

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 3rd September 2026, commencing at 11:15am
Lecture Theatre 1, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)	Preparation
PATIENT STORY (11:15am-11:30am)						
1.	26/27/148	11:30 (1 min)	Apologies.	Chair	To note apologies.	N For noting
2.	26/27/149	11:31 (1 min)	Declarations of Interest.	All	Board members to declare an interest in particular agenda items, if appropriate.	R For noting
3.	26/27/150	11.32 (2 min)	Minutes of the Previous Meeting.	Chair	To consider and approve the minutes of the meetings held on: 23rd June 2026 and 2nd July 2026.	D Read enclosure
4.	26/27/151	11:34 (1 min)	Matters Arising and Action Log.	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	A Read enclosure
5.	26/27/152	11:35 (10 mins)	Chair’s/Chief Executive’s Update, including: Southport Public Inquiry (Phase 2).	Chair/ J. Grinnell E. Saunders	To receive an update on key issues and discuss any queries from information items.	N Verbal
					To receive an update on the current position.	N Verbal
Strategic Update						
6.	26/27/153	11:45 (30 mins)	Vision 2030: - HWWWITF update. - Widening Participation (Improve My Life Chances). - Digital, Data and Technology update.	A Bateman/ M. Swindell K. Birch	To receive an update on progress.	A Presentation
						A Presentation
				K. Warriner		A Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action:		Preparation
					Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		
7.	26/27/154	12:15 (10 mins)	C&M System Update.	D. Jones	To receive an update on progress.	A	Presentation
8.	26/27/155	12:25 (10 mins)	Clinical Strategy 2026-2030.	N. Askew	To receive and approve the final version of the Clinical Strategy for 2026-2030.	D	Read report (Publication date: End of September 2026)
Lunch (12:35pm-13:00pm)							
Performance Against Annual Plan							
9.	26/27/156	13:00 (10 mins)	Winter Plan, 2026/27; including: Update on plans for acute paediatrics, UEC and Ward 4C.	A. Bateman/ B. Pettorini	To receive the Winter Plan for 2026/27.	A	Read report/ Presentation
10.	26/27/157	13:10 (35 mins)	Evidence of Our Performance: - Flash Report. - Integrated Performance Report for M4, 2026/27: - Experience and Safety. - Revolutionising Care. - Pioneering. - People. - Collaborating for CYP. - Resources. - Clinical Systems.	A. Bateman A. Bateman N. Askew A. Bateman K. Warriner M. Swindell D. Jones R. Lea System 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
11.	26/27/158	13:45 (15 mins)	Delivering the Trust's Financial Plan.	R. Lea	To receive an update on the current position.	A	Presentation
Unrivalled Experience							
12.	26/27/159	14:00 (5 mins)	NHSE Quality Strategy for NHS Funded Care in England.	N. Askew	To receive an overview of the recently published NHS England Quality Strategy.	D/N	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action:		Preparation
					Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		
13.	26/27/160	14:05 (5 mins)	Learning from the Nottingham Maternity Review and the National Maternity and Neonatal Investigation.	N. Askew	To receive a briefing on the oversight of the national maternity and neonatal investigation findings and recommendations.	D/N	Read report
14.	26/27/161	14:10 (5 mins)	Safeguarding Annual Report, 2025/26.	N. Askew	To receive the Safeguarding Annual Report for 2025/26.	R/N	Read report
15.	26/27/162	14:15 (5 mins)	Compliments, Complaints and PALS Report, Q1.	N. Askew	To receive the PALS and Complaints Report for Q1.	A	Read report
16.	26/27/163	14:20 (5 mins)	Learning from Patient Safety Incidents.	N. Askew	To receive the Learning from Patient Safety Incidents Report for Q1.	A	Read report
17.	26/27/164	14:25 (15 mins)	Infection, Prevention and Control Report, Q1.	A. Bass	To receive the Infection, Prevention and Control Report for Q1.	A	Read report
18.	26/27/165	14:40 (5 mins)	Safety and Quality Assurance Committee: - Chair's verbal update from the meeting held on the 22.7.26. - Approved minutes from the meeting held on the 24.6.26.	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 24.6.26.	A	Read enclosures
Supporting our People							
19.	26/27/166	14:45 (30 mins)	10 Point Plan for Improving Working Lives of Resident Doctors.	S. Ogbuagu F. Cameron/ L. Ramasubramanian	To receive an update on the 10 Point Plan for improving the working lives of Resident Doctors.	A	Presentation
20.	26/27/167	15:15 (20 mins)	Sickness Absence Update.	M. Swindell	To receive an update on the current position.	A	Read reports/ Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action:		Preparation
					Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		
21.	26/27/168	15:35 (15 mins)	Strategic People Update; including: - NHS Staff Standards. - EHRC Code of Practice, Supreme Court Judgement and Single-Sex Spaces. - Legal advice following publication of the Lord Mann Report.	M. Swindell/ E. Saunders	To receive an update on the current position.	A	Read reports/ Presentation
22.	26/27/169	15:50 (5 mins)	People and Culture Committee: - Chair's verbal update from the meeting held on the 29.7.26. - The approved minutes from the meeting held on the 29.6.26.	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 29.6.26.	A	Read enclosures
23.	26/27/170	15:55 (10 mins)	Freedom To Speak Up Update.	J. Fitzpatrick	To receive an update on the current position.	A	Read reports
Strong Foundations (Board Assurance)							
24.	26/27/171	16:05 (5 mins)	Audit and Risk Committee: - Chair's Highlight Report from the meeting held on the 16.7.26. - Approved minutes from the meeting held on the 18.6.26.	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 18.6.26.	A	Read enclosures
25.	26/27/172	16:10 (5 mins)	Finance, Transformation and Performance Committee: Chair's verbal update from the meeting held on the 20.8.26 .	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 30.6.26 and 3.8.26.	A	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- Approved minutes from the meetings held on the 30.6.26 and 3.8.26. - 2026/27 Priority Areas.				
26.	26/27/173	16:15 (5 mins)	Board Assurance Framework Report; including: • Corporate Risk Register.	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	A	Read reports
27.	26/27/174	16:20 (4 mins)	Any Other Business.	All	To discuss any further business before the close of the meeting.	N	Verbal
28.	26/27/175	16:24 (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, 1 st October 2026, LT1, Institute in the Park.							

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Report submitted to the People Committee on the 19.11.25 - Resident Doctor Experience at Alder Hey (GMC Survey; Improving the Working Lives of Doctors in Training; NHSE Education Quality Review)	K Birch
Financial Metrics, M4, 2026/27	R. Lea

EXTRAORDINARY MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Tuesday 23rd June 2026 at 3:00pm**
in 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. Bateman	Chief Operating Officer/Deputy CEO	(AB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 26/27/105	Mr. H. Rohimun	Executive Director, Ernst & Young	(EY)
Apologies:	Ms. S. Almond	Consultant Paediatric Surgeon	(SA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Ms. C. Lee	ACOO, Division of Surgery	(CL)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	Mr. D. Powell	Development Director	(DP)

26/27/103 Welcome and Apologies

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

26/27/104 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.

26/27/105 Draft Annual Report and Accounts for 2025/26

Annual Report 2025/26

The Chief Corporate Affairs Officer, Erica Saunders (ES) presented the draft Annual Report for 2025/26 to the Board for approval purposes. It was confirmed that the report has been prepared in accordance with the NHS Annual Reporting Manual

and provides a fair, accurate and balanced reflection of the Trust's activities, performance and achievements throughout the year.

Annual Accounts 2025/26

The Chief Finance Officer, Rachel Lea (RL), presented the draft Annual Accounts for 2025/26, confirming that the accounts remained consistent with the financial performance reported during the year. It was confirmed that the Trust achieved its planned financial control total, reporting a £7.1m surplus. While the accounts state a £7.3m deficit, this is after taking into account the exceptional items which are not measured by NHS England (NHSE) such as asset impairments and donated income. The Board was advised that all reporting remained aligned with NHSE's expectations and that the auditors hadn't identified any material adjustments to the accounts.

The Chair of the Audit and Risk Committee (ARC), Kerry Byrne (KB), commented that the Annual Report provides a valuable opportunity to review and learn more about the Trust's work during the year, noting that while it often includes new information, there had been no unexpected issues or matters of concern. In terms of the Annual Accounts, it was reported that ARC received assurance from the audit process, which it was felt was a well-planned and effective audit, with no significant issues arising. KB confirmed that the Committee was satisfied that the remaining audit actions will be completed and was content to endorse the 2025/26 Annual Report and Accounts for Board approval.

The Chair thanked all those who have worked hard to achieve the results detailed in the Annual Report and Accounts, and particular thanks were expressed to Jill Preece for her sterling work in producing an excellent report.

External Audit Year-end Report, 2025/26 – 'ISA260'.

The Executive Director from Ernst and Young (E&Y), Hassan Rohimun (HR), presented the External Audit Year End Report for 2025/26 advising that the audit was substantially complete, with E&Y expecting to issue an unqualified opinion on the Trust's 2025/26 financial statements. The audit didn't identify any unadjusted audit differences or matters exceeding materiality thresholds. In relation to E&Y's Value for Money (VFM) responsibilities, it was confirmed that no significant weaknesses have been identified in the Trust's arrangements and there have been no requirements to report by exception. HR congratulated the Trust on its Advanced Foundation Trust (AFT) status noting that this provided additional evidence of organisational maturity and effective governance. A number of recommendations have been made where arrangement can be improved in respect to related party disclosures.

The Board was advised that subject to completion of final review procedures, receipt of the Letter of Representation and confirmation of no subsequent events, E&Y remain on track to conclude the audit and issue its opinion as planned. HR thanked the Finance and Governance teams for their cooperation and professionalism throughout the audit process.

Letter of Representations

KB drew the Board's attention to an additional declaration included within the 2025/26 Letter of Representation (LoR) relating to the deployment of Artificial Intelligence (AI) in the preparation of annual accounts. ARC has considered the implications of this new requirement, and it has been agreed to review this further over the next twelve months. KB highlighted this as an emerging area of governance and assurance that will require ongoing consideration as the Trust's use of AI continues to evolve.

KB noted that, while E&Y will continue as the Trust's External Auditor for a further year, HR will be handing over to a colleague after nine years of working with the Trust, in order to maintain audit independence. KB thanked HR for his pragmatic and supportive approach, recognising the important role he played in helping the Trust to meet its statutory and governance responsibilities especially during challenging periods. KB welcomed the planned transition to HR's successor, Claire Mellons.

The Chair also thanked HR for his contributions over the years and expressed appreciation for the constructive and collaborative way in which he has worked with the Trust. The Chair noted that this reflected a strong partnership and positive working relationship and wished him well for the future. HR thanked everyone for their comments.

Resolved:

The Board:

- Approved the Trust's Annual Report and Accounts for 2025/26.
- Received and noted the External Audit Year-end report, 2025/26 'ISA260'.
- Agreed for the Letter of Representations to be signed.

26/27/106 Committee Annual Reports for 2025/26

The Board received the following Committee Annual Reports for 2025/26, noting that each Committee had fulfilled its Terms of Reference and managed its governance processes during the year:

- Audit and Risk Committee (ARC).
- Finance, Transformation and Performance Committee (FTPC).
- Safety and Quality Assurance Committee (SQAC).
- People Committee.
- Growth and Opportunity Committee (GO).

Recognition was given to the improved clarity of assurance statements within the Annual Reports, enabling enhanced Board oversight. Thanks were also offered to JP for compiling the reports.

Resolved:

The Board received and approved the 2025/26 Annual Reports for each of the Assurance Committees.

26/27/107 Board Self-Certification of Compliance with the Provider Licence

The Board was advised that the self-certification of compliance with the Provider Licence is no longer a formal requirement, although it remains unclear whether a similar process may be introduced as part of assurance arrangements for AFTs. The Trust has continued to undertake the exercise to provide an additional layer of assurance that licence conditions are being reviewed routinely and annually to check that the Trust is meeting its obligations as a Foundation Trust (FT). It was confirmed that the self-assessment did not identify any areas of concern and that the Trust remains fully compliant with its licence conditions and constitutional requirements. The update was commended to the Board for approval.

Resolved:

The Board approved the proposed confirmation of compliance with condition CoS7: Availability of Resources in the Provider Licence.

26/27/108 Any Other Business

There was none to discuss.

26/27/109 Review of the Meeting

The Chair reflected positively on another successful year for the Trust, recognising the collective contributions of Executive Directors, Non-Executive Directors, Committee Chairs and supporting teams in strengthening the organisation's governance and assurance arrangements. The Chair welcomed the positive outcome of the External Audit and expressed pride in the Trust's achievements.

Date and Time of Next Meeting: Thursday 2nd July, 9:00am, LT1, Institute in the Park.

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 2nd July 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. Bateman	Chief Operating Officer/Deputy CEO	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Ms. C. Lee	ACOO, Division of Surgery	(CL)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 26/27/122	Ms. F. Ashcroft	CEO of the Charity	(FA)
Item 26/27/122	Mr. G. Morris	Chair of the Charity	(GM)
Item 26/27/125	Ms. J. Grice	Mortality Lead	(JG)
Item 26/27/129	Helen Blackburn	Education Services & Revalidation Manager	(HB)
Observing:	Ms. C. Hill	Director of AQuA	(CH)
Apologies	Ms. S. Almond	Consultant Paediatric Surgeon	(SA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Director of Development	(DP)

Patient Story

The Chair welcomed Christie who was invited to July's Trust Board to share her story and journey with Alder Hey. The Chair also welcomed Christie's guardian Karen, Dr. Alexandra Scott-Heyes (*Lead Clinical Psychologist for the SARC Psychology Service*) and Elaine Prescott (*SARC Nurse Manager*) who accompanied Christie.

Christie shared her experiences of accessing support through Alder Hey's Sexual Assault Referral Centre (SARC) and Psychology services and spoke about the importance of being listened to, building trust and receiving care that was tailored to her individual needs. The Board also heard how the service had supported Christie not only in processing past trauma but also in developing coping mechanisms, improving her emotional wellbeing and enabling her to express her experiences through poetry. Christie reflected positively on the flexibility of the therapeutic

approach, the involvement of her guardian and the compassionate, non-judgemental environment created by staff. The Board also Christie's message of encouragement to other young people facing similar experiences, emphasising the importance of seeking support and speaking openly.

The Chair thanked Christie for her courage in sharing her story, noting the valuable insight it provided into the difference the service had made to her life and recovery.

26/27/117 Welcome and Apologies

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

The Board was advised that Alder Hey has commissioned Advancing Quality Alliance (AQuA) to undertake a Well-Led Developmental Review. The Chair welcomed Cath Hill from AQuA, who advised that the review will take a forward-looking approach to well-led arrangements at the Trust, while applying an Advanced Foundation Trust (AFT) lens to ensure any additional well-led plus considerations are addressed as part of the process. Interviews and observations of Board and Committee meetings will be undertaken by the review team, with a detailed report and feedback to be provided on completion of the review. Cath Hill acknowledged that some Board members have previously participated in similar observations as part of the Trust's AFT application process and apologised for any duplication but advised that this process has to be repeated as part of the review in accordance with the requirements of the CQC Well Led framework.

