook for the year end and shared with NHSE, noting the outstanding risks with commissioners. Weekly monitoring is in place to ensure grip and control continues with a focus on activity delivery to meet Q4 stretch targets.

  The final medium term will be submitted in February and continue to show achievement of the financial targets across the next 3 years assuming delivery of a 5% CIP target in year 1. The Financial Improvement Programme will form part of the transformation programme in 26/27 and beyond and will provide structure and governance to deliver the scale of financial challenge. 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 for February 2026.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Risk score remains 9. Actions updated to reflect progress with financial gap and capacity building funding call.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  Risk reviewed remains at 16. Infrastructure work progressing well and on track to be completed by Feb 26. Key items supported at Capital Prioritisation Group. Good progress being made via Digital, Data and AI Collab. HWWWITF work in progress and due to commence towards the end of February.

5. Corporate risks (15+) linked to BAF Risks (as at 4th February 2026)

There are currently 29 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

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
421	Closure of Little Hearts at Home programme due to lack of ongoing funding ***(NEW)***	4x5	Corporate Services	3.4 & 4.1	Aug 2025	Jan 2026
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 ***(NEW)***	3x5	Community	1.2	Oct 2025	Jan 2026
513	Insufficient Capital funding	4x4	Surgery	3.4	Aug 2022	Feb 2024
510	Inability to provide a safe and effective service - Medical Engineering & Equipment Library ***(NEW)***	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
287	Radiology consultant on-call is at risk of failure	4x4	Medicine	2.1	May 2025	Sept 2025
293	Staffing in Biochemistry	4x4	Medicine	2.1	Dec 2024	May 2025
297	Transcription delay and increase of turnaround times	4x4	Corporate Services	2.1	Dec 2024	Apr 2025
341	Named Doctor for Children in Care	4x4	Community		Apr 2025	Apr 2025
399	Three Anti Barricade doors not opening outwards on patient bedrooms and faulty swipe entry on patients bedrooms	4x4	Community		Jun 2025	Aug 2025
409	Inability to provide safe staffing levels	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
496	NICU delay due to isolation of live services and service connections	4x4	Corporate Services	1.3	Nov 2025	Nov 2025

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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
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 ***(NEW)***	3x5	Community	1.1	Oct 2025	Jan 2026
1.3 Building and infrastructure defects that could affect quality and provision of services (4x4=16)						
496	NICU delay due to isolation of live services and service connections	4x4	Corporate Services	1.1	Nov 2025	Nov 2025
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
510	Inability to provide a safe and effective service - Medical Engineering & Equipment Library ***(NEW)***	4x4	Surgery	1.1	Dec 2025	Jan 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

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 2024
293	Staffing in Biochemistry	4x4	Medicine	1.2	Dec 2024	May 2025
520	Pharmacy Capacity	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)						
496	NICU go live delay	4x4	Corporate Services	1.1	Nov 2025	Nov 2025
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (4x4=16)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x5=20)						
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
421	Closure of Little Hearts at Home programme due to lack of ongoing funding ***(NEW)***	4x5	Corporate Services	1.1 & 4.1	Aug 2025	Jan 2026
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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)						
421	Closure of Little Hearts at Home programme due to lack of ongoing funding ***(NEW)***	4x5	Corporate Services	1.1 & 3.4	Aug 2025	Jan 2026
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
368	Digital infrastructure capacity and age	4x4	Corporate Services		May 2025	May 2025
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
Safe		Nathan Askew

Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety and Quality Assurance Committee

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards in the current challenging financial environment.

Control description	Control assurance (How is this control monitored?)
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
Administration of IV antibiotics within 1hr for CYP with suspected sepsis	Monitored monthly through SQAC
Brilliant Basics	Formal and informal training and coaching available to support departments to make positive changes. Reported to board bi-annually including update against NHS Impact Self-Assessment.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Internal: Patient safety meeting actions monitored through SQAC External: Care Quality Commission (CQC), MIAA
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board
Programme of quality assurance rounds, ward and departmental accreditation is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC. Triangulation of data through Aggregated Analysis Reports to SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I)	Annual QIA assurance report and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAs
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. External: Care Quality Commission, MIAA, NHS Improvement
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
The Trust has a Patient Experience Group that reports against the workplan derived from the Patient Experience Strategy based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. Chairs report to SQAC.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.

Gaps in Controls / Assurance
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis 2. Robust reduction programme in the number of medication incidents and near misses 3. Emerging CQC oversight framework which may reduce our CQC ratings 4. The 2030 vision sees a shift towards and experience led organisation without additional resources for delivery of the plan 5. Increased oversight relating to the financial pressures resulting in inability to deliver 2030 Strategy

Action	Description	February 2026	
		Due Date	Action Update
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures (no further controls required, monitoring controls are in place)	31/03/2026	(no further controls required, monitoring controls are in place)
2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2026	(no further controls required, monitoring controls are in place)
3. New CQC Assessment Framework	3. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2026	Trust continues to engage with CQC through regular engagement meetings
4. Patient Experience	4. Experience Strategy Group established to evaluate resource required. SQAC will have oversight of ambition and achievements of the Group	31/03/2026	PEG continues to report into SQAC
5. Delivery of 2030 Strategy	5. Revise EQIA process, establish a Clinical Cabinet. Oversight through SQAC, FTPC and Trust Board	31/03/2026	The Trust has established a clinical cabinet chaired jointly by the CNO and CMO. The EQIA process has been revised and been strengthened through integration in the FIP. Oversight is monitored through both SQAC and FTPC, with sight at trust board.