26/27/118 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.

26/27/119 Minutes of the previous meeting held on 4th June 2026.

Resolved:

The minutes from the meeting held on the 4.6.26 were agreed as an accurate record of the meeting, pending the following amendment:

- Agenda item 26/27/82, paragraph 5, first line: add the letter "d" to the end of Gerald Meehan's christian name.

26/27/120 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 26/27/86.1: *Evidence of our Performance - Flash Report (Provide assurance that mitigations are in place to address the cohort of patients waiting more than two years for a follow-up appointment)* – An update was provided during the Division of Surgery performance update. **ACTION CLOSED**

26/27/121 Chair's and CEO's Update

The Board was informed of the successful celebration of the inaugural National CYP Nurses' Day, which created a positive atmosphere across the Trust. The event included activities for children and young people (CYP), a bake-off, and a Quality Assurance Round (QAR). The event was supported by a local bakery who donated four large cakes which were delivered at no cost to the Trust. It is hoped that CYP Nurses' Day will become a recurring national event.

The Chair informed the Board of her attendance at a recent meeting of the Charity's Trustees, where Garth Dallas was welcomed as a new member of the Charity's Board. The Chair commended the Charity's continued success, noting its strong fundraising performance in a challenging environment and its ambition to achieve further growth over the coming year. It was pointed out that the Charity has continued to support a wide range of Trust programmes and has agreed to fundraise for robotic surgical technology, following a demonstration of the equipment. The Chair described this technology as transformational, with benefits for clinical practice, training and staff wellbeing. Attention was drawn to the importance of maintaining a strong pipeline of future projects to sustain donor engagement and fundraising momentum, particularly in relation to the new Neonatal Unit, as donors are seeking updates on progress.

The Board was advised of a recent visit from representatives of Hospitals in Bloom, who commended the Trust's effective use of green spaces to engage and support the wellbeing of CYP and staff. The visitors took a holistic view of the campus and were particularly impressed by the way the environment contributes to patient and workforce experience. The Board welcomed the positive feedback received.

Attention was drawn to the publication of a national review concerning maternity and neonatal care led by Baroness Amos, which has followed shortly after the publication of the Ockenden report. Whilst noting that Alder Hey does not provide maternity services, it was pointed out that both reports contain important learning relevant to the wider NHS and midwifery recommendations that are applicable. Detailed briefing papers have been prepared for consideration in July by the Safety and Quality Assurance Committee (SQAC) and a formal action plan will subsequently be developed in response to the Ockenden recommendations. It was confirmed that a further update, including proposed actions and oversight arrangements, will be presented to the Board in September.

Application for AFT Status

It was reported that the Trust received exceptionally positive feedback from the assessors in relation to its AFT application. It was pointed out that this recognition reflects the strength of the organisation and will provide a platform from which the Trust can further develop its leadership role across Cheshire and Merseyside (C&M), supporting improved outcomes for CYP both within its services and across the wider system.

Southport Public Inquiry (Phase 2)

It was confirmed that Alder Hey has not been granted 'Core Participant' status for the second phase of the Inquiry; however, the Trust has been informed that it is

likely to be invited to provide evidence under Rule 9. The Inquiry hearings are to be held in London and will involve government departments, multi-agencies, and the affected families. It was pointed out that the Inquiry will be run differently than the initial phase, with focus groups and workshops which may provide an opportunity for the Trust to provide data that highlights its waiting list pressures and service demand challenges. An opening hearing is scheduled for the 8th of July, after which the Inquiry will adjourn until the autumn, with proceedings expected to recommence in early September.

Resolved:

The Board noted the updates.

26/27/122 Charity Strategy Update

The Chair of the Charity, Graham Morris (GMO), introduced the strategy update by reflecting on the significant progress achieved by the Charity over the past year, including an increase in income from just over £4m to £10m, and the expansion of the Charity's team which required a substantial investment. GMO acknowledged the strong leadership of the CEO, Fiona Ashcroft, and the team in delivering this success and emphasised the importance of the close and collaborative relationship between the Charity and the Trust. Thanks were also expressed to the Chair and CEO of Alder Hey for their continued support, openness and partnership, which has helped enable the Charity's growth and its increasing contribution to support Alder Hey's strategic ambitions and improving outcomes for CYP.

The CEO of the Charity Fiona Ashcroft (FA) provided the Board with an update on the Charity's Strategy. It was reported that Income for 2025/26 was £10.2m, an increase of 117% since 2019/2020. Charitable grants to the Trust totalled £5.5m, up by 72%, supporting community programmes, medical equipment, research and innovation, education, and enhanced patient and family experiences.

The Charity outlined its 2026–2031 objectives: improving stakeholder experience, growing income, maximising impact, and investing in people and culture. Eight strategic priorities were identified, including legacy income, transformational gifts, grateful patients, regional growth, brand, advocacy and impact. It was reported that fundraising performance compared favourably with peer organisations, with only one organisation performing better than the Charity.

A dedicated grateful patients' programme was highlighted as a significant growth opportunity. The proposal will establish a sensitive pathway for families wishing to give, improve staff awareness and referrals, and develop longer-term fundraising and legacy relationships.

It was reported that the Charity's ambition is to double annual income within five years and reach £50m within ten years. Delivery will require investment in people, digital capability, data and AI, brand awareness, Trust engagement and timely information sharing, while managing financial pressures and technological change.

The Board welcomed the Charity's strategy and noted the need for the Trust and the Charity to work together more strategically to identify a clear and compelling pipeline of projects that could support future fundraising. The Board acknowledged the importance of aligning fundraising opportunities with the Trust's strategic priorities, including both major capital schemes and smaller grants that make a

meaningful difference to patient and staff experience. The Board also recognised the Charity's strong communications approach.

A discussion took place regarding the opportunities to improve awareness of the Charity among patients and families, including the concept of "grateful patient" giving and how the Trust could make it easier for those who wish to donate. The programme would enable staff to signpost interested families to the Charity when they express a wish to give back. It was emphasised that staff will never be expected to request donations, but clear routes should be available for those wishing to support the Trust. Potential opportunities through the patient portal, television systems and enhanced communications are also being considered.

A question was raised about maintaining an appropriate tone when encouraging charitable donations, particularly given the current cost-of-living pressures on families. The importance of this issue was acknowledged, and it was explained that considerable effort has been made to ensure that all fundraising communications remain sensitive, appropriate and focused on giving families the opportunity to express gratitude rather than feeling under any obligation to contribute financially.

The Chair offered thanks to the Charity for their ongoing support, noting that some of the programmes that the Charity is supporting are so significant and would not be possible without the dedication and commitment of the Charity and its team.

GMO advised that the Charity has recently been recognised as one of the Sunday Times Best Places to Work in 2026. It was pointed out that this award reflects the strong workplace culture that has been nurtured and the significant investment made in staff engagement and team development.

Resolved:

The Board noted the Charity's update on its strategy.

26/27/123 Vision 2030 Update

How We Work in the Future Programme

It was reported that the implementation of the Trust's five new systems has gone live, although further transition work remains at middle management level. The Senior Leadership Team, excluding Executive Directors, has begun operating collectively as the senior team responsible for leading the Trust.

The inaugural meeting of the new Senior Leadership Team has taken place. It was pointed out that these meetings are intended to strengthen cross-system communication, support collaborative working, reduce siloed decision-making and help clarify how performance will be driven, monitored and assured as the operating model continues to develop.

It was pointed out that workforce planning focussed on preparing for the future whilst also reducing costs, while it was noted that organisational redesign has contributed to a reduction in the Trust's workforce from approximately 4,400 to 4,200 staff, representing a reduction of approximately 4.5%. It was reported that delivery of the Cost Improvement Programme (CIP) will require further workforce reductions, with the next phase.

As the programme moves into Phase 2, the focus will shift from structural redesign to developing leadership, culture, behaviours and advanced team working. It was reported that further work is required to close the gap in areas of clinical redesign, where progress has been slower and a £5m CIP gap remains.

It has been agreed to undertake a learning review of Phase 1, with support from the Transformation Unit, recognising the scale and difficulties of the transition and that the change programme is still ongoing. Discussions have also taken place regarding the support needed to deliver Phase 2. The Board was informed that progress in appointing to medical roles has been slower than expected, with interviews for the Deputy Chief Medical Officer role scheduled for the 7.7.26. Once this appointment has been made, the next layers of the structure are expected to progress.

Transformation Programme – A Transformation Director has been appointed as part of the Organisational Change Programme and has commenced in post. The responsibility of the Transformation Director is to hold the Trust to account on the wider transformation programme.

AFT Update

John Grinnell updated the Board on the Trust's AFT status, following a meeting with Sir Glen Burley, Miranda Carter, and representatives from the other five AFT organisations. The Board was advised that discussions during the meeting were positive and open, with recognition that the programme evolved as it progressed and that further detail remains to be developed.

The meeting itself focused on how the five AFT organisations could work together to raise the profile of the flagship programme and identify practical areas for collective action. The overarching message was that AFT organisations should adopt an entrepreneurial approach, actively testing and maximising the freedoms available rather than waiting for a fully prescribed national model. It was reported that this group will continue to meet in order to remain connected.

A question was raised about the financial flexibilities of AFT status. It was explained that AFT status allows an organisation to use its surplus for revenue or capital as long as that revenue relates to recurring transformational benefits.

Resolved:

The Board noted the updates.

26/27/124 Evidence of Our Performance

Flash Report

The Trust has retained its strong position within the refreshed National Oversight Framework (NOF), remaining in Segment 1 and ranked 15th nationally. Improvements have continued in waiting time performance across a number of acute and community services, whilst key areas requiring a sustained focus include sickness absence, infection prevention and control (IPC), and audiology. Tribute was paid to the IPC and domestic teams for their focused work on cleanliness in June, and it was noted that there have been no C diff cases for seven months.

It was reported that audiology has been identified as a national risk, reflecting

challenges linked to demand. Following a national review of Audiology services, which led to auditing across services, the outcome of the Trust's audit confirmed zero harm to patients, but a moderate rating has been assigned due to demand and waiting times. Discussions have taken place with the respective team regarding service modernisation and actions to reduce waiting times. This area of work will be monitored via the Finance, Transformation and Performance Committee (FTPC).

Integrated Performance Report

Outstanding Care

- Formal and informal complaints response times have improved.

Support Our People

- Sickness absence increased to 6.07% in May, driven primarily by short-term absence. Whilst more recent data indicates some improvement, attendance levels continue to require close monitoring. Dedicated resource remains in place to support managers in maintaining focus on short-term sickness absence.

It was queried as to whether a transition plan is needed to ensure the organisation continues to monitor sickness absence metrics effectively and prevent any issues from being missed as the organisation moves into its new way of working. A question was also raised about whether individual team performance should be reviewed to support timely intervention where required. It was agreed that further consideration will be given to this matter

26/27/124.1 Action: MS

Pioneering

- The Trust hosted a visit from the Chief Digital, Data and Technology Officer for the Department of Health and Social Care, Rob Thompson. Feedback was positive in respect to Alder Hey's digital innovation and transformation work, and the visit has led to discussions regarding future collaboration on large-scale transformation initiatives and opportunities for national engagement, including an invitation for the Trust's Chief Digital and Transformation Officer to join a national advisory group that is being established by Rob Thompson.
- The Trust is due to receive representatives from Toronto's SickKids Hospital as part of the developing international partnership between the two organisations. The visit will include dedicated sessions with Alder Hey colleagues, together with a wider engagement event involving external partners and representatives from the Foreign Office. The partnership is creating opportunities to replicate work developed in Canada within the UK, including wider strategic opportunities for the Paediatric Open Innovation Zone (POIZ) and the Liverpool City Region.
- *POIZ* – A formal Programme Board was being established to strengthen governance, oversight and accountability as the POIZ programme progresses.

Community and Mental Health Division

ADHD medication shortages: Medikinet, one of the most commonly prescribed ADHD medications, has recently been out of stock. This is creating operational pressures as CYP receiving this treatment are required to be reviewed and, where appropriate, transferred onto alternative medications, resulting in additional clinical assessments and follow-up activity. The Board was advised that this matter has been escalated nationally and that discussions are ongoing with the ICB about transferring prescribing responsibility for patients aged over

18 to adult services in September/October, with a view to include patients aged 17 and a half, enabling the Trust to begin seeing CYP on its waiting lists.

- *Sunflower House*: An improvement plan is in place, with continued support from NHSE. The Trust is exploring the use of an external assessor to provide an independent view of the current challenges, and a new Consultant Psychiatrist is due to start in August who will provide the leadership required.

Reference was made to Was Not Brought (WNB), and it was pointed out that the Welfare Hub has identified transport costs as a barrier preventing some families from accessing services and it was queried as to whether this applies in the community. It was confirmed that this is the case, and a discussion took place about the possible opportunity for a local Health Centre to be widely developed in partnership with other agencies which will support neighbourhood working and help reduce transport costs for families. It was also pointed out that the CYP Forum is in regular contact with the Mayor's Office about free transport for CYP and it was felt that it would be beneficial to raise this matter again.

Division of Medicine

- It was reported that the proportion of CYP treated in ED within four hours had reduced in June. Sickness absence within the service was also noted, and discussions have taken place with clinical and operational leads to identify actions to support improvement.

Division of Surgery

- *CYP Waiting over 52 Weeks*: The most significant pressures relate to dentistry, cardiology and chronic pain services, although improvements continue to be seen in dental waiting lists.
- *ERF*: It was reported that cardiac surgery activity is currently below plan by 20 cases due to non-elective pressures and reduced demand. Actions are underway to increase capacity, optimise workforce utilisation and explore mutual aid opportunities with other specialist centres to support recovery and improve performance.
- *Follow-up Care*: Long-wait challenges are concentrated within a number of specialty areas; paediatric surgery, plastic surgery and audiology. In relation to audiology, a recovery plan has been implemented and over 3,000 patients have been identified for validation through a new digital approach, including the use of an opt-in/opt-out process. Rapid screening clinics are also being introduced to increase capacity and reduce waiting times through shorter, more targeted appointments. With regard to plastic surgery, validation exercises are being prioritised to ensure waiting lists accurately reflect current patient need and to support recovery of performance.

It was pointed out that surgical income is behind plan and requires focused action to improve the position, noting that key commissioner decisions are expected in months 7 and 9 with a risk that activity could be redirected if performance does not recover. The Board was advised that that a targeted review on activity is to be undertaken on the four areas that require deeper analysis.

Following discussion, it was felt that the Board should maintain a focus on ED performance and financial performance, as these areas are important to the Trust's NOF segment position. Although action plans are in place, it was pointed out that there is a need for close oversight of emerging areas of concern before they become critical. They should be monitored via FTFC, Executive discussions and relevant Assurance Committees, with modelling to be submitted to the Executive Team to support early review and action.