Children and young people not having timely and safe access to elective, urgent and follow up care.					
Risk Number		Strategic Objectives			
1.2		Outstanding care and experience			
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Effective		Adam Bateman	15	4	▪ Finance Transformation & Performance Committee ▪ Safety and Quality Assurance Committee

Description

With a growth in demand for elective, urgent and follow-up care maintaining timely access to high quality care and meeting national access standards is challenging. This is compounded by a tight financial environment and our NHS contract has limited scope for growth in income to fund additional capacity; productivity improvements are insufficient to meet demand and lower waiting times. Our approach is centred on providing enhanced support to departments with significant demand or service issues, helping them to create centre of excellence; innovating; seizing productivity opportunities; and collaborating with providers and system partners to modernise and optimise our patient pathways and service models.

Control description	Control assurance (How is this control monitored?)
Controls for improving access to follow-up care: - Real time report on the follow-up waiting list, waiting times and risk categories - Patient Initiated Follow Up (PIFU) pathway and system initiated - Patient portal for ISLA Care supports waiting list validation and PIFU	Weekly Executive Summary - Follow up metrics included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board - Safe Waiting List Management Group Chaired by Patient Safety Lead
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Monthly access to care with General Managers from the divisions - Activity plans for 25/26 adjusted to achieve national access targets - Real time reporting of RTT waiting list and tracking tool which highlights patients that could breach monthly / quarterly targets - Transformation programme to re-imagine elective care services to create centres of excellence	- Weekly Performance Report to Executive Directors - The NHSE weekly waiting time submission is reviewed and signed off by the Head of Performance - RTT performance is included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board
Our controls for delivering timely care in the Emergency Department (ED) includes: - Acute response Team and Patient Flow - Emergency Department staffing rotas, establishment and skill mix reviews support staffing levels to meet minimum safe standards and align to demand - Safety huddles and patient handover huddles - A new Paediatric Assessment Unit and Urgent Care Centre - Winter Plan with flow and escalation procedures - Two transformation collaboratives driving service improvement: i) Neighbourhood Care supporting prevention and more care in the community - Ii) Acute, Diagnostics and Urgent Care	Daily reports to NHS England -Daily situational reports and patient flow meetings - Staffing reports reviewed at staffing huddle meetings - Daily Performance summary -@ monthly ED performance report to Operational delivery group -@ Performance reports to FTP Board Sub-@Committee

Gaps in Controls / Assurance

1. There is inadequate capacity in ENT and Paediatric Dentistry to have less than 1% of children and young people on the waiting list waiting over 52 weeks for treatment
2. In urgent care there are opportunities to further improve timeliness of care and experience through a Same Day Emergency Care Centre, expanded Paediatric Assessment Unit and virtual urgent care service.
3. To achieve a sustainable position in follow-up care, as measured by having no patients waiting 6 months beyond their target date, a more radical shift in follow- care pathways is required.

Action	Description	February 2026	
		Due Date	Action Update
Recruit a Locum Consultant in ENT	The executive board have approved a paper which allows the department to recruit a Locum Consutlant	31/10/2025	The department have a locum consultant post advertised and at least one interested candidate. However one of the locum consultants who is currently working for the department has resigned therefore the department may recruit however it may not lead to an increase in capacity
Restart weekend theatres in ENT	Weekend operating ceased when the AHP local pay rate was reduced from 1st July. The division have been working to reinstate weekend operating as it will increase capacity in ENT.	31/10/2025	The first weekend operating list since June is scheduled for 18th October.
Overbook outpatient clinic with new patients	Roll out overbooking to clinicians whose clinic utilisation consitute it requires an additional patient booked to increase actual clinic utilisation to as close to 100% as possible.	30/11/2025	The following services are now live with overbooking - Dentistry - Plastic Surgery - Community Ophthalmology and Ophthalmology The following services go live from 13th October - Urology - Paediatric Surgery - Gynaecology
Request mutual aid for dentistry patients	Mutual aid request submitted which asks for 35 patients to be transferred to the community dentists. The trust is also exploring whether MFT can accept 25 patients.	31/12/2025	
2. Open Same Day Emergency Care Centre	Expanded Paediatric Assessment Unit	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
3. Deploy Ambient Artificial Intelligence to improve productivity	Deploy Ambient Artificial Intelligence to improve productivity	30/03/2026	
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.
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	
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.

Building and Infrastructure defects that could affect the quality and provision of services					
Risk Number			Strategic Objectives		
1.3			Outstanding care and experience		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Safe		Rachel Lea	16	4	▪ Finance Transformation & Performance Committee ▪ Safety and Quality Assurance Committee

Description

- Building defects that remain unresolved could impact on patient services, reputation and financial sustainability and the ability to carry out changes and variations which could lead to delays and challenges.
- Risk relating to the contractual position on the Project Company.

Control description	Control assurance (How is this control monitored?)
Appointment of external expertise to advise Trust	- Reporting of external advisors to DD and Exec lead which informs the action plans and response back to SPV - Regular contact with Lawyers on the contractual status
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations.	-Review of the action plan takes place monthly to ensure all remains on track. - Where applicable, a team from the service provider is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact
Joint oversight by SPV and Trust through formal Liaison meeting	-Defects and action plan standing item on the monthly Liaison meeting attended by both Trust and SPV directors. - Minutes taken and circulated on key actions and risks
Regular oversight of defect issues by Trust committee (FTPC)	- Monthly report to FTPC on progress of remedial works through the PFI report - Escalation meetings when required with FTPC
Sharing of information with NHSE and DoH	Regular dialogue with NHSE and DoH
Sub oversight group established delegated by Board	Group to feed into FTPC monthly to include NED membership
Trust Board awareness of ongoing status of issues and defects including the actions taken	-Report to Trust Board outlining key risks and actions.