Finance

- The Trust delivered a £1.5m surplus in M2, resulting in a YTD surplus of £2.4m, both of which were in line with plan.
- The Trust remains on course to achieve its planned year-end surplus of £700k, although this is dependent on the successful delivery of the Cost Improvement Programme (CIP). It was confirmed that £9.5m of savings have been transacted.
- Cash remains in line with plan, although this will need to be closely monitored.
- At M2, the divisional position was £600k behind plan following the allocation of cost funding, with the Division of Surgery below plan due to income underperformance.
- M3 position continues to be reviewed through the lens of the new systems model. The early view of M3 indicates that the Trust will close the position in month.
- CIP remains behind plan; however, progress has been made since M2, with £14.5m either in development or fully developed and 75% of the CIP now identified.

It was noted that Q2 is critical in terms of delivering the CIP programme, with recognition that decisive action is required to address the current gap. Attention was also drawn to the risk associated with the transition to new budget holders during a period of system change. It was reported that the next FTPC will be a critical meeting, with new budget holders expected to discuss performance, undertake reforecasting and identify any underlying issues. The Board was advised that the new senior leadership team has a strong sense of collective ownership, supported by close system leader oversight, to help reduce the risk of issues being missed during the transitional period.

Resolved:

The Board:

- Noted the Flash Report for M3.
- Noted the content of the IPR for Month 2.

26/27/125 Mortality Report, Q4

The Board received the Q4 Mortality Report and was advised that external benchmarking has returned to the expected position, with further improvement anticipated. It was noted that the issues identified in 2024/25 related to coding and documentation; although the national data for that year could not be refreshed, the issues identified in 2025/26 have been addressed and the data refreshed nationally. Systems are in place to sustain this position, and the increase in deaths is considered consistent for the time of year.

It was noted that learning has been identified from complex cases, and it was recognised that the Trust is reflecting on areas for improvement and acting on the learning identified through the learning from deaths process. During a recent meeting, positive feedback was received from the new Designated Doctor for Child Death in Liverpool, colleagues from Manchester and the new Child Death Overview Panel (CDOP) Manager, who had commended the openness and reflective culture demonstrated by the Trust, together with positive feedback from two families who had described the bereavement care they received as outstanding.

It was noted that learning has been identified from complex cases, with the Trust reflecting on areas for improvement and acting on the learning identified. During a recent meeting, positive feedback was received from the new Designated Doctor for Child Death in Liverpool, colleagues in Manchester and the new Child Death Overview Panel (CDOP) Manager, who commended the Trust's openness and reflective culture. The Board also noted positive feedback from two families, who described the bereavement care they received as outstanding.

Reference was made to core update 6, which highlighted the need for greater understanding of the Palliative Care Team's role, and it was queried as to how this action will be taken forward. It was explained that a review identified the need to improve understanding of the team's role and to have clearer communications for families to ensure expectations are managed appropriately. Further staff education and awareness activity will be undertaken in response to the learning identified.

Resolved:

The Board received and noted the Mortality Report for Q4.

26/27/126 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 20.5.26 were submitted to the Board for information and assurance purposes.

During June's meeting the Committee received assurance regarding the Trust's arrangements for the management of controlled drugs, including the appointment of the organisation's Chief Pharmacist as the Trust's Accountable Officer for Controlled Drugs. The Board was advised that there were no matters requiring escalation from the Committee's most recent meeting.

Resolved:

The Board noted the Chair's Highlight Report from the meeting held on the 24.6.26 and the approved minutes from the meeting held on the 20.5.26.

26/27/127 Collaborate for Children and Young People: Partnerships Update

The Board was provided with an update on key milestones and alignment in Q1. The following points were highlighted:

- *National:* Alder Hey hosted the ICB's National Neighbourhood Assessment visit, led by Dr. Claire Fuller. Positive feedback was received on the progress made in neighbourhood working across C&M, with particular strengths noted in CYP and digital data.
- *C&M:* Partnership alignment continues across C&M, supported by improved CYP governance and ongoing collaboration with the ICB, local authority partners, and the voluntary and community sector.
- *Local:* The Trust is continuing to work with Liverpool City Council (LCC) and Place partners. It was reported that the Chief Strategy and Partnerships Officer, Dani Jones has been invited to attend the Liverpool Health and Wellbeing Board.
- *North Mersey Provider Partnership:* Meetings have been held with primary care leaders across Liverpool, Sefton and Knowsley. Discussions have indicated support for working collaboratively on behalf of the population, with commitment emerging around neighbourhood working. It was reported that the new Interim Chief Executive of the University Hospitals of Liverpool

Group, David Loughton, commenced in post on the 1.7.26, and a meeting has been scheduled w/c 6.7.26 as part of the Tripartite arrangements.

- *Global:* Alder Hey has been invited to join the Liverpool Global Partnership, which aims to align the City's brand and assets into a cohesive proposition for international collaboration and investment. This presents a significant opportunity for Alder Hey, with new areas for follow-up. The Trust has also been invited to participate in the 'Liverpool Welcomes Europe' programme.

Resolved:

The Board noted the collaborate for CYP Partnerships update.

26/27/128 Growth and Opportunities Committee

The approved minutes from the meeting held on the 30.4.26 were submitted to the Board for information and assurance purposes.

During June's meeting the Committee received updates on the Trust's global partnerships, digital innovation and artificial intelligence (AI) agenda. It was reported that significant progress is being made in relation to international collaborations and opportunities, including the developing partnership with Toronto's SickKids Hospital. Attention was also drawn to the newly developed AI Policy which provides an Alder Hey specific framework and robust governance for the safe and responsible use of AI which it was felt might be of interest to other trusts.

Resolved:

The Board noted the Chair's verbal update from the meeting held on the 25.6.26 and the approved minutes from the meeting held on the 30.4.26.

26/27/129 Annual Submission to NHSE NW: Framework for Quality Assurance and Improvement, 2025/26

The Board was provided with assurance that appropriate processes and systems are in place to enable all medical practitioners holding a GMC licence to practice to undertake an annual appraisal. Where an appraisal is not undertaken, or cannot be completed, this is formally documented with a clear reason and requires approval by the Responsible Officer. For the reporting year 2025–2026, the Trust achieved an appraisal compliance rate of 97.3%. This compliance is slightly lower than the previous year, reflecting the impact of organisational change and staff sickness during the reporting period. It was confirmed that work will continue to improve compliance rates.

It was reported that a risk has been added to the risk register because of the challenges being experienced in securing and retaining medical appraisers. This is due to a small number of appraisers stepping down from their roles as they are unable to include the responsibilities within their job plans and a lack of funding for these roles. Attention was drawn to the importance of establishing a suitable funding solution to support appraisal capacity, noting that reliance on external appraisers would incur significantly greater costs to the Trust. It was confirmed that this issue is being addressed via an ongoing piece of work.

Resolved:

The Board received and noted the annual submission to NHSE NW: Framework for Quality Assurance and Improvement for 2025/26

26/27/130 Strategic People Update

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

- There is a sustained demand for the Trust's Staff Advice Liaison Service (SALS) service, with more than 900 contacts and 180 new referrals received over the previous ten weeks, demonstrating the ongoing value of the support available to staff.
- The Voluntary Redundancy (VR) Programme is nearing completion with work taking place to address a small number of outstanding appeals. It was reported that 62 VR applications have been approved to date,

Lord Mann Review

The Board received the Lord Mann Review, noting the findings in relation to antisemitism, racism and wider discrimination across the NHS. The review identified 36 recommendations with five key themes, which NHS England has accepted, relating to leadership, reporting and investigation, staff support, education and training, and the use of data. The Board noted that the Trust has already undertaken significant work in this area, including the delivery of its Anti-Racism Strategy and achievement of Bronze Anti-Racism accreditation. Following consideration of the report and supporting recommendations, the Board agreed to formally support and adopt the recommendations of the Lord Mann Review, with implementation and ongoing oversight to be undertaken via the Trust's Equality, Diversity and Inclusion (EDI) Steering Group.

Non-Executive Director Garth Dallas (GD) emphasised the importance of moving beyond compliance and ensuring that progress can be measured and evidenced. GD highlighted the need for the Trust to continue showing visible leadership in challenging racism and discrimination, including anti-Muslim hostility, and to maintain strong oversight through existing EDI governance arrangements.

The Chair advised the Board that, following her recent attendance at a REACH Staff Network meeting, she has invited the network to attend a Board meeting in the autumn to share their ideas. The Chair noted that, although progress is being made, further work is required to support staff experiencing discrimination and to ensure racist behaviour is actively challenged.

Resolved:

The Board:

- Received and noted the content of the Strategic People update.
- Agreed to formally support and adopt the recommendations of the Lord Mann Review

26/27/131 People Committee

The approved minutes from the meeting held on the 13.5.26 were submitted to the Board for information and assurance purposes.

During June's meeting, the Committee received the Health and Safety Annual Report, the Lord Mann Report and an update from the Freedom to Speak Up Guardian (FTSUG). Particular focus was given to sickness absence levels and the actions being implemented to improve attendance, alongside continued monitoring

of workforce numbers and transition arrangements following the move to the new organisational structure. It was confirmed that progress remains on track across people-related areas. The Committee now meets on a monthly basis and has been renamed the People and Culture Committee.

Resolved:

The Board noted the Chair's verbal update from the meeting held on the 29.6.26 and the approved minutes from the meeting held on the 13.5.26 .

26/27/132 Audit and Risk Committee

The approved minutes from the meeting held on the 16.4.26 were submitted to the Board for information and assurance purposes.

During June's meeting the Committee focused primarily on the Trust's Annual Report and Accounts and related year-end governance matters.

Resolved:

The Board noted the Chair's Highlight Report from the meeting held on the 18.6.26 and the approved minutes from the meeting held on the 16.4.26.

26/27/133 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 3.6.26 were submitted to the Board for information and assurance purposes.

During June's meeting the Committee reviewed its five key priority areas: finance, operational performance, cost improvement and transformation, capital, and growth and investment. It was noted that growth and investment is the only area rated as green/on track. Attention was also given to the Trust's position against the National Oversight Framework (NOF). It was reported that some of the current ratings may change due to the complexity of the Trust's strategic priorities.

Resolved:

The Board noted the Chair's verbal update from the meeting held on the 30.6.26, the approved minutes from the meeting held on the 3.6.26 and the FTPC priority areas update for month 2, 2026/27.

26/27/134 Board of Directors – Annual Fit and Proper Persons Check

The Board received the annual Fit and Proper Persons Test assurance report for assurance purposes. It was confirmed that all required checks had been completed in line with national requirements via the Trust's established process and that submissions have been made within the required timescales. The Board was advised that all Directors continue to meet the Fit and Proper Persons requirements and that no issues have been identified through the annual review process.

Resolved:

The Board noted that the Fit and Proper Persons Test has been conducted for 2026, and all Board members satisfy the requirements.

26/27/135 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:

- A small number of areas are to be reviewed to ensure the risk score remains appropriate.
- Assurance Committee discussions have highlighted transport related issues affecting the Neonatal Development Programme, which will continue to feature in future reporting.
- FTPC risks have been reviewed in detail and further consideration is being given as to whether the infrastructure risk can be reduced.
- Deep dives into people risks will be undertaken during the next cycle.
- The implementation of the Trust's new systems-based organisational structure, together with the achievement of AFT status represents a significant change to the Trust's operating environment and will require ongoing review of the Trust's existing risk profile to ensure that risks, controls and assurances remain appropriate. It was pointed out that strategic and operational risks may need to be reassessed in light of the new leadership arrangements, governance structures and ways of working now being established across the organisation. Further assurance work is to be undertaken, and senior leadership input will help determine whether the current risk profile remains aligned to the Trust's evolving organisational structure and strategic priorities.

Resolved:

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

26/27/136 Any Other Business

Nottingham maternity review findings on post death care and key actions required following the Fuller Inquiry.

The Board was informed of the letter that the Trust received from NHS England (NHSE) following publication of the Nottingham Maternity Review. The letter seeks to address one of the main concerns of the review which relates to the post death care of women and babies, particularly post-mortem procedures for babies.

It was reported that the Trust has been asked to complete a self-assurance table comprising of five statements that needs to be submitted to NHSE by the 31.7.26. It was clarified that the assurance statements do not require confirmation that all arrangements are fully in place, but it does ask for assurance that the topics are considered and that there is a plan in place that directs the organisation to comply with certain national timeframes. The Board was asked to review the statements and confirm its approval to submit with an answer of yes for all five statements.

The Chair of SQAC, Fiona Beveridge, advised that the Committee has seen the update on the report and is assured that an action plan has been developed. The Fuller action plan will be reviewed by SQAC during its normal meeting cycle in

September and then it will be submitted to Board along with two other pieces of work.

A discussion took place regarding the five assurance statements, and the following actions were agreed:

- Regular review of the Trust's mortuary services to be included on the Clinical Audit Plan.
- 26/27/136.1 Action: NA**
- Arrange for the Freedom To Speak Up Guardian to visit the Mortuary team.
- 26/27/136.2 Action: NA**
- Cross reference Annexe 1 (*summary of national updates made or planned in response to the Fuller Inquiry*) to make sure that all national updates have been included in the action plan.
- 26/27/136.3 Action: NA**
- Discussion to take place regarding the NHS' Premises Assurance Model (PAM) - Refer to assurance statement 5.
- 26/27/136.4 Action: MS/RL**

Resolved:

The Board confirmed its approval of the five assurance statements in the self-assurance table.

26/27/137 Review of the Meeting

The Chair thanked Board members for their contributions and acknowledged the significant progress made by the Trust in recent months, particularly its strong position at the end of the 2025/26 financial year.

The Chair highlighted the positive recognition associated with the Trust's AFT status and the opportunities this presented to further improve outcomes for CYP. The successful implementation of the new organisational structure and continued progress in advancing the Trust's transformation agenda was also noted. Looking ahead to September, the Chair acknowledged that the Board will have greater clarity on the remaining challenges, while emphasising that progress is being made.

Date and Time of Next Meeting: Thursday 3.9.26, LT1, Institute in the Park.

Trust Board (Public)
Action Log
(April 2026 – March 2027)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
ACTIONS FOR SEPTEMBER 2026							
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	Sep-26	
2.7.26	26/27/124.1	IPR (Supporting Our People)	Consider whether a transition plan is required to ensure sickness absence metrics continue to be monitored effectively to prevent any issues from being missed as the organisation moves to its new way of working. Consideration should also be given to reviewing individual team performance to support timely intervention where required.	M. Swindell	Sep-26	On track Sep-26	
2.7.26	26/27/136.4	Any Other Business (<i>Nottingham maternity review findings on post death care and key actions required following the Fuller Inquiry</i>)	Discussion to take place regarding the NHS' Premises Assurance Model (PAM) - Refer to assurance statement 5.	M. Swindell/ R. Lea	Sep-26	On track Sep-26	
Actions for December 2026							
4.6.26	26/27/89.1	Infection, Prevention and Control Report, Q4	Invite a member of the Trust's cleaning team to share their experiences of the actions taken to reduce C. diff infection rates.	K. McKeown	Dec-26	On track Dec-26	

Trust Board (Public)
Action Log
(April 2026 – March 2027)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for April 2027							
4.6.26	26/27/81.1	Chair's and CEO's Update	Invite representatives of the CYP Forum to attend Board on an annual basis to provide an update on their activities.	K. McKeown	Mar-27	On track Apr-27	4.6.26
Status							
Overdue							
On Track							
Closed							

Trust Board (Public)
Closed Actions
(April 2026 – March 2027)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
7.5.26	26/27/64.1	Audit and Risk Committee	<i>Risks</i> - Ensure all significant risks are captured, including commercial matters linked to system risks discussed in the private Board session. Undertake further work to ensure that such risks are consistently reflected within the risk register for completeness and alignment of risk reporting to the Board.	E. Saunders	Jul-26	Closed	18.8.26 – Work is on-going to address this action. ACTION CLOSED
4.6.26	26/27/81.2	Application for AFT Status	Set time aside to define what AFT status should mean for Alder Hey, with initial reflections to be discussed during July's Trust Board.	J. Grinnell	Jul-26	Closed	2.7.26 – An update will be provided during July's meeting. ACTION CLOSED
4.6.26	26/27/86.1	Evidence of our Performance - Flash Report	Provide assurance that mitigations are in place to address the cohort of patients waiting more than two years for a follow-up appointment.	S. Almond	Jul-26	Closed	2.7.26 – This action was addressed as part of the IPR update. ACTION CLOSED
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	Closed	18.8.26 – An update on the landmark Supreme Court judgement will be included in the Strategic People Update Report. ACTION CLOSED

Trust Board (Public)
Closed Actions
(April 2026 – March 2027)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
4.6.26	26/27/84.1	Clinical Strategy 2026-2030	Update the Clinical Strategy with the actions identified through discussion during June's Board and submit the final version to the Board for approval.	M. Ashe	Sep-26	Closed	18.8.26 – The Clinical Strategy is to be submitted to the Board during September's meeting for approval. ACTION CLOSED
4.6.26	26/27/85.1	Digital, Data and Technology Update	Review CQC's recommendations on the use of AI in healthcare.	K. Warriner	Sep-26	Closed	18.8.26 - this has been completed and key items included in the AI strategy. ACTION CLOSED
2.7.26	26/27/136.1	Any Other Business (Nottingham maternity review findings on post death care and key actions required following the Fuller Inquiry)	Regular review of the Trust's mortuary services to be included on the Clinical Audit Plan.	N. Askew	Sep-26	Closed	25.8.26 – This action has been addressed. ACTION CLOSED
2.7.26	26/27/136.2	Any Other Business (Nottingham maternity review findings on post death care and key actions required following the Fuller Inquiry)	Arrange for the Freedom To Speak Up Guardian to visit the Mortuary team.	N. Askew	Sep-26	Closed	25.8.26 – The FTSU Guardian is in the process of arranging to visit the Mortuary Team. ACTION CLOSED
2.7.26	26/27/136.3	Any Other Business (Nottingham maternity review findings on post death care and key actions required following the Fuller Inquiry)	Cross reference Annexe 1 (summary of national updates made or planned in response to the Fuller Inquiry) to make sure that all national updates	N. Askew	Sep-26	Closed	25.8.26 - This will be included in the next update to SQAC. ACTION CLOSED

Trust Board (Public)
Closed Actions
(April 2026 – March 2027)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
		<i>actions required following the Fuller Inquiry)</i>	have been included in the action plan.				
Status							
Overdue							
On Track							
Closed							

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Digital, Data and Artificial Intelligence Update
Report of:	Kate Warriner – Chief Digital and Transformation Officer
Paper Prepared by:	Kate Warriner – Chief Digital and Transformation Officer; Ian Gilbertson – Deputy Chief Digital and Information Officer

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

Does this relate to a risk? Yes ☐ No R						
If “No”, is a new risk required? Yes ☐ No R						
Risk Number	Risk Description					Score
4.2	Digital and Data Strategic Development & Delivery					16
Level of assurance (as defined against the risk in InPhase)	R	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 the Board of Directors with an update on progress on Digital, Data and Artificial Intelligence (AI). It reports on the overall service, key areas of transformation and operational performance.

Key headlines include:

- Strong outcomes from the SickKids partnership and return visit
- Good progress with digital, data and AI transformation programme
- Steady operational performance

The Board of Directors is asked to note progress to date.

2. National and Regional Updates

2.1 Sick Kids Partnership

Alder Hey hosted a return visit in the Innovation Hub for colleagues from SickKids Toronto, the Children's Health Alliance (CHA), the Foreign, Commonwealth & Development Office (FCDO) and partner NHS organisations. The visit demonstrated a new approach to innovation and transformation, bringing together clinical, operational, digital, innovation and transformation teams to jointly assess challenges, explore emerging solutions and identify opportunities for collaboration. This multidisciplinary model was particularly well received, with partners recognising the strength of aligning innovation activity closely to frontline clinical and operational priorities to deliver measurable benefits.

2.2 Neighbourhoods Progress

Neighbourhood Health digital proof of concept is now focused on delivery planning, with Alder Hey supporting regional work to define requirements for a shared digital platform to underpin neighbourhood models of care across Cheshire and Merseyside. Alongside this, a business case is being developed to establish investment requirements and identify funding opportunities. Over the coming months, the programme will move towards agreeing technology options, securing funding and developing an implementation roadmap for deployment.

3. Vision 2030 – Digital, Data and AI

3.1 Optimising Digital Systems

The transition of Physiotherapy and Occupational Therapy services onto Meditech has continued to progress, with sustained digital support provided to help teams embed new workflows and optimise use of the system. This has supported greater standardisation, improved visibility of patient information, and reduced reliance on manual processes, while also supporting the Trust's wider move towards bringing all services onto a single EPR.



GP pathology requesting is now live across all GP practices in Cheshire and Merseyside, strengthening connectivity between primary and secondary care and supporting more streamlined requesting pathways. The focus is now moving to Radiology GP requesting, with the aim of providing the same level of digital

connectivity and streamlined access for primary care referrers.

The Meditech Expanse 2.2 Programme Board has now met twice, establishing governance and oversight for the upgrade from version 2.1 to 2.2. Planning is progressing well, with focus on delivery plans, workstream priorities and programme assurance. The next Programme Board will concentrate on testing and clinical safety to ensure robust governance, clear ownership and readiness for a planned spring go-live.

3.2 Enhancing Safety Through Digital.

The Digital Clinical Nursing Team has worked with the Community Children's Nursing Team (CCNT) to review and improve the current CCNT order form. The revised form has been developed around an SBAR approach, supporting clearer and more structured communication of clinical requests. Once completed, the order will be sent directly to the CCNT email address, enabling the team to use the information to contact extended agencies and coordinate follow up more effectively.

3.3 Virtual Care

Alder Connect, Alder Hey's Patient Portal, went live in April 2026 and continues to show strong adoption across patients, families and carers. Registrations have increased from 51,362 at the last Board to 53,646 currently, an increase of 2,284 in July. Digital appointment letters have increased from 54,106 to 74,417, an increase of 20,311, reducing reliance on paper correspondence and supporting more timely communication.

Since go live, 164,793 SMS reminders have been issued, alongside 36,921 digital clinic letters. Appointment letters posted have reduced from 7,369 at the last Board to 6,235 currently, a reduction of 1,134. This demonstrates continued progress in shifting communication activity to digital channels while maintaining access for families who require postal correspondence.

The programme is now closing Phase 1 and moving towards the next phase of delivery, with work under way to define and evidence the benefits realised to date. This includes reviewing adoption, communication volumes, reduced paper flow, operational impact and the future benefits associated with further portal functionality. Phase 2 is expected to commence in October.

3.4 Advancing AI

Adoption of Lyrebird Ambient Voice Technology continues to grow across medicine, surgery, community and mental health, with c.1500 clinicians now using the system and adoption for outpatient communications at 97%. The programme has now moved into Phase 2, with a focus on optimisation, productivity, benefits realisation and exploring further opportunities for clinical use. This includes assessing how Lyrebird could support Emergency Department (ED) triage, helping clinicians capture high quality documentation in real time while reducing administrative burden.



Alder Hey hosted a workshop with Hero AI, an AI-powered clinical decision support platform, to explore opportunities to improve clinical and operational workflows. Initial focus has been on the Emergency Department, with consideration being given to how the technology could support patient flow, triage and decision making alongside

existing digital pathways. Funding options are being explored, and a draft business case is expected to be finalised in August.

AI Clinical Coding is progressing as a solution to support coders by reviewing documentation, identifying potential ICD and OPCS codes, and surfacing supporting evidence. The ambition is to automate appropriate lower complexity areas, such as day case spells. External auditor testing of the solution is underway.

A Microsoft 365 Copilot+ evaluation programme is being established, providing access to up to 1,000 licences on a 90 day trial basis from September 2026. The programme will support the identification, testing and evaluation of high-value use cases across the organisation, building on those already identified.

3.5 Data Driven Care

The Data Platform work continues to progress, with the portal currently being demonstrated to the leadership team to gather input and shape the next stage of development. Dashboard rationalisation is now complete, ensuring that only actively used, decision-critical reporting is migrated to the new platform. The wider platform is scheduled to complete before the end of 2026.

The Secure Data Environment programme has also progressed, with the first Board now having met to support governance and direction. Work is underway to explore resourcing options, alongside engagement with other Trusts that have established or are developing SDE capability, to inform Alder Hey's approach and ensure alignment with appropriate governance, controls and assurance.

4. Digital Centre of Excellence and Performance

4.1 Digital Technology

The Regional Private Cloud Datacentre Refresh programme remains on track, with the majority of servers now migrated to the new resilient platform. Final server migrations are due to complete by the end of August, after which focus will shift to the migration of SQL databases and decommissioning of legacy infrastructure, reducing operational risk and improving resilience.

The bleep upgrade project has completed build, testing and readiness activities. Key blockers have been resolved and preparations for deployment are underway, with go live currently planned for October 2026.

4.2 Operational Performance

The tables below provide an oversight of the performance between February & July 2026. Performance has been generally steady with a good correlation between incidents logged and resolved.



The SLA stabilisation work has continued to improve the SLA level – with July’s SLA breach level being just 0.8% below our 95% target. The aim is to improve this further for August and achieve our SLA target, and sustain this into the future.

Incidents Logged

Feb	Mar	Apr	May	June	July
2,678	3,042	2,917	2,662	2,737	2,441

Incidents Resolved

Feb	Mar	Apr	May	June	July
2,601	2,876	2,967	2,950	2,883	2,420

Incidents Resolved Within SLA (%)

Feb	Mar	Apr	May	June	July
92	93	86	88	91	94

Target 95%

First PoC Resolved in Tech Bar

Feb	Mar	Apr	May	June	July
63	86	75	89	82	81

Target 70%

4.3 Cyber Security

Alerts and investigations from trust intelligence tools continue to show a good level of security across systems and any high-priority alerts/alarms are investigated and resolved within 48-72 hours. Focussed work has progressed with closing out audit actions, monitored and reported through the NED cyber assurance group.

Broader trust engagement and support for mandatory Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT), and wider NHS England requirements continued to be progressed.

4.4 Coding

The uncoded backlog has reduced from around 4.6k in February 2026 to 1.9k in August 2026, driven by sustained recovery actions and temporary support to mitigate vacancies and long-term sickness. While recruitment is progressing and the backlog remains on track to stay below the current 10% flex reporting threshold, a further reduction of 1k-1.2k cases is required to achieve optimal in-month performance.

Coding quality continues to improve, with elective coding depth increasing year-on-year and strong performance maintained across day case activity. Regular day cases have shown the most significant improvement, while non-elective coding remains stable.

4.5 Information Governance

Since the previous report, the following key updates are provided:

- The Trust submitted a ‘Standards Met’ DSPT return on 30 June 2026
- A final audit meeting was held with the Information Commissioners Office (ICO) in relation to the children’s data governance & cyber audit completed in November 2025. The ICO agreed all elements of the action plan, supplementary evidence and provided positive feedback. A final closure report will now be issued.
- FOIA compliance during Q1 achieved 87.37% with highest compliance observed at 92% during the quarter.

4.6 Access to Health, Health Records and Transcription

Information Governance compliance improved throughout Q1, with further technical, process and resourcing changes implemented to strengthen Access to Health performance.



Responsibility for Access to Health now sits within the Information Governance Team, providing greater oversight and focus on compliance improvement.

Health Records services continue to maintain timely scanning, while the paper-light programme progresses with the planned removal of paper ED CAS cards. In line with national requirements, routine records destruction remains suspended to support the preservation of documents linked to the independent inquiry into grooming gangs.

Transcription performance remains strong, with clinical correspondence completed within an average of two days. Following organisational change, the service has successfully transitioned to a predominantly outsourced model while reducing internal staffing through natural turnover and redeployment. Work is now underway to implement automation and AI-enabled processes aligned to the Lyrebird AI strategy, with the aim of significantly reducing outsourcing requirements from October 2026 onwards.

5. Summary and Recommendation

In summary, progress with digital, data and AI developments and delivery at Alder Hey remain good and on track against plans. There are several challenges however all have mitigation plans in place. Performance of operational key performance indicators have dropped slightly below targets and will be reviewed to understand root cause. This will then inform a recovery plan.

The Board of Directors is asked to note progress to date.

BOARD OF DIRECTORS
Thursday, 3rd September 2026

Paper Title:	Winter Plan 2026/27
Report of:	Adam Bateman, Chief Operating Officer
Paper Prepared by:	Sian Calderwood-Jones, Director of Operations and Performance

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☒ Regulation ☐		
Action/Decision Required:	To note ☒ To approve ☒		
Summary / supporting information	This is the plan for managing in Winter 2026-2027. This has been created in collaboration with key stakeholders across the organisation and with clinical oversight. This plan will be implemented through a dedicated working groups including cross system and cross discipline representation and weekly monitoring.		
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:	Any additional resource requirements are currently subject to separate business case proposals.		
Does this relate to a risk? Yes ☐ No ☒ If "No", is a new risk required? Yes ☐ No ☐			
Risk Number	Risk Description	Score	
Level of assurance (as defined against the risk in InPhase)	☐ Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ Not Assured Evidence indicates poor effectiveness of controls

Alder Hey

Autumn & Winter

Emergency Response

Plan

August 2026

Version 1

[Contents](#)

1. Introduction	5
1.1 Purpose of the Plan	5
1.2 Scope	5
2. Approach to Alder Hey's Winter Plan 2026-27	5
2.1 Overarching Aim	5
2.2 Key Principles	5
2.3 Reflections on 2025-26's Winter Plan	6
3. Demand Modelling.....	7
3.1 Emergency Attendances	7
3.2 Emergency Admissions	7
3.3 Australian Influenza 2025	8
4. National Guidance.....	9
5. Alder Hey's Winter Initiatives for 2025-26	10
5.1 Assessment Capacity	11
5.2 Capacity & Flow	12
5.2 Alternative Services	13
5.3 Staff Health and Wellbeing	13
6. Capacity and Escalation Plan.....	14
6.1 General & Acute Capacity	14
6.2 Critical Care	15
6.3 ED Capacity	16
6.4 Staffing Capacity	17
6.5 Staffing Escalation	17
7. Enabling Factors	18
7.1 Patient Flow	18
7.2 Escalation Plans	19
7.3 Finance	19
8. Monitoring	20
8.1 Performance Metrics and Key Indicators	20
8.2 Data Collection and Reporting	20
8.3 Escalation Protocols	20
8.4 Workforce Monitoring	21
8.5 Patient Safety Monitoring	21
8.6 Collaboration with Other Stakeholders	21

9. Conclusion..... 24

Appendix 1: Escalation Areas..... 25

Appendix 2: ED Escalation Levels..... 28

1. Introduction

1.1 Purpose of the Plan

The primary objective of this Winter Planning Document is to provide a clear framework for preparedness, response, and resilience, ensuring that the Trust can effectively navigate the increased demand and maintain the delivery of high-quality care throughout the winter period.