Gaps in Controls / Assurance

- Lack of progress with remedial works
- Lack of confidence in timescales for completion of remedial works
- Lack of ownership / accountability by SPV on issues
- Lack of transparency
- Risk of issues escalated impacting on NHS services

Action	Description	February 2026	
		Due Date	Action Update
Appropriate Legal Advice	Continue to seek appropriate legal, commercial and technical advice	31/03/2026	Legal advice remains ongoing with Bevan Brittan.
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.
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
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
15	4	Finance Transformation & Performance Committee

Description

Since 2020 there has been a significant increase in demand for Specialist Mental Health Services at Alder Hey, which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours, there has also been an increase in the clinical urgency of referrals received.
This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Control description	Control assurance (How is this control monitored?)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software
Existing BI Dashboard developed to support management of open caseload	Open caseload dashboard routinely reviewed by clinical leads and assistant clinical leads with practitioners
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required. Meetings and regular meeting with commissioners to update on service delivery and any challenges.	Monthly assurance processes include: Monthly contract statements Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Ongoing attendance at Cheshire and Merseyside Mental Health Workforce Planning groups	- Reviewed attendance across the range of meetings and Alder Hey lead/s identified - Feedback loop agenda item as part of Mental Health Business Meeting - Cheshire and Merseyside Lead attends Alder Hey business meetings.
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Trajectories developed to support improvement in access and waiting times	Monitored through - leadership meetings - weekly waiting times & access to care - regular meetings with divisional director - regular meetings with commissioners
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	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)

Action	Description	February 2026	
		Due Date	Action Update
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	13/02/2026	Trajectories for improvement are in place, and agreed with commissioners: **Liverpool CAMHS:** 92% CYP receiving urgent choice within 2 weeks of referral by 30.06.2025 - not achieved by end of June, but achieved and maintained from August onwards 0 CYP waiting over 52 weeks by 30.09.2025 - not achieved, but 0 expected by 31.10.2025 92% CYP receiving choice within 6 weeks of referral by 31.10.2025 - off track, but RTT improved in Sept. Expected to achieve. 0 CYP waiting over 40 weeks by 31.01.2026 - on track 75% CYP receiving partnership withing 18 weeks of referral by 31.1.2026 - on track 10% WNB rate by 31.12.2025 - off track, WNB rate for Aug higher than expected. Work ongoing **Sefton CAMHS:** 92% CYP receiving choice within 6 weeks of referral by 31.1.2026 - on track 92% CYP receiving partnership within 18 weeks of referral by 30.4.2026 - on track
104 week waits	task and finish group implemented to review 104+ week waits and CYP expected to "tip in"	28/02/2026	
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
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
ROMS collection and reporting	improve recording and reporting of routine outcome measures	31/03/2026	work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.					
Risk Number			Strategic Objectives		
2.1			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
▪ Safe ▪ Well-Led		Melissa Swindell	16	4	People Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and development practices to improve workforce diversity and progression 4. Not developing a Trust wide approach to succession planning and talent management 5. The Trust would be unlikely to successfully achieve the vision set out in both the People Plan and Vision 2030 if the right workforce is not available 6. Impact of national financial pressures on workforce numbers to deliver patient care 7. Not having a sustainable workforce will impact upon culture

Control description	Control assurance (How is this control monitored?)
Apprenticeship Strategy implemented	
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	reviewed at EDI steering group and monitored at People Committee also reported in the statutory WRES and WDES
Financial Improvement Programme	Monitored at FTPC
Health and Wellbeing Forum	Health and Well being Forum Terms of Reference - reporting through to People Committee
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
Monthly monitoring through Ops Board, Board, Execs and People Committee	Regular reporting of delivery against compliance targets via divisional reports
Nurse Retention Lead	Bi-monthly reports to PC
Nursing Workforce Report	Reports to People Committee, SQAC and Board
PDR and appraisal process in place	Monthly reporting to Board and PC
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
People Policies	All Trust Policies available for staff to access on intranet
Recruitment Strategy	progress to be reported PC
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Workforce Efficiencies Programme	Monitored at FTPC, and People Committee

Gaps in Controls / Assurance
1. Training/development 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Lack of robust talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity and progression opportunities across the organisation 7. The national and regional requirements to reduce NHS financial deficit, which is directly impacting on WTE

Action	Description	February 2026	
		Due Date	Action Update
3. Future Workforce	3. The work of the Organisational Design Collaborative will shape the future leadership structure, as well as review the structures across other professional staff groups to meet changing organisational pathways and patient need.	28/02/2026	The medium-term plan has been completed and submitted to the ICB 9 Feb 2026. This action can now be closed as completed. In addition the target operating model has identified new leadership structures and consultation is underway.
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.
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
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.
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
▪ Caring ▪ Safe ▪ Well-Led		Melissa Swindell

Risk Rating		
Actual	Target	Assurance Committee
12	4	People Committee

Description

- Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision and adapt well to other significant external and internal organisational changes.
- Failure to create a happy, healthy, fair place to work for staff that is trauma informed and based on restorative, just and learning principles
- Failure to communicate effectively with staff and have the right intelligence to be responsive to their unmet needs
- Failure to design, develop and support compassionate and effective leadership at all levels