1.2 Scope

This document encompasses all critical aspects of service delivery at Alder Hey which would be impacted by seasonal winter pressures including, urgent and emergency care, critical care and elective care. It outlines the coordination of resources, staffing requirements, patient flow management, and infrastructure considerations. The scope extends to both immediate response mechanisms and longer-term strategic initiatives designed to enhance overall operational resilience.

This plan therefore sets out the modelling, escalation framework and capacity interventions that underpin this year's winter plan. This plan is focused on delivering outstanding safe care for Children and Young People (CYP) through, and keeping our staff safe, through this period of higher demand.

2. Approach to Alder Hey's Winter Plan 2026-27

2.1 Overarching Aim

To ensure the Trust is prepared to manage anticipated seasonal pressures, maintaining a focus on providing safe, effective and efficient care for children and young people, while also supporting our staff to remain safe and well at work.

2.2 Key Principles

The overarching aim of the Winter Plan will be delivered through three key areas:

1. Optimising Assessment Capacity
2. Capacity and Flow
3. Staff Health and Wellbeing

These will all be underpinned by robust datasets and accountability frameworks.

2.3 Reflections on 2025-26's Winter Plan

Before developing the Winter Plan for 2026/27 colleagues across the Trust considered key reflections on last year's winter plan identifying areas which worked well and areas which may require further focus and prioritisation this year.

The table below shows a summary of key performance measures from 2024/25 and 2025/26 noting key performance improvements.

Measure	2024/25	2025/26	Change
ED attendances	36,858	38,213	+1,355
4-hour performance	79.0%	84.1%	+5.1 pts
Bed occupancy	86.9%	78.7%	-8.2 pts
4-hour breaches	7,770	6,035	-1,735

3. Demand Modelling

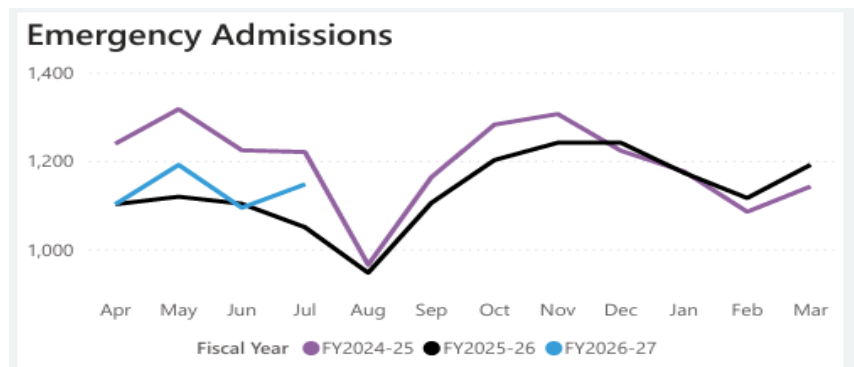
3.1 Emergency Attendances

	2024_25			2025_26			2026_27		
	Breaches	Attends	%	Breaches	Attends	%	Breaches	Attends	%
April	705	5627	87.5%	794	5665	86.0%	772	6058	87.3%
May	818	6132	86.7%	904	5927	84.7%	1032	6431	84.0%
June	932	5733	83.7%	888	5799	84.7%	1086	6125	82.3%
July	668	5493	87.8%	806	5390	85.0%			
August	302	4093	92.6%	432	4312	90.0%			
September	825	5337	84.5%	660	5268	87.5%			
October	1145	6255	81.7%	838	6432	87.0%			
November	1756	6641	73.6%	1087	6739	83.9%			
December	1164	6151	81.1%	1085	6798	84.0%			
January	1247	5804	78.5%	835	6021	86.1%			
February	1153	5547	79.2%	1098	5576	80.3%			
March	1305	6460	79.8%	1092	6647	83.6%			

Average monthly attendances in 2025/26 were 100 higher than the previous year; however, more children were seen within 4hours. So far 2026/27 has seen an increase in average attendances for the first quarter of the year.

3.2 Emergency Admissions

The below chart shows the emergency admissions since 1st April 2024 up to 30th July 2026 including Emergency Decisions Unit and Paediatric Assessment Unit admissions. For the first quarter for the year, we have experienced a decrease in admissions compared for 2024/25 for two consecutive years. This demonstrates a real change in acute admission pathways despite the increasing attendances in the ED.

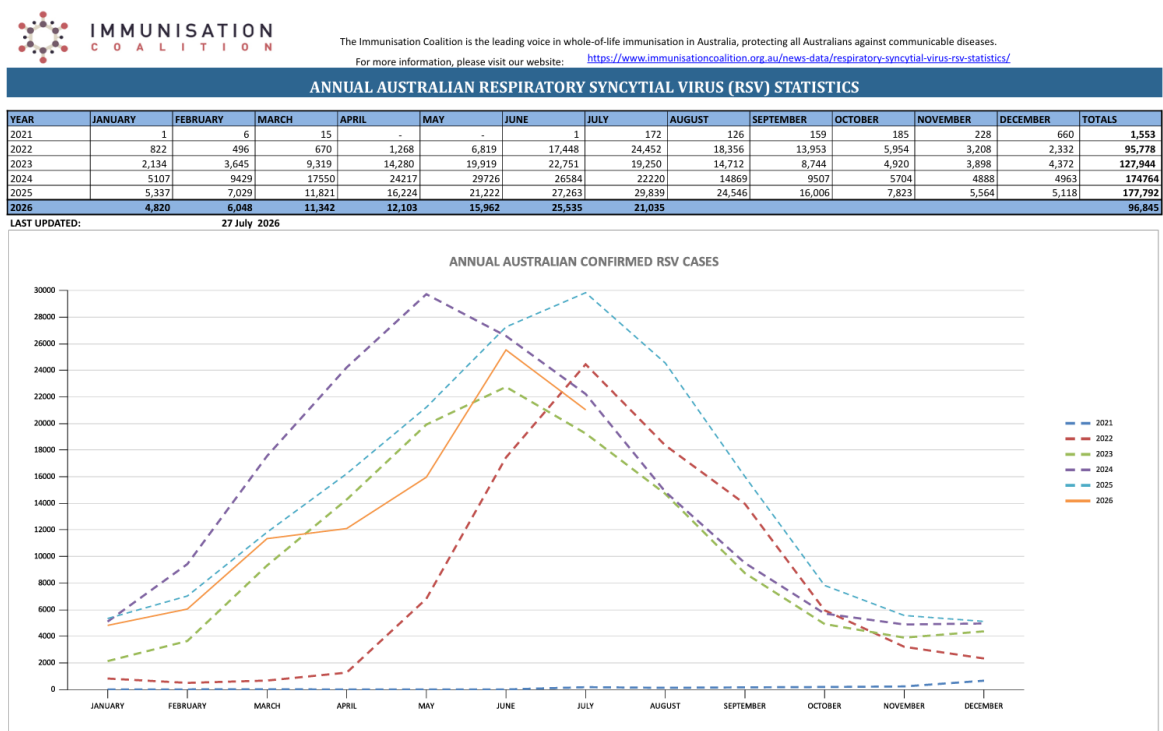


3.3 Elective Demand

The elective schedule will run as per the same schedule a last winter. There has been a slight change to speciality allocation in theatres based on ERF recovery plans; however, these changes are being monitored on a weekly basis via the theatre scheduling group. Additional, expansion of day case procedures will be prioritised during winter months with the 3A day case pilot under review.

Assumptions have been made surrounding the data modelling for elective demand and the impact on bed occupancy. Once TCI's have been scheduled the review against the bed model and occupancy predictions will be considered in the weekly forward look meetings established for this winter.

3.3 Australian Influenza 2025



As pre previous years we have reviewed the impact of Flu and RSV in the southern hemisphere during their winter months. From initial review no significant change in trends from previous years. Flu has a greater impact compared to RVS. Australia had unusually high flu activity going into winter, and the Australian CDC specifically warned in April that late 2025 flu levels had been unusually high. Despite the early presentations and pending final data release; it is expected that overall total numbers will

not be too different to previous years. RSV is behaving seasonally rather than showing an obvious alarming new pattern from the information currently available.

3.5 Hospital Occupancy 2024-2025

The below shows the overall hospital midnight occupancy for winter 2024/25 and 2025/26 including high care beds and excluding assessment beds.

Hospital Bed Occupancy

Year	Beds Occupied	Available Beds	Occupancy %
2024	7140	8768	81.4%
2025	9501	11392	83.4%
2026	5633	6784	83.0%

Despite experiencing peaks of occupancy above 90% over all the Trust remained at an average within the 80s. The deep dive into this data in particular has supported the decisions regarding changing acute admission beds into assessment beds.

4. National Guidance

The National Planning Guidance for Acute Trusts this year emphasis the requirement to complete the following:

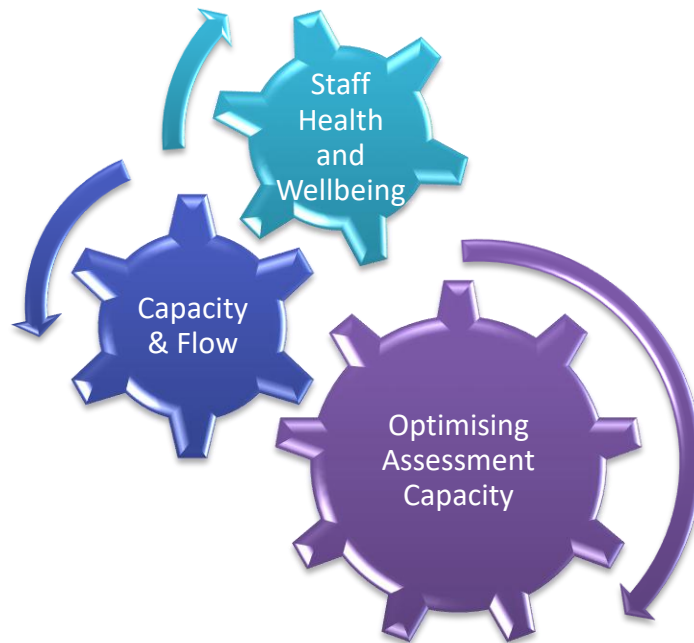
- complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- implement the Model emergency department (ED), Model acute pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care treated as a patient safety priority, while maintaining elective capacity throughout the winter period
- assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

A gap analysis for the Model Emergency Department and Model Acute Pathway has been considered by the Trust. The key winter plan prioritise in addition to the plans for the ED to achieve 95% have been established to achieve these objectives.

Central themes underpinning the delivery of these priorities are leadership accountability, integrated winter planning, and performance transparency, with clear roles and responsibilities assigned to NHS England, trusts, integrated care boards, and local authorities to ensure timely, safe, and effective care delivery. These have been considered in the context for Children and Young People when designing the initiatives for this year for Alder Hey.

5. Alder Hey's Winter Initiatives for 2025-26

For this winter The Trust's three priorities are:



The table below provides an overview of the high impact initiatives in place and under development to ensure the delivery of the Winter Plan.

	Description	Initiatives	Goals
Optimising Assessment Capacity	Increased capacity to assess patients and treat promptly to avoid acute admission.	• Expansion of Assessment capacity increasing by 6 beds within the Trust • Increasing PAU by 2 beds • Opening new Speciality Assessment capacity, 2 beds • Opening new SDEC / EEMAC pathways supported by 2 bed spaces • Expansion of the C&M Paediatric CAS • Improving WICs access to ED support and input to improve assessment in Walk in Centres	• To avoid unnecessary admissions by increasing assessment pathways for CYP
Capacity & Flow	Manage resources and patient flow efficiently, with clear escalation	• Daily Sit Rep for Front Facing Teams	• Clear decision-making framework • Visible leadership

	roles and responsibilities.	• New ED Escalation plan aligned with SHREWD • Hierarchy of escalation spaces and defined criteria • Elective forward look dashboards • Review of key roles within hospital flow • Clinically Ready to Proceed¹ • Reduce admissions through increase in RSV uptake	• Ability to de-escalate in a timely manner • Collective ownership of the challenge • Consistent message • Proactive management
Staff Health & Wellbeing	Support staff to remain healthy, protected and able to work through winter pressure.	• Staff vaccination programme • Expansion of fit testing programme • Improvement in recording of interventions through ESR	• Minimum 50% staff vaccination rate • Minimum 80% fit testing compliance across high-risk groups

5.1 Assessment Capacity

PAU –Following the successful development of the Paediatric Assessment Unit expanding capacity for the paediatric team to see more CYP in this manner aims to reduce acute admissions further and ensure CYP are seen and treatment more promptly.

SAU – recognising the impact of PAU for CYP requirement medical input we recognise the need to expand further for CYP under speciality care requiring acute assessment. Expanding pathways will provide a formal route for CYP to receive the treatment needed by their specialist team as required. Noting the specialities under initial development will be Paediatric Surgery.

SDEC – with the new acute ground floor opening in 2027 expanding SDEC capacity over winter provide clinical teams with an opportunity to develop pathways prior to the build opening. Equally supporting the optimisation of same day emergency care for CYP during peak winter demand.

¹ Clinically Ready to Proceed refers to the point at which a healthcare professional determines that a patient no longer requires active treatment or monitoring in ED and is ready to move on to the next stage of care

EEMAC – is a newly developed function to support with the achievement of 95% of CYP being seen within 4 hours. Increasing medical assessment space under ED will allow the team to provide the care required in prepared manner.

5.2 Capacity & Flow

Escalation Plans – The ratification of a new ED escalation plan aligned with SHREWD metrics with clear actions to address. This will be established alongside a hierarchy of clinical escalation spaces in extremis (Appendix 1).

Medical Model – The medical model of care within escalation from both a clinical and leadership perspective is under review to ensure we are maximising the opportunity to manage capacity challenges utilising this workforce.

Clinically Ready to Proceed – The roll out and publication of Clinically Ready to Proceed (CRtP) within ED and owned at speciality level across the organisation with actions to address non-timely responses. This will support management of the four-hour target and improvements that we are looking to make.

Elective Management – Proactive data driven elective management and escalation at ward and speciality to maximise delivery of the elective programme.

Leadership – Clear expectations of key roles across the organisation including Nursing Leads, Hospital Manager of the Week, Senior Manager On Call and Executive On Call include visibility throughout the week.