Control description	Control assurance (How is this control monitored?)
Action Plans for Staff Survey	Staff Survey Action Group, People Committee reports
Alignment of staff safety and patient safety work via developing safety culture training, developing Restorative Just & Learning culture strategy and focussed work on Avoidable Employee Harm with People Services	People Committee reports and Safety Culture reporting to Patient Safety Strategy Board
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Plan delivered moved into business as usual.
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Director of Culture in post focussed on staff experience, safety culture, leadership, & high performing teams	Director of Culture reporting to People Committee and Board
Freedom to Speak Up programme	Board reports and minutes
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to People Committee
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic, People Committee reports
Occupational Health Service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Partnership working with Staff Side representatives and FTSU Guardian	Staff Partnership Forum meeting minutes
People Pulse results available	People Committee reports
Regular communication channels including managers and leaders briefings and all staff Ask the Execs meetings	Internal Communication reports to People Committee
Regular Schwartz Rounds in place	Monthly Schwartz Steering Group meetings
Restorative just and learning principles embedded into key employment policies including Disciplinary Policy	People Committee reports
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Staff Networks	EDI Steering Group and People Committee
Staff surveys analysed and followed up (shows improvement)	2024 Staff Survey Report - main report, divisional reports and team level reports
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to People Committee
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	Newly revised People Paper to include data relating to fragile teams
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered

Gaps in Controls / Assurance

- lack of embedded safety culture across the organisation
- lack of understanding about a just and restorative culture approach
- lack of consistent compassionate leadership
- Inconsistent application of Trust values and behavioural framework
- insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas
- insufficient OD resource available to fully address all culture tensions and challenges when they arise
- lack of aligned communications approach that is responsive to organisational needs
- lack of control of system decisions and pressures regarding the financial environment

Action	Description	February 2026	
		Due Date	Action Update
	listening routes such as SALS that pertain to the financial environment to help to shape communications and relevant interventions		
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
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2026	
Responsive communications	Links to be strengthened with communications team to ensure that communications are responsive to organisational need, values based and aligned to the culture. To be achieved via attendance at newly developed Communications Board and via closer links with comms team in values working group and other relevant fora	31/03/2026	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
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.
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.

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
▪ Effective ▪ Well-Led		Melissa Swindell

Risk Rating		
Actual	Target	Assurance Committee
12	4	People Committee

Description

- Failure to attract, recruit, and retain a workforce which reflects the demographics of the local population.
- Failure to foster an inclusive work place where staff feel respected, valued, and are able to contribution fully as an individual.
- Failure to provide equitable access to career development, progression, and leadership opportunities.
- Failure to meet statutory obligations under the public sector equality duty and wider equality obligations.

Control description	Control assurance (How is this control monitored?)
Actions taken in response to EDS22	Reported to EDI Steering Group, People Committee, and Patient Experience Group
Actions taken in response to Gender Pay Gap	Gender Pay Gap action plan, reports to People Committee and is part of the High Impact Actions
Actions taken in response to the North West BAME Assembly Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to the WRES/WDES	monthly recruitment reports provided by HR to divisions to incorporate WRES/WDES actions and report to People Committee
Collaborating across the Liverpool City Region to align regional and system wide practices	Building strong partnerships across the city region to ensure the EDI work aligns and that we share best practice, utilise opportunities and resources and relationships that will support the EDI work.
EDI Steering Group established - Chaired by NED	Minutes reported into People Committee. Membership has grown and will include Divisional Representation
Education and training for staff in relation to EDI	Mandatory EDI Training for all staff. current compliance above Trust target of 90%. Management Essentials Introduction to EDI Launched 2024, Thriving Leaders Programme includes module on EDI. Extensive online EDI training programme available for all staff to access. Anthony Walker Anti-Racism training provided as part of Thriving Leaders programme and also to certain identified areas. Neurodiversity training also delivered to certain areas and as part of the Thriving Leaders Programme.
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives Policy just updated.
Full time Head of EDI now in place	Full time Head of EDI and part time EDI officer. HR advisors/managers identified to support each of the staff network and also support the implementation of EDI projects embedding EDI into HR practices.
Inclusive People Policies and training	People Policies (held on intranet for staff to access). Recruitment and Selection training launched incorporating inclusive practice. Staff Networks support policy develop and are invited to EPRG
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 6 of delivery, continues to include a focus on inclusive leadership. Development of a targeted leadership programme for our Internationally recruited staff
NHS England EDI Improvement Plan supported by Trust Board, and associated high impact actions	NHSE EDI Improvement Plan reported to Board
Organisational approach to equality analysis, which includes EDI audits and more robust demographic data collection process	Equality Impact Assessments undertaken for every policy & project the process is being reviewed and revised and a staff resource being developed to support application EDS 22 Publication working in collaboration with Patient service leads
People Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	- bi-monthly reporting to Board via People Committee on diversity and inclusion issues - monthly Corporate report (including Workforce KPIs) to the Board
Staff Networks, providing continuous support to grow and contribute to embedding EDI	All networks have appointed chairs, supported by Head of EDI are members of EDI Steering Group and report bi-monthly into the group. All staff networks have an executive sponsor
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	Monitored through People Committee. Staff Survey Action Group developed to support the implementation of initiatives that will support Staff Survey.
Sufficient EDI resourced to support the EDI agenda	

Work with Communications colleagues to ensure that messaging is inclusive, supported by a dedicated communications plan, fostering a culture of belonging across the organisation	Work with communications to ensure that we are providing the organisation with the right messages. Support with all EDI related events. Head of EDI supports staff awards judging, communications colleagues are members of the EDI steering group. Development of a clear communication plan.

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	February 2026	
		Due Date	Action Update
Informal processes that limit equitable access to career development and advancement of opportunity	Launch: - Mutual Mentoring programme. - LCR Leadership Shadowing programme. - Grow to Lead Leadership Programme targeted at International recruited staff, including sponsors to support candidates. Closer monitoring of uptake of CPD uptake	06/04/2026	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. Mutual Mentoring programme launched. Alder Hey part of the LCR Leadership Shadowing programme. Development of Grow to Lead Leadership Programme targeted at International recruited staff, including sponsors to support candidates. Closer monitoring of uptake of CPD uptake
Lack of inclusive leadership behaviour and accountability for embedding cultural change	Inclusive training for managers to be launched as part of the Thriving leaders Programme. Mutual Mentoring Programme to be launched with staff networks. Staff Survey Action Group to be developed, focusing on targeted EDI results, High Impact Actions plan to be implemented. Trust EDI Objectives to be co-produced with staff networks.	31/07/2026	'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 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.
1. Multi-factoral issues spanning training and education	Launch EDI training programme. Training needs to be assessed to identify learning needs. Inclusive recruitment and selection training to be developed and launched which includes EDI. Neurodiversity training to be delivered to specific clinical areas.	31/10/2026	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. 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

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
▪ Effective ▪ Safe		Rachel Lea

Risk Rating		
Actual	Target	Assurance Committee
6	4	Finance Transformation & Performance Committee

Description

The Alder Hey long term vision for the Alder Hey Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations.

Control description	Control assurance (How is this control monitored?)
Business Cases developed for clarity on work required to complete Park and campus	- Information provided to capital prioritisation on areas that require capital spend - Tracking of budget and spend in line with business cases through the development team and finance.
Delivery of Design and Access Statement (included in planning application)	- Compliance reporting from Park Project Team
Development monthly meetings with Divisions	- Monthly meetings held with Development Team and Divisions tracking progress of various schemes and escalation of issues - Outputs reported to FTPC via Project Update
Executive Design group to seek input into plans	- Quartely meeting to take place with key executives to share master plans, schemes and seek input - Feedback into Trust Board - NED sponsor
Funding availability and potential market inflation	Continual monitoring of market inflation
Handover of Park	Handover of Park now complete
Implement planning approval for full park development.	- Full planning permission gained in December 2019 for the park development in line with the vision - Tracking of works completed to ensure in line with planning approval - Regular updates and meeting with Liverpool City Council and the planning department to discharge pre-commencement conditions -
Neonatal Programme Board in place to ensure scheme delivers in line with business case and vision of clinical teams.	- monthly meeting in place with relevant teams including project highlight reports and any areas of escalation - Regular reports to LNP board on scheme
Planning permission granted for Neonatal and Urgent Care	- Regular updates on implementation of NICU scheme in line with planning permission granted
Regular updates to CEO, Executive Lead and Communications	Fortnightly Report submitted from DD on all areas of campus and any issues for escalation
Report monitoring progress on all areas of campus	- Monthly report to Board on campus - Campus highlighted as a top 5 risk at FTPC and reported through this mechanism with clear risk and escalation where required. - Stakeholder events / reported to Trust Board and CoG - Weekly tracking through Senior Development Team Meetings
Strategic Estates and Space Allocation Group to approve changes to the campus to ensure alignment to vision	- Monthly meetings from September chaired by exec lead and supported by DD

Gaps in Controls / Assurance

PARK:
1. Adoption of the SWALE by United Utilities
2. Weather conditions causing potential delays
CAMPUS:
1. Stakeholder Engagement
2. Successful realisation of the moves plan.

Action	Description	February 2026	
		Due Date	Action Update
CAMPUS 1: Stakeholder Engagement	Engage with LCC, Friends of Springfield Park and community stakeholders and issue regular Comms	31/03/2026	Stakeholder engagement with LCC continues
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
Well-Led		Kate Warriner

Risk Rating		
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	February 2026	
		Due Date	Action Update
1. Developing skills and capacity to deliver the Strategy 2030	The approval of the People Plan by the Trust Board marks a significant milestone in ensuring we understand the skills and capabilities needed for our Future Workforce (2030). The upcoming phase in our strategic plan, Shape of Alder Hey 2030, will further allow us to assess the broader skills and capabilities our workforce will require to meet future needs.	31/03/2026	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
2. Failure to deprioritise to enable requisite focus on areas of need and transformational change	Focus on transformational change	31/03/2026	Draft of new Strategic Programme 2026-2030 has been developed and is going through further iterations
3. Risk of mission creep associated to the Strategy	Sharp focus at Strategy Board on core mission	31/03/2026	Continue to manage as a 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
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Rachel Lea