Weekly LOS Meetings – The Medical Division has a well-established weekly LOS meeting chaired by Head of Nursing and attended by ward leads and the Complex Discharge teams. The Paediatrics Matron/Ward manager undertake daily huddles on 4C to review inpatients with an out of area (OoA) post code with a view to repatriation; bed managers actively manage repatriations to local DGHs once identified.

PAU Model – An enhanced model of PAU cover is in the process of being recruited to following successful approval of a business case. This will support senior decision making at the front door 7 days per week.

Weekly Performance Reports – Weekly performance reports will be issued to clinical teams demonstrating overall performance against length of stay and discharge metrics to support clinical ownership. Close monitoring of the ED target will also occur utilising this information with Trust wide ownership as we strive towards achieving 95% seen and discharged or transferred within 4 hours.

5.2 Alternative Services

ED Streaming – Maximising streaming from the front door to the onsite UTC with double capacity in the primary care stream from October-March.

Paediatric Assessment Unit – Increasing effectiveness and reducing length of stay on the Paediatric Assessment Unit through the implementation of the new model of care and establishing new operational oversight.

Virtual Ward – Expansion of virtual ward pathways to increase admission avoidance and reduce overall length of stay. Furthermore, expanding the number of GP practices onboard with direct access referrals into the virtual ward in order to avoid attendances where appropriate.

Complex Care Team – Working within community to keep patients at home rather than attending ED.

Paediatric CAS – The implementation of a dedicated Paediatric 111 Clinical Advisory Service (PCAS) for Cheshire & Merseyside (C&M), aimed at delivering urgent, paediatric-specific clinical advice to families with children aged 0–5. This initiative will enhance the existing NHS 111 pathway, improving clinical outcomes, reducing unnecessary Emergency Department (ED) visits, and generating substantial financial and operational efficiencies.

Bluebell House – Bluebell House has opened this year as a day unit for children and young people with eating disorders. This facilitate will support reducing admissions to acute wards for patients who do not require medical intervention.

5.3 Staff Health and Wellbeing

Improved Vaccination Rates: flu vaccination roll out aiming for minimum of 50%. The trust is offering online bookable appointment and drop-in sessions in addition to targeted vaccination in high volume areas. There is also a refreshed communication campaign to support the launch of this service.

SALS Support: ongoing staff support is available via the SALS team with any specific season channels identified feeding into the winter planning meetings.

Proactive sickness management: Review of highest sickness reasons within departments and proactively trying to mitigate.

FIT Testing: Ensuring improved FIT testing compliance with a minimum of 80% in high risk areas and then the subsequent access to appropriate PPE to protect staff through the course of their work.

6. Capacity and Escalation Plan

This section will focus on the Trust's available capacity this winter and escalation options.

6.1 General & Acute Capacity

Table One – G&A Bed Capacity

The below table summarised the total G&A bed capacity planed for this winter compared to previous. As you can see there is significant opportunity this winter to flex capacity demandant on demand to ensure the most effective use of resources.

G&A Bed Capacity	
2024-25	188
2025-26	175-191
2026-27	169-186

Table Two – Total G&A Bed Capacity

The table below demonstrates the change in G&A bed based over recent years based on the implementation of new models of care and the reconfiguration required while the acute ground floor estate is under development. The key changes for Winter 2026/27 are highlighted; the closer of G&A beds on ward 3C and 4C.

Acute Bed Base	Original Bed Base	Budget pre Aug 2024 (EDU Closure)	Winter 2025/26	Winter 2026/27
Burns	5	5	5	5
Cardiac	23	23	23	23
Neo	9	9	9	9
3A	32	32	28-32	28-32
3B	13	13	13	13
3C	32	31	23-31	23
4A	32	32	28-32	28-32
4B	21	21	24	24
4C	32	22	22	16
Total	199	188	175-191	169-185

Table Three – Assessment Capacity

The table below demonstrates the changes in assessment capacity and the movement from A&G beds to assessment over previous years. The highlighted changes in yellow demonstrate the plan for this winter to increase access to the Paediatric Assessment Unit (PAU) and the

expansion of Surgical Assessment Capacity (SAU), Same Day Emergency Care (SDEC) and Extended Emergency Medicine Ambulatory Care (EEMAC).

Assessment Beds	Original Bed Base	Budget pre Aug 2024 (EDU Closure)	Winter 2025/26	Winter 2026/27
EDU	12	4	4	4
PAU	0	8	6	8
SAU				2
SDEC/EEMAC	0	0	0	2
Total	12	12	10	16

Table Four- Summary of total beds and escalation capacity

	Weekday
Core Capacity	169
Assessment Capacity	16
Escalation capacity	16
Total Winter Capacity	201

Consideration has been given to the wider estate that could be utilised for escalation in extremis. This detail is provided in appendix 1.

6.2 Critical Care

As in any Winter a key priority is to maintain access to critical care services for CYP requiring emergency or urgent access. Therefore, our plans are centred on resilient staffing and service arrangements to provide care for paediatric patients. If the situation changes to a worst-case scenario either nationally or regionally, we will work with colleagues in the network and support as needed based on the balance of clinical need across all age ranges.

Table Five- Critical Care bed capacity

Critical Care	2025-26 Capacity	2026-27 Capacity	- Variance
PICU	21	21	0
HDU	13	13	0

HDU is continuing to operate with 2 less beds compared to its core establishment. This is a result of a full critical care demand and capacity review which has seen the re-alignment in care for a number of neonates to the neonatal unit, following implementation of enhanced pathways and a 24/7 Neonatal Medical model. The review also indicated that a proportion of HDU level patients were being cared for (appropriately) at HDU level on the Cardiac ward.

This change has been carefully considered, and clear surge staffing plans have been put in place which can be enacted in a timely manner to increase HDU capacity within the critical care unit to 15 beds. The full surge escalation plan for HDU can be seen in appendix 3.

Table Six- Critical Care surge capacity

	Level 3 beds	Level 2 beds	Total
A. Baseline (commissioned)	21	15	36
B. Severe pressure surge	23	18	41
C. Extreme pressure surge	28	20	48

There is physical space in critical care for 43 beds. Therefore, in level 3 'severe pressures' scenario it is possible to flex capacity up to 41 bed spaces (23 ventilated ICU + 18 HDU). This would be dependent on staffing levels with additional support to ensure safe nurse to patient ratios.

In extreme pressure the additional surge beds in reserve would be opened on the Burns Unit and a business continuity plan for Burns would be enacted re-providing the service in a Surgical Ward.

The staffing for the extreme surge beds would need to be supported from other departments across the trust; therefore, there would need to be a reduction in elective activity to facilitate this.

6.3 ED Capacity

Despite securing increased capacity to See and Treat low acuity patients through the Urgent Treatment Centre, the Emergency department at peak times may experience capacity challenges within the department. This would be within the waiting care, assessment cubicles or within resus capacity. The response in increase demand and necessary steps are included

within the ED escalation document. The ED triggers for escalation can be found in appendix 2.

6.4 Staffing Capacity

Where low staffing availability or high patient acuity affects staffing levels and ratios and capacity requires review, the following process will be followed to request the closure of bed capacity: [Opening and Closing of Wards Policy](#).

6.5 Staffing Escalation

Daily Safer Staffing meetings take place to review nurse staffing levels and arrangements. Where possible the trust will work to maintaining the nationally recognised levels of nursing care. There may be times when the ideal nursing levels will fall short and then the Safer Staffing chair or out of hours is the Clinical Site Practitioner will make decisions to balance the risk across all areas of the organisation.

At times this may lead to working to alternative ratios. The ward managers and senior nursing team have agreed the minimum staffing requirements which are articulated through a red, amber or green staffing model and describe the skill mix required for each ward. Where an alternative staffing model is in use the nurse in charge of the relevant area will need to make alterations to how staff work to facilitate safe care for all children and young people. This may involve, for example, the use of task allocation nursing. Core key standards relating to staffing will be maintained as referenced in the Respiratory syncytial virus 2021 preparedness Children's safer nurse staffing framework for inpatient care in acute hospitals (2021) which is supported by relevant professional bodies and trade unions.

If the Trust is escalating through capacity levels staff may be required to change their working commitments to support The Emergency Department or Wards. All options will be considered via the Safer Staffing group; however, considerations would include:

- Staff in educational or training roles returning to patient facing roles
- A suspension of non-urgent meetings for clinical managers
- Requesting support from nurse specialities who are not usually base on the wards

All escalation protocols are included in the Trust Escalation Plan [Trust Escalation Plan](#) (policy currently under review for updating).

7. Enabling Factors

7.1 Patient Flow

A detailed [Patient Flow Policy](#) is in place to support with the effective management of low across the organisation.

The arrangements and routines for the management of patient flow (including transfers from critical care, emergency and elective admissions are managed as follows) are summarised below:

Daily Bed Meetings and Trust Status Report: Bed meetings run at 08:30 hrs, 12:00 hrs and 15:30 hrs. The aim of the daily bed meetings is to establish the predicted admission rates from an emergency and elective perspective and ensure patient flow is maintained by ensuring timely discharges and inter hospital transfers.

The bed meetings are chaired by the Bed Management Team and supported by the Hospital Manager of the Week.

Safer Staffing Huddle: This meeting runs prior to all the bed meetings to review nurse staffing across and agree the staffing models to be deployed. The meeting is chaired by a member of the trust's senior nursing team and attended by a matron from each clinical division. This staffing model confirms the staffing on each ward and advises it is safe to proceed with the established bed numbers for each ward.

Daily Forward Look/ Bed Meeting: At the 15:30 Bed Meeting, the next day's staffing, elective demand, and capacity is reviewed. This may mean that actions are required to expedite discharges, prioritise TCI's, and in extreme circumstances reduce elective admissions. These actions and decisions are taken by the Hospital Manager of the Week.

Emergency Department Safety Huddle: This daily meeting is held at 17:15 and is attended by the Senior Clinical Site Coordinator, Bed Management Team, Emergency Department Nurse in Charge, the Emergency Department Consultant in Charge, and the Senior Manager On Call when required.

Weekend Planning: Every Friday by midday a detailed weekend plan will be issued by the Bed Management Team.

Tactical Command: In periods of heightened and sustained levels of escalation the establishment of an operational Tactical Command Room will be deployed. This will run by a Tactical Commander appointed by the Chief Operating Officer.

7.2 Escalation Plans

Departmental escalation plans (including for Paediatric Intensive Care Unit and the Emergency Department) are contained in the [Trust Escalation Plan](#).

7.3 Finance

Within this plan there is no planned additional financial expenditure for winter however there may be additional ad hoc expenditure relating to surges in pressures dependent upon activity seen. For example, a significant surge in infection or disease outbreak may result in increased domestic and IPC staffing requirements. Any additional costs that may require to be incurred will be authorised through the existing financial control forums with full rationale for approval.

8. Monitoring

This section of the Trust's winter plan outlines the strategies and systems in place to ensure that the plan is effectively implemented, and that patient care and hospital operations are sustained during the winter months. Monitoring of the plan against demand and performance is crucial to ensure escalation protocols are triggered and maintain focus on ensuring the delivery of safe patient care.

8.1 Performance Metrics and Key Indicators

- **Capacity Utilisation:** Monitoring bed occupancy rates, ICU capacity, and overall hospital space to ensure there is enough capacity to handle increased demand.
- **Emergency Department (ED) Performance:** Regular review of waiting times, particularly the four-hour ED target, and patient flow through urgent care services.
- **Discharge Rates and Delayed Transfers of Care:** Monitoring how quickly patients are being discharged and identifying any blockages in the discharge process to free up hospital beds.
- **Length of Stay:** Tracking the length of patient stays to identify any delays or inefficiencies that could impact capacity.
- **Ambulance Handover Delays:** Monitoring ambulance handover times to ensure patients are transferred to hospital care quickly and that ambulances are available for the next call.

8.2 Data Collection and Reporting

- **Real-Time Data Monitoring:** Acute trusts are required to have systems in place to monitor key performance indicators in real time, using dashboards and reporting mechanisms.
- **Daily and Weekly Reporting:** The trust management must provide daily and weekly reports to NHS England or regional teams. This helps in assessing pressures across the system and identifying where intervention may be required.
- **Bed-State Reporting:** Hospitals report on bed availability to ensure accurate assessments of current capacity and resource allocation.

8.3 Escalation Protocols

- **Triggers for Escalation:** Monitoring must identify when predefined capacity thresholds or performance triggers are breached (e.g., high bed occupancy, long waits in A&E, or ambulance delays). These breaches would prompt the activation of contingency measures, such as opening additional wards or redirecting resources.
- **Integrated Care Systems (ICS) Coordination:** Close coordination with the wider Integrated Care System (ICS) and local authorities to ensure that social care and

community services are prepared to take patients and support hospital discharges when needed.

8.4 Workforce Monitoring

- **Staffing Levels:** Real-time monitoring of staffing levels, particularly for critical areas such as emergency departments and intensive care. This includes tracking staff sickness rates, which tend to increase during the winter, and ensuring there are sufficient staffing contingencies in place.
- **Agency and Bank Staff Usage:** Monitoring the use of temporary staff to meet demand and ensure they are integrated effectively into teams without compromising the quality of care.

8.5 Patient Safety Monitoring

- **Incident Reporting:** Tracking incidents such as extended waits, infections, and medication errors, which might rise due to pressure on services. This ensures that even in high-demand periods, patient safety is maintained. Relevant incidents reported will feed into the weekly winter preparedness meetings.
- **Infection Control:** Monitoring the incidence of flu, COVID-19, and other infectious diseases, alongside compliance with infection control protocols.
- **Flu and COVID-19 Vaccination Uptake:** Monitoring vaccination uptake among staff and eligible patients to ensure compliance with national targets for flu and COVID-19 vaccination.

8.6 Collaboration with Other Stakeholders

- **Regional and National Reporting:** Acute trusts must collaborate with NHS regional and national teams to provide a comprehensive view of system pressures.
- **Partnership with Primary Care and Community Services:** Close monitoring of referrals from primary care and effective coordination with community services to prevent unnecessary admissions and to manage discharges.