Risk Rating		
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 FTPC through monthly updates at top 5 key risk
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through Operational Board and FT&P with divisional leads ('3 at the Top'). Clear escalation to FTPC where required for high risk areas.
Financial Improvement Programme (FIP) in place to drive financial decision making whilst ensuring quality and safety impact is minimised subject to programme assessment and sub-committee performance management	FIP now in place with weekly strategic command meetings to approve financial decisions and drive cost reduction. Executive leadership through COO and CFO. Reported weekly through Exec Meeting and monthly through FTPC and Trust Board. All decisions will have a EIA/QIA approved before implementation.
Financial performance escalation framework in place	Any area/division that is off plan is expected to attend a financial review panel meeting with DOF with action plan detailing mitigation to bring back into budget. Quarterly divisional performance at Ops Board and FTPC along with deep dive into any high-risk areas. Divisional Directors report on performance at Trust Board.
Financial systems, budgetary control and financial reporting processes.	-@Daily activity tracker to support divisional Performance management of activity delivery -@ Full electronic access to budgets &@ specialty Performance results enhanced further with Finance App -@ Finance reports shared with each division/@department monthly and now readily available on Finance App -@ Financial in-month and forecast position reported through SDG, Exec team, FT&P, and trust Board including run rate analysis in detail -@ Financial recovery plans reported through SDG and FT&P -@ Internal and External Audit reporting through Audit Committee. -@ interactive financial dashboard rollout to all budget holders with all information readily available in one place.
Focused programme on closing the financial gap in year and realising the recurrent benefits.	8 key areas including in year transformation programme, with executive lead to drive financial benefits at pace to close the CIP gap in year Reporting into FIP and strategic command fortnightly with decision documents on financial savings.
Monthly monitoring of FTPC Top 5 risks	Risks monitored through FTPC
Organisation-wide financial annual plan monitored throughout year by Board and sub-committee to ensure delivery.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FTPC) - Monitored through IPR and the monthly financial report that is shared with FTPC and Trust Board. -
Transformation Programme & benefits realisation	Weekly meetings are in pace for the transformation collaborative which includes benefits realisation and cost reduction and savings. Reported to FTPC as a top 5 key risk. Enhance reporting through FIP and strategic command for 2 of the areas to accelerate in year financial savings.

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations including a cap on growth and overall financial position of Trust.
2. Inequity of CYP in prioritisation in national funding .
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Current system spending is above fair share funding allocation
5. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
6. Funding models not aligned to 2030 creating a shortfall.
7. Deliverability of high risk recurrent CIP programme
8. Increasing inflationary pressures outside of AH control
9. Divisional budget positions are not achieved due to emerging cost pressures.
10. Challenged system financial position and additional controls to be followed by providers

Action	Description	February 2026	
		Due Date	Action Update
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan 2. Working closely with the ICB	31/03/2026	Monitoring continues through Trust Board and FTPC
Delivery of 5 year capital programme	Risks around Capital Plan to be monitored closely. Capital management group established and regular reporting from capital leads. Reporting into FTPC and Board. Capital remains a key risk on FTPC	31/03/2026	Risks around Capital Plan continue to be monitored closely via Capital management group. Reporting into FTPC and Board. Capital remains a key risk on FTPC
Devolved specialist commissioning	Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk Financial analysis to be undertaken on impact of revision to allocations Regular exec to exec meetings with specialized commissioning	31/03/2026	Regular reporting to strategic execs and assurance to FTP and Trust Board Regular exec to exec meetings with specialized commissioning continues
High risk recurrent Efficiency programme	Transformation programme to be established reporting into the portfolio board and weekly execs. New reporting dashboards to be put in place reporting weekly to execs and into FTPC showing the latest CIP position with focus on recurrent schemes.	31/03/2026	Transformation programme now in place with weekly check ins on collaboratives reporting into the portfolio board and weekly execs.
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.
Shortfall against Long Term Financial Plan	LTFM produced to e shared with FTPC and Board and submitted to ICB. Annual planning process complete and bridge completed by Division. however, further delays to the completion of LTFM and the productivity work has resulted in this not being completed in the time frame initially set. This will form part of the 2030 financial strategy to be completed in Q2	30/09/2026	

System working to deliver 2030 Strategy

Risk Number	Strategic Objectives
3.5	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

Risk Rating		
Actual	Target	Assurance Committee
16	4	▪ Growth and Opportunities Committee ▪ Strategy Board

Description

Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory and political and system environment.

Impact of membership of a system that is in national financial recovery.

Risk of failure to keep CYP prioritised in the wider NHS context and competing priorities, and therefore risk to delivery of Vision 2030.

Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.