Below are examples of the monitoring reports created via Power BI app including:

- Daily SitRep for clinical and ward based teams
- The Trust's Operational daily SITREP for management and Executive Oversight
- Dedicated winter plan report
- Clinically Ready to Proceed Data
- NWAS Turnaround Dashboard

Daily SitRep

Alder Hey Children's
NHS Foundation Trust



Operational SitRep

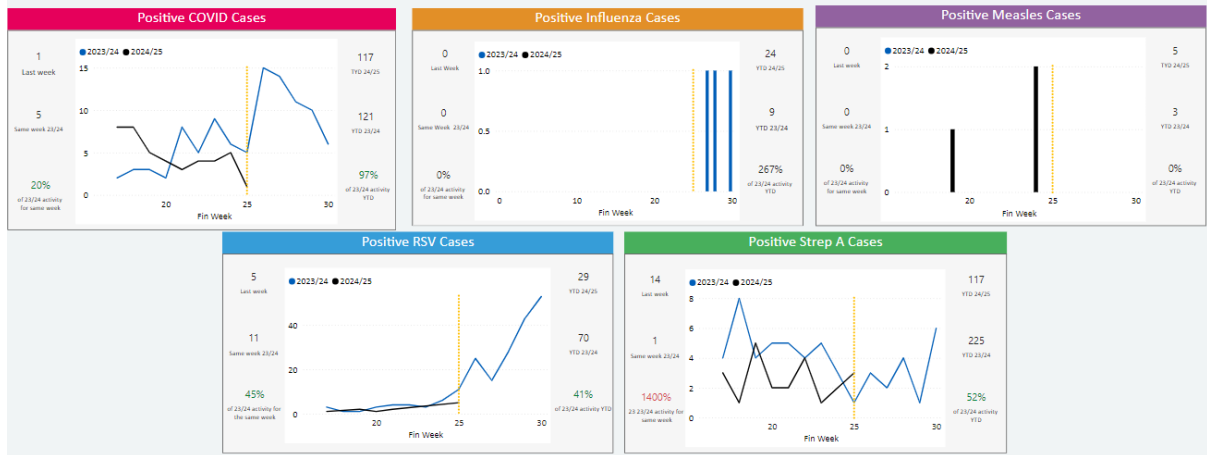
Report refreshed 30/09/2024 04:46 Automated metrics are refreshed every 30 minutes Last data load dates

Alder Hey Children's
NHS Foundation Trust



Infections - Alder Hey Prevalence

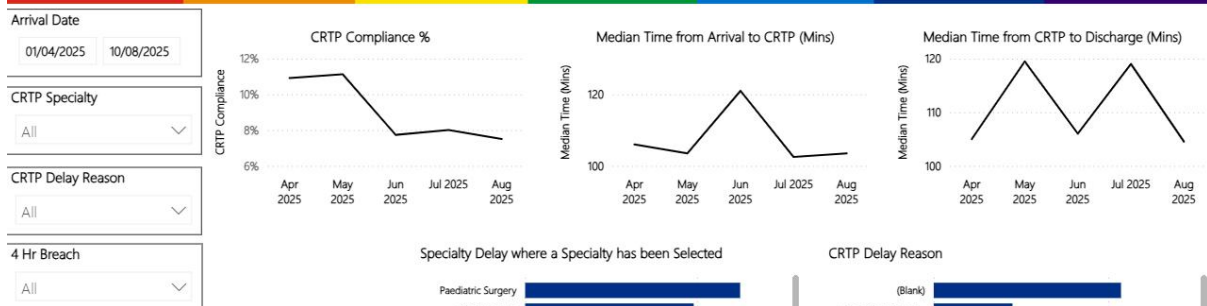
What the data tells us: Actions:



Baseline is set as 2023/04.

Report refreshed 25/09/2024 12:55

Clinically Ready to Proceed - CRTP



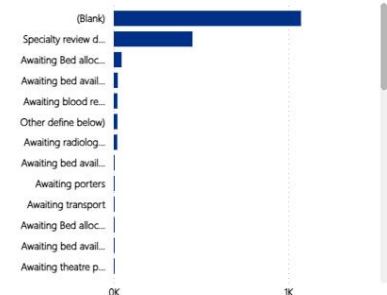
CRTP Compliance by Month Attended

Attendance Month	Number of Records that should have CRTP Timestamp	Number of Records with CRTP Completed	CRTP Compliance
Apr 2025	4030	440	10.92%
May 2025	4170	464	11.13%
Jun 2025	4408	341	7.74%
Jul 2025	4271	342	8.01%
Aug 2025	1145	86	7.51%
Total	18024	1673	9.28%

Specialty Delay where a Specialty has been Selected



CRTP Delay Reason



NWAS Weekly Handover Data

A&E arrival data based on A&E Dept. attendances to HAS Candidate Sites.

Attendances - A&E attendances by ambulance

Handover measurable - Handover times are only measurable if the hospital arrival time is recorded using the HAS screen when entering the hospital

Handover times refer to the time duration between arrival at acute and subsequent handover of patient as recorded at a HAS screen.

Clear times refer to the time duration between patient handover as recorded on HAS screen and the crew subsequently becoming clear and available.

Turnaround times are calculated between time of vehicle arrival (garage or ambulance button press) and time the vehicle becomes available and clear for next allocation. The turnaround time comprises time for the crew to notify Acute, the acute to subsequently receive the patient (handover) and vehicle clean-up, re-stock and 'clear'.

Note the time band '0-15m' includes the time precisely equal to 15mins. '15-30m' begins at 15:01.

The % attends which 0-15mins measures recorded time bands divided by all attends, including ones where times are not recorded.

To achieve 100%, all attendances must be times (and compliant) and also the duration of handover must be 0 to 15 minutes.

The RAG rating for Handover and clear calculated as follows:

<15mins = Green, 15-16mins = AMBER, >16mins = RED

The RAG rating is calculated based on turnaround as follows:

<30mins = Green, 30-32mins = AMBER, >32mins = RED

Compliance (% Measurable)



Week Commencing	Ambulance attendances	Average turnaround time (hh:mm)	Longest turnaround time (hh:mm)	Handover measurable	Weekly Measurable %	Average Arrival to Vehicle handover time (hh:mm)	Longest Arrival to Vehicle Handover (hh:mm)	Arrival to Vehicle handover 0-15m	Arrival to Vehicle handover 15-30m	Arrival to Vehicle handover 30-45m	Arrival to Vehicle handover >45m	% attends where Arrival to Vehicle Handover 0-15mins	% attends where Arrival to Vehicle Handover Exceeding 45 mins	Average hand clear
28/07/2025	55	00:32	01:45	52	94.55%	00:21	05:56	29	13	5	5	55.80%	9.62%	Green
21/07/2025	50	00:30	01:36	47	94.00%	00:19	03:56	25	12	7	3	53.20%	6.38%	Green
14/07/2025	68	00:34	01:42	62	91.18%	00:25	06:09	24	17	16	5	38.70%	8.06%	Green
07/07/2025	65	00:30	01:26	59	90.77%	00:21	05:36	27	19	11	2	45.80%	3.39%	Green
30/06/2025	59	00:32	01:22	54	91.53%	00:22	05:42	25	15	7	7	46.30%	12.96%	Green
23/06/2025	67	00:32	01:12	63	94.03%	00:24	06:00	26	18	10	9	41.30%	14.29%	Green
16/06/2025	73	00:37	01:55	66	90.41%	00:29	07:43	21	19	11	15	31.80%	22.73%	Green
09/06/2025	60	00:31	01:19	55	91.67%	00:22	05:52	24	19	8	4	43.60%	7.27%	Green
02/06/2025	55	00:36	02:12	51	92.73%	00:26	07:21	20	12	11	8	39.20%	15.69%	Green
26/05/2025	56	00:29	01:11	54	96.43%	00:20	04:33	28	13	9	4	51.90%	7.41%	Green
19/05/2025	63	00:32	01:16	54	85.71%	00:24	05:50	20	18	10	6	37.00%	11.11%	Green
12/05/2025	53	00:35	01:11	49	92.45%	00:27	05:48	16	14	8	11	32.70%	22.45%	Green
05/05/2025	68	00:33	01:18	62	91.18%	00:23	05:58	27	15	13	7	43.50%	11.29%	Green

The monitoring section of the plan plays a critical role in ensuring that NHS acute trusts are resilient and prepared to handle the increased demands of winter. It focuses on real-time data, rapid escalation of issues, and coordination across the healthcare system to deliver safe and efficient care.

9. Conclusion

In conclusion the Winter Plan outlines a comprehensive strategy to ensure the Trust is fully prepared to manage the increased demand during the winter period. By focusing on optimising capacity, improving patient flow, ensuring robust staffing, and enhancing collaboration with community partners, the Trust aims to provide safe, efficient, and high-quality care to all patients, even during peak pressure times.

Appendix 1: Escalation Areas

Winter Escalation Beds

Escalation Option	Location	Space Available	Staffing Model	Proposed Clinical Criteria
1	Ward 3C	8 Cubicle beds	2 RN or Amber staffing	As per ward admissions
2	Ward 4A	4 Ward Beds	1RN or Amber staffing	As per ward admissions
3	Ward 3A	4 Beds (Weekend Only)	1RN or Amber staffing	As per ward admissions

Escalation Red

Escalation Option	Location	Space Available	Staffing Model	Proposed Clinical Criteria	Points to Note
4	Specialist G&A Beds	Burns Unit 1C Cardiac	Amber staffing model	Appropriate clinical patient as per criteria	
5	3B Oncology Bay	3 Beds	Amber staffing model	Oncology only	Escalation policy as per:  Escalation policy 120924.docx

Escalation in Extreme Measures

The following areas are clinical areas on the Alder Hey site that do not currently house acute general admission patients but could potentially be repurposed should it be required in extremis. Extremis would be defined as:

- Capacity sustainably on black with no plan to de-escalate
- ED is at risk of providing corridor care
- Significant major incident

To utilise any of these spaces would require the agreement of COO and CNO in hours and Executive On Call Out of Hours. Consideration should also be given to the level of business continuity the organisation is operating at:

Location	Space Available	Staffing Model	Proposed Clinical Criteria	Points to Note
HDU	4 beds	2RN	Post op surgical patients if appropriate OR Decant Burns to HDU to free up Cubicles on Burns	
Clinical Research Unit	2 Beds	2RN – Monday-Friday RN potential available from CRF 8am-6pm	Lowest acuity patients as agreed by HoN's (research senior medical/ nursing leadership to be involved in agreeing acceptance of patients).	Pause in routine research activity and any release of research nurses would be reported to funders as CRF is NIHR funded facility. This will result in financial and reputational harm. Urgent reviews of patients on clinical trials (i.e. adverse events after experimental medicine are required to continue). Patient safety incidents through delayed treatments for those that have commenced within the trial will be monitored.
Medical Day Case Unit	2 Beds	2RN	Lowest acuity patients as agreed by HoN's	Would result in day case cancellations
Surgical Day Case	26 beds (however shared air handling with theatre recovery)	Theatre and day case staff during the day. No facilities for overnight.	One big open space – consideration would need to be given around isolation. Daytime escalation valve whilst additional overnight capacity could be established or discharges facilitated.	Would stop day case throughput (5 theatres) which would have a negative impact on the experience of patients and families as well as financial position. No facilities for showering, kitchen for parents, limited toilet facilities.

			EDU type patients or those stable and transferring to the ward bed within 8 hours	
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Appendix 2: ED Escalation Levels

Emergency Department Escalation Level	Trigger
GREEN SHREWD Level 1 <i>Business as usual – low risk to patient safety and experience</i>	No triggers
AMBER SHREWD Level 2 <i>Low to moderate risk to patient safety and experience</i>	TWO of the following*: <3 EDU/PAU Beds Available - Ambulance Handover delays (15-30 minutes for standard handover) 30-49 in Dept >20 pts in ED waiting area 10-15 pts attend per hours for 2 consecutive hours (non-streamed patients) - Resuscitation capacity (to include HD cubicles) less than 2 spaces 1 RN gap not covered - Less than 6 on medical rota at one time (weekdays 8:00-22:00 weekends 12:00-22:00) or less than 4 on weekends 08:00-12:00). Less than 3 on night. - Delay in triage > 15 mins > 5 patients with a delay of 60-90mins for 1st clinician assessment - Delay of 60-90 mins for speciality referral review - Longest length of stay in department > 8 hours - ED 4 Hour Performance between 70%-78% >30 min waits for allocation of inpatient bed and transfer after DTA 50% reduction of UTC stream capacity *Can be one trigger by professional judgement with joint decision of CIC and NIC
RED SHREWD Level 3 <i>Moderate to high risk to patient safety and experience</i>	TWO of the following*: No EDU/PAU capacity

	❖ Ambulance Handover delays (31-60 minutes for standard handover) ❖ 50-70 pts in ED (in any area) ❖ >30 pts in waiting room ❖ 15-20 pts attend for 2 consecutive hours (non-streamed) ❖ Resuscitation capacity (to include HD cubicles) only 1 space available ❖ 2 clinician gaps not covered ❖ 2 RN gap not covered ❖ Less than 5 on medical rota at one time (weekdays 8:00-22:00 weekends 12:00-22:00) or less than 3 on weekends 08:00-12:00). Less than 3 on night. ❖ Delay in triage >30 mins ❖ 5 patients with a delay of 90-120mins for 1st clinician assessment ❖ Delay of 90-120 mins for speciality assessment ❖ Longest length of stay in the department >10 hours ❖ ED 4 Hour Performance between 60-69% ❖ >60 min waits for allocation of inpatient bed and transfer ❖ No UTC capacity
BLACK SHREWD Level 4 <i>High to severe risk to patient safety and experience</i>	TWO of the following: ❖ Ambulance Handover delays (more than 60 minutes for standard handover) ❖ 20+ pts attend for 2 consecutive hours (non-streamed) ❖ 70+ in Dept ❖ 40+ pts waiting in waiting area ❖ Resuscitation capacity (including HD cubicles) full, with no immediate ability to create space for unexpected arrival ❖ Staff shortage – more than 50% of establishment of any clinical staff group ❖ Delay triage > 60 mins ❖ 5 patients with a delay of 240+ mins for 1st clinician assessment ❖ Delay of 240+ mins for speciality clinician assessment ❖ Longest length of stay in the department > 12 hours ❖ ED performance <60%

	❖ >90 min wait for allocation of inpatient bed and transfer ❖ No UTC capacity
--	---

Appendix 3- HDU surge plan 2026/27

A review of critical care and high dependency capacity and demand was undertaken to ensure that the current provision was providing the right care, to the right patient at the right time.

The work towards establishing the surgical neonatal intensive care unit has meant that the current neonatal ward is now working to BAPM standards and providing an increased level of care to neonates in comparison to previous years. This has seen a realignment in area of care for an increased number of neonates resulting in a reduced demand in the central high dependency unit (HDU).

The Trust must be ready to enact a plan based on national guidance and best practice to facilitate the expansion of critical care capacity to provide care to babies, children and young people. The Trust should also be ready to move to alternative models of providing acute ward-based care which may be impacting critical care capacity, and details of these plans are contained with the winter plan.

This document sets out clear expectations and responsibilities to ensure that staff are fully prepared for redeployment during periods of increased demand for central critical care capacity, specifically in HDU.

Alder Hey are committed to ensuring the continued provision of high quality safe and effective care for children and young people requiring critical and enhanced care, and this guidance outlines how this can be maintained when a surge in capacity is required. This paper relates specifically to the nursing workforce, as opening 2 additional beds would not impact the provision of care from medical or allied health professional (AHP) teams.

The below steps outline measures which can be considered to increase capacity in HDU from 13-15 beds and should be used in conjunction with the current operational escalation for instances of 'no available bed' – appendix A.