Control description	Control assurance (How is this control monitored?)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually). Update: New CEO & leadership arrangements at RMCH - exec to exec scheduled for July 25 Sept 25 update: organisation change at RMCH has delayed NWPPB regrouping. New management is in post Sept 25, and we will now engage and progress this agenda. Oct 25 Update: No further update this month. Dec 25 Update: Alder Hey continue to work in partnership with RMCH on a variety of clinical services. The NWPPB has not yet re-grouped - though MDs routinely connect and the new RMCH CEO is now connected with Alder Hey CEO and the new RMCH CEO. Management structures supporting the ODNs at RMCH are under change; Alder Hey lead maintaining close liaison. Jan 26 Update: Control is unchanged. Feb 26 Update: Alder Hey and RMCH CEOs have begun engagement and executive teams are due to convene in February to refresh our partnership working.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS - update funding confirmed for 25/26 March 25 Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board. Dec 25 Update: No change to arrangements Jan 26 Update: Control is unchanged. Feb 26 Update: Control is unchanged.
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy. Dec 25 Update: No change to arrangements Jan 26 Update: Alder Hey are working with the C&M ICB to determine the best governance structure for CYP in 2026. Feb 26 Update: Control is unchanged - Alder Hey continue to work closely with the C&M ICB to shape the best governance structure for CYP.
Capacity and capability building for the implementation of Vision 2030 is being captured in the forthcoming clinical strategies (blueprints) and target operating model work, to ensure Alder Hey have the ability to deliver in the new system environment. This requires both capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Incorporated into Executive Away Day planning discussions and development of 2025+ transformation plan Update Jun 25: Further embedding of the partnership priorities/leadership within the Tx Clinical Collaboratives Sept 25 update: capacity and capability building will be captured in the forthcoming blueprints and TOM work. Oct 25 Update: capacity and capability building continues to be built into the blueprints and TOM, which are in development and due for completion Dec 25. Control details updated. Dec 25 Update: A final version the clinical blueprints is developed. The target operating model work is ongoing. Jan 26 Update: Control is unchanged and the TOM work is ongoing. Feb 26 Update: Control is unchanged and the TOM work is ongoing.
Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for CYP.	Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25 Sept 25 update: NHSE and ICB structural changes are causing uncertainty on timeframes: we continue to monitor and engage with the system on next steps. Oct 25 Update: No further clarity on structure or time frames available. Dec 25 Update: Specialised services are due to be fully transferred to the ICB by March 27 (not delegated). Awaiting further clarity on structure and phases. Jan 26 Update: Control is unchanged. Feb 26 Update: Control is unchanged, still awaiting further clarity on structure and phases of delegation.
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings. Feb 25 - System-wide CYP Neighbourhood engagement event with LCR and all key partners Oct 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately. Dec 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately. Jan 26 Update: Changes in the C&M ICS structure and leadership team are underway - Alder Hey continue to engage with existing and emerging key stakeholders. Feb 26 Update: C&M ICS leadership changes are still underway, and Alder Hey continue to engage with the system, and all key partners.

Growth and Opportunities Committee oversight of growth element of Vision 2030.	Oct 25 Update: New control Dec 25 Update: The first committee meeting took place in Oct, with the subsequent meeting due in Dec. The Committee is developing the work plan and metrics. TOR approved Dec 25. Jan 26 Update: The second GO Committee took place in Dec 25 and received updates on research, innovation, private patients, global health and strategic partnerships. The workplan is developing. Feb 26 Update: No significant update - the GO Committee is due to meet later this month.
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board Oct 25 Update: continue to track developments and report back into the relevant forums. Dec 25 Update: continue to track developments and report back into relevant forums. Jan 26 Update: Control is unchanged. Feb 26 Update: Control is unchanged.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board Update Jun 25 : Strategic Pships governance within new 'GO' Committee developments Sept 25 update: Stakeholder management: An options paper on professionalising stakeholder management was completed for execs on Aug 25. Due to financial constraints, only no/low cost CRM tool options will be considered this year. The need for effective CRM tools is acknowledged, and the Strategy Board will receive an update in October as part of the broader GO review. Oct 25 Update: Strategic partnerships will report through the GO Committee, commencing in Oct, with Exec and non-Exec membership. Assurance continues to be provided through Trust Board also. Dec 25 Update: Inaugural Strategic partnership assurance piece reported to GO Committee in Dec 25. The breadth of partnership working has increased and this will be reflected into the new Committee with refreshed / appropriate level of governance arrangements in place. Jan 26 Update: An assurance paper was taken through GO Committee in Dec 25, and a decision was reached to to create a sub committee focusing on strategic partnerships. This will provide oversight and assurance that Alder Hey have the right partnerships, with appropriate governance in place, with all partners receiving the intended benefits. Feb 26 Update: Control is unchanged.
Joint development of new models of care to enable 10 year plan 3 shifts / Vision 2030 on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool. Sept 25 update: Recent Lung Health event took place, organised by Tripartite: Alder Hey, Merseycare and LUHG. Neighbourhood Model - system wide development with Place Partners Oct 25 Update: Joint models of care continue to evolve, for example 0-19 services and tripartite lung health. Dec 25 Update: Joint models of care continue to evolve, and positive progress is being made against e.g. tripartite lung health programme and neighborhood models. Jan 26 Update: Control is unchanged. Feb 26 Update: Joint working continues to progress. For example the North Mersey Provider Partnership MOU has been approved by partner Boards in Q4, and is due to come to Alder Hey Trust Board in March. We are proactively working with multiple partners locally, regionally and nationally to co-design models of care for CYP.
Maintain existing relationships and continually build new ones with system regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December Dec 25 Update: relationships are consistently maintained. Jan 26 Update: Control is unchanged. Feb 26 Update: Control is unchanged.
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	Membership of CMPC provider collaboratives. Dec 25 Update: Membership and engagement in place. Jan 26 Update: Control is unchanged. Feb 26 Update: Control is unchanged.
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES Partnership Plans developing with CYP focus. Update Jun 25: High disruption of Places due to ICB new model - however Alder Hey continued commitment in all 3 Oct 25 Update: Alder Hey continue to represent at Place. Alder Hey leading Place CYP Neighbourhood models, C&M-wide, through 'Beyond' programme and as local provider in all 3 North Mersey Places. Dec 25 Update: Alder Hey continue to represent at Place; significant local work re: Neighbourhood/CYP model ongoing. Jan 26 Update: Control is unchanged. Feb 26 Update: Alder Hey continue to represent at Place; significant local work re: Neighbourhood/CYP model ongoing which we are actively engaged in.

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	February 2026	
		Due Date	Action Update
1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2026	Awaiting clarity from commissioners (Feb 26) No further update for Jan 20. Awaiting clarity from commissioners (Feb 26)
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 Feb 26. No further update for Jan 26. Awaiting further clarity on delegation in Feb 26.
3. CYP System and Partners	3. NHS England's Medium Term Planning guidance has clarified the NHS Operating Model including a re-set of the foundations in which to transform care and deliver on the 3 shifts of the 10 Year Health Plan. This will need to done in collaboration / partnership across the CYP system.	31/03/2026	Our AFT application is progressing, with Board and Committees being shadowed in Q4. We continue to proactively engage with multiple partners across the system
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	Financial environment remains a significant challenge. We are due to submit our medium term plan response this month which details our priorities for the next 3 years.

Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.

Risk Number	Strategic Objectives
4.1	Pioneering Breakthroughs

CQC Domains	Linked Risks	Owner
• Caring • Effective • Safe • Well-Led		John Chester

Risk Rating		
Actual	Target	Assurance Committee
9	4	Growth and Opportunities Committee

Description

Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries.
Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities.
Risk of exposure to ethical challenges and national and international reputational risks.

Control description	Control assurance (How is this control monitored?)
Clear management structures and operational accountability within Futures including the Clinical Research Division, Innovation team and Futures aspects of Education and Digital	Reports to 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	February 2026	
		Due Date	Action Update
5. Comms Strategy for Futures	Development of Futures comms approach	30/09/2025	awaiting final comms narrative for innovation inc POIZ - on track for end of Feb
1. Establishment of Futures Management Board to ensure integrated Futures leadership	Integration of activities across Research, Innovation, Education and Digital into Futures through the establishment of Futures Management Board with representation from Research, Innovation, Education and Digital. Includes monitoring performance against external targets from major funders to mitigate reputational risk.	28/02/2026	Individual performance meetings underway throughout Feb
2/3. Financial Model	- Securing external investment (Grow and Discover Pillar) - Building capacity and capability funding through commercial research, NIHR grant applications, AH charity partnership and and other external funding which attracts indirect costs (Grow, Discover and Develop Pillar) - Supporting cost saving initiatives across the Trust through adoption of innovative technology (Tranform Pillar)	31/03/2026	External income progressing well against targets. Financial gap remains for MRI and RPA (see departmental risks). Decisions taken at FIP on 20th Nov to set up priority setting group and releasing operational resource for CRD for MRI and review MARS and other benefit release options for RPA 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 acheiving income targets for MRI and RPA business cases driving current issues with financial position - being managed through FIP - report due on 28th August Actions continue to close financial the gap in MRI and RPA business cases. POIZ transactions up to date to end of Sept.
4. Capacity and capability	Create an R&I enabled workforce through the Futures Develop Pillar	31/03/2026	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

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families

Risk Number	Strategic Objectives
4.2	Revolutionise Care

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Safe		Kate Warriner

Risk Rating		
Actual	Target	Assurance Committee
16	4	Finance Transformation & Performance Committee

Description

Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Control description	Control assurance (How is this control monitored?)
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence tracking delivery
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
Digital Strategy refresh underway to reflect changing environment. Digital Data and Insights key components of Vision 2030 and associated governance and plans	Digital Centre of Excellence. Relationship with Futures. Digital and Data Collaborative established.
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Executive level CIO in place	Commenced in post April 2019, Deputy CDIO in place across iDigital Service
External oversight of programme	Strong links to system, regional and national digital governance via internal and external relationships.
Formal change control processes in place	Weekly Change Board in place
High levels of externally validated digital services	HIMSS 7 Accreditation
Monthly digital performance meeting in place	iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.
Regular update to Trust Board on digital developments, Monthly update to FTP	Board agendas, reports and minutes

Gaps in Controls / Assurance

1. Cyber security investment for additional controls approved - dashboards and specialist resource in place. Continual review underway to assess additional requirements.
2. Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs
3. Issues securing experienced resources in some services
4. Aging hardware/device estate and financial restrictions preventing all equipment being replaced, most notably in clinical areas
5. Capital investment anticipated lower than required
6. Optimizing user experience of digital systems review

Action	Description	February 2026	
		Due Date	Action Update
Cyber Assurance Framework & Strategic review of Cyber Security with Recommendations and Outputs	This has replaced the action around Cyber Essentials +. Links to the Cyber continual review gap in control	27/03/2026	Review and update of Cyber Security Improvement plan in progress. Refreshed governance also being discussed with Non Execs to ensure its as robust as it needs to be. New sub committee to be established in April which will review reporting details.
Review of Benefits from Digital, Data and AI Collab and produce report.	Produce a report on realised benefits. Links to Transformation at Pace gap in control	27/03/2026	Good progress has been made via Digital, Data and AI collab. Piece of work underway to amalgamate all realised benefits into one report.
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	Progressing really well, expecting both data centres to be completed by end of Feb. Support for network and telephony refresh at Capital Prioritisation Group in January. Once all 4 pieces of work are completed risk can be closed.
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	First draft of organisational redesign paper completed and under review with HR. Hoping to commence work towards end of Feb and complete in early April. This should enable us to recruit to key roles required to effectively run the service. Current baseline assessment has been completed and now working through the future state and proposed structures. On track to deliver by required deadline.
Digital systems review	Digital systems review	30/10/2026	EMIS work is progressing. AlderCare 2.2 technical infrastructure to be completed in Feb with new upgraded platform available in March.