Escalation point 1:

- Review all patient acuity and consider if there are ward level patients who are not able to move out of HDU but could be cared for by a registered nurse (RN) redeployed from a ward area.
- Re-allocate appropriately skilled nurse from another area.
- If there are no available nurses within the Trust, consider the existing staffing models and if it would be safe to work to an amber or red model in another area to facilitate this move.
- **This model could only be sustained whilst there were ward level care patients within HDU.**

Escalation point 2:

- If no ward level care patients on HDU, consider list of staff across the trust with HDU competencies and look to redeploy to HDU.
- Review staffing models in use across the Trust to support this and follow review timeframes outlined within this modelling in terms of acceptable timeframes to work to this altered standard.
- MDT huddle* to be convened prior to commence of the next shift to consider the length of time this model needs to be in place. If an adapted model is required for more than 24 hours move to option 3.
- Place bank staffing to support any areas of need.
- Reports into trust bed meeting in hours and to response out of hours.

*The MDT huddle should consist of: The HDU Consultant, HDU unit manager and/or co-ordinator, HoN/AHP's, Bed Manager/ Response team member.

Escalation point 3:

- MDT huddle to be held to review anticipated length of increased capacity.
- If increased occupancy is above 36 hours (3 shifts) consider the proactive redeployment of nurses to HDU for the anticipated length of increased demand and place bank to backfill as needed. This is to ensure safe staffing models can be supported in other areas.
- MDT huddles should happen at least once per shift to review the current arrangement.
- Reports in to trust bed meeting in hours and response team out of hours.

Escalation point 4:

This escalation requires nursing care to be provided outside of the PCCS standards, in line with best endeavours and should only be used in extremis, e.g. regional pandemic. Discussion must take place with an ACN prior to implementation of this model and must only be used following all other escalations being reviewed and attempted.

- MDT huddle to take place and consider which patients can only be cared for by HDU competent staff. Consideration must then be given to the number of nurses requiring redeployment based on this discussion and assessment. E.g. if all patients in cubicles require HDU competent nurses, more than 2 RN's may be required to be redeployed to HDU to ensure safety.
- In hours HoN/AHP's to identify areas to redeploy from and review staffing model on home ward and any bed closures/patient cancellations which may be required. Existing Trust process to be followed for this.
- Redeployed nurses to be supported by HDU nurses on shift and a team-based approach to care is to be undertaken for patients identified in huddle as safe for this approach.
- A team leader in each pod and a coordinating nurse must be retained whilst in this escalation point for every shift.
- Model to be reviewed in MDT huddle at least once per shift and status update to be reported into bed meeting in hours and response team out of hours.

Flash Report

August 2026

Performance is subject to change



Alder Hey Children's
NHS Foundation Trust



REVOLUTIONISE CARE



89.2%

ED: % Treated
within 4 Hours



168

Number of RTT
Patients waiting
>52 weeks



66.7%

% Patients
waiting within
18 weeks (RTT)



82.1%

Diagnostic
Performance



OUR PEOPLE



-9

Estimated
Workforce Plan



10.4%

Staff
Turnover



64%

% PDRs
Completed



OUTSTANDING CARE AND EXPERIENCE



0

Severe / Fatal
Incidents /
Never Events



0

Patient Safety
Incident
Investigations



93.7%

FFT - %
Recommending
Trust



4

Healthcare
associated
Infections



11

Patients
deteriorating
from an
inpatient bed



FINANCIAL SUSTAINABILITY



• I&E Position (actual in month)
£0.2m surplus, in line with plan



• I&E Forecast
£0.677m, in line with plan



• CIP Gap (Risk adjusted forecast
vs full year target)
£2.5m in-year gap and
£4.5m recurrent gap



HIGHLIGHTS

- ✓ ED time to be seen and treated performance has improved, with performance now just below the increased 90% target. Performance has remained above 80% in every month since April 2025.
- ✓ Reduction in number of RTT >52 week waits.
- ✓ 0 Never Events, Severe Incidents or PSII's.
- ✓ Continued good patient experiences scores above 90%.
- ✓ Estimated workforce below plan.



CHALLENGES

- Reduction in performance of diagnostic under six weeks, pending validation.
- Reduction in performance for % patients waiting under 18 weeks for treatment.
- Infections note - x2 MSSA, x1 C.Diff, x1 E.Coli.
- Reduction in PDR compliance.



FOCUS / NEXT STEPS

- Plan created towards achieving 95% ED performance.
- Reduce RTT >52 week waits.
- Agree clear 18-week trajectories and service-level targets, supported by focused validation of waiting lists.
- Weekly DM01 recovery cell in place.
- Improve PDR compliance.



Performance is subject to change. Data is based on latest in-month positions known.

**VISION
2030**

NHS

Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report



Published: August 2026



Performance: July 2026



Compassion

We see you and act



Courage

We speak up and
step forward



Commitment

We keep our promises



Community

We lift each other up



Integrated Performance Report Contents

**VISION
2030**

A healthier, happier
and fairer future for
children and young people

NHS

Alder Hey Children's
NHS Foundation Trust



STRATEGIC DOMAINS	
	Executive Summary 3
	Outstanding Care & Experience 5
	Revolutionise Care 8
	Support Our People 11
	Pioneering Breakthroughs 13
	Financial Sustainability 14
	Risk Management 15

SYSTEM PERFORMANCE	
	Acute & Specialist Care 16
	Neighbourhood, Public and Mental Health 20
	Personalised Care, Therapeutics and Diagnostics 23
BENCHMARKING & TRANSFORMATION	
	National Oversight Framework (NOF) 28
	Transformation Scorecard 29



OUTSTANDING CARE & EXPERIENCE

Patient safety performance remains strong, with no Never Events or incidents resulting in serious harm. A robust PSIRI panel process continues to review all incidents reported as Moderate harm or above, including proposed downgrades. The requirement for restrictive interventions has remained lower for eight consecutive months, supported by the ongoing work of the Restrictive Practice Forum. Sepsis treatment performance was positive, with 100% of inpatients and 91% of Emergency Department patients receiving antibiotics within six minutes where sepsis was suspected.

Families continue to use Martha's Rule appropriately, no cases of C. difficile were reported, and targeted deep cleaning and hydrogen peroxide vapour decontamination have been completed in identified clinical areas. PALS responsiveness also remains high, with 95% of concerns answered within five working days.

The Trust continues to experience a sustained increase in the volume and complexity of formal complaints, reflecting a wider national trend. This includes greater use of artificial intelligence by families to support the preparation of complaints, which the Trust recognises as a potential enabler for raising concerns. A review of the complaints management process, including triage arrangements, is planned and will inform an updated policy.

Medication errors resulting in harm have also increased over the past two months, although numbers remain low relative to overall prescribing and medicines administration activity. Continued focus will be placed on safe medication practice, learning from incidents and recognising staff interventions that prevent errors from reaching patients.

Key measures

	Value	Target
 Patients deteriorating from an inpatient bed admitted to PICU	9	n/a
 Number of Incidents per 1,000 bed days – No Harm	68	77.8
 Number of Incidents per 1,000 bed days – Low Harm and above	17	15.2

REVOLUTIONISE CARE

Access performance showed improvement during July. Emergency Department time-to-be-seen-and-treated performance increased to 89%, exceeding the target, while the proportion of RTT patients waiting more than 52 weeks reduced to the 1% target. Within Community Services, 80% of children and young people on the waiting list had waited 18 weeks or less.

Key challenges remain in diagnostic and cancer performance. DM01 performance reduced due to lower compliance within Endoscopy, with a final validated position of 89%, and there was a breach of the 31-day cancer standard from urgent referral to first treatment.

Although the 52-week RTT target was achieved in July, performance continues to fluctuate, with risks identified across six sub-specialties. Detailed modelling is underway to assess delivery against current activity rates and support the ambition of eliminating 52-week waits by March 2027.

A weekly DM01 recovery cell and additional short-term capacity are in place, alongside a full capacity and demand review planned for completion by September.

Key measures

	Value	Target
 ED % Treated Within 4 Hours	88.8%	85%
 RTT Waiting List Within 18 Weeks*	67.6%	69.7%

SUPPORT OUR PEOPLE

Mandatory training compliance remains strong at over 90%.

Sickness absence continues to be a key area of focus, with an update provided to the Executive Team and ongoing oversight through the People and Culture Committee. September reporting will include an overview of occupational health activity. A refreshed and detailed action plan is now in place, including assessment of potential run-rate savings that could be achieved through reducing absence.

PDR completion has declined, largely because a significant number of reviews were completed during the equivalent period last year and have now fallen due for renewal. Learning and Development colleagues continue to work with and support managers to improve completion rates.

Key measures	Value	Target
 Workforce Plan	4,189	4,199
 Staff Turnover	10.4%	10%
 Sickness Absence (Total)	6.62%	4.5%

FINANCIAL SUSTAINABILITY

The Trust reported a £0.2 million deficit in July (Month 4) and a £2.9 million year-to-date deficit, both in line with plan. The external forecast remains aligned with delivery of the planned £0.677 million surplus, subject to successful delivery of further cost improvement programme savings, ERF income recovery and reductions in recurrent run-rate pressures.

The Month 4 forecast improved by £1 million at system level, supported by mitigations within the Acute and Specialist system, although this was partly offset by deterioration elsewhere. A further £5 million improvement is required from the current internal forecast, and control-total targets have therefore been allocated to each system.

CIP delivery was £0.4 million ahead of plan in July but £0.1 million behind plan year to date. The risk-adjusted in-year forecast is £21.3 million, leaving a £3.3 million gap, while the recurrent forecast is £19.8 million, with a more significant £4.8 million gap. Key risks include ERF underperformance, ongoing cost pressures such as energy inflation, and bank expenditure forecast to exceed the NHS England cap by approximately £0.3 million.

Cash remains in line with plan but is being closely monitored because the forecast assumes that most CIP schemes will generate cash-releasing savings. Capital expenditure is behind plan due to phasing and pending approval of NHS England strategic funding. Continued focus is required on recurrent efficiencies, ERF recovery, run-rate reduction and temporary staffing controls.

System-level forecast delivery will be monitored through EPOG and FIP, with reporting from September placing greater emphasis on recurrent CIP and the underlying financial position ahead of planning for April 2027. Final capital prioritisation will follow updated NICU expenditure forecasts and decisions on schemes awaiting PDC support.

Key measures	Value	Target
 I&E Year End Forecast	£0.67m	£0.67m
 CIP Risk Adjusted Forecast	£21.5m	£24.6m
 ERF Income (YTD)	£34.3m	£35.3m

Outstanding Care & Experience: Safe & Caring

Executive Summary

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

Highlights

- No Never Events or incidents resulting in serious harm. Robust process in place to review all incidents reported as Moderate harm or above through the PSIRI panel. This includes review of all incidents where it is proposed they are downgraded
- Maintained a lower requirement for restrictive interventions for past 8 months. Restrictive Practice Forum in place which meets regularly to review practice, processes, policy and training
- 100% of inpatients and 91% of ED patients received antibiotics within 6 minutes for sepsis concern
- Families using Martha's Rule when they need to raise a concern
- No reported cases of C-diff. Deep cleans / HPV (hydrogen peroxide vapour) decontamination undertaken in Ward 4A, Renal Unit and Ward 3B Day Case
- 95% of PALS concerns responded to within 5 working days

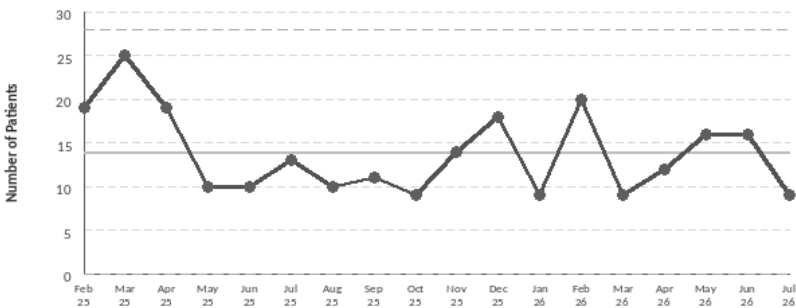
Areas of Concern

- Trust is continuing to see a very high number of formal complaints in the last 6 months compared to previous years - this increase is also being reported nationally and by the PHSO. Increase in complexity of complaints and also complaints using AI to help generate. The Trust recognises that AI can be an enabler to help support families to raise a concern. Further review of complaints management process planned and then associated update of policy
- Increase in medication errors resulting in harm over last two months however remains low in the context of how many medications are prescribed, dispensed, prepared and administered. Staff continue to prevent medication errors reaching the patient by following the '5 Rights' - recognised as Good Catches at the weekly Patient Safety Meeting

Forward Look (with actions)

- Review of complaints management process including triage

1. Number of Patients Deteriorating from an Inpatient Bed Admitted to Critical Care



Current (Jul 26)

9

Previous Month (Jun 26)

16

vs Previous Month

↓ 7

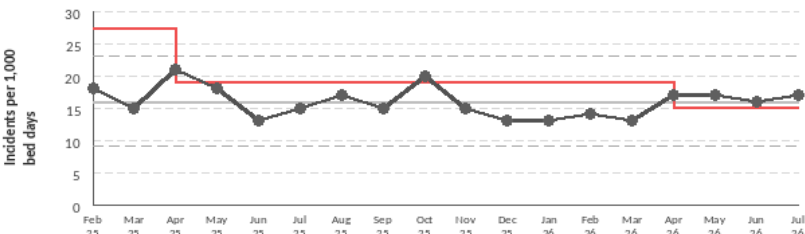
Technical Analysis:

Common cause variation observed with 9 patients deteriorating from an inpatient bed to PICU with an average of 14 a month during the last 18 months. Lowest month since March 2026

Priority Actions:

Reduction in patients admitted to PICU from wards following deterioration. Deteriorating Patient working group reports to Patient Safety Board and through to SOAC

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



Current (Jul 26)

17

Target Monthly Average

15.2

Position

Above Target

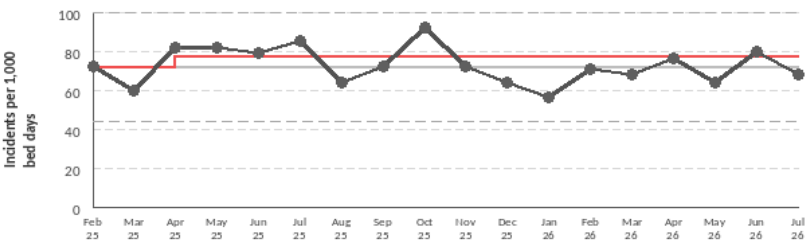
Technical Analysis:

Common cause variation with performance of 17 incidents of harm per 1,000 bed days, with a monthly average of 16 incidents during the period. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 25/26 which is an average of 15.2 a month

Priority Actions:

Increase in last 4 months of incidents resulting in low harm or above. All staff encouraged to report. Robust processes for reviewing incidents, harm level and disseminating learning

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



Current (Jul 26)

68

Target Monthly Average

77.8

Position

Below target

Technical Analysis:

Common cause variation observed with 68 incidents of no harm per 1000 bed days. Incidents are assessed on both Physical and Psychological Harms. The target is set against a 5% improvement on 25/26 with a monthly target of 77.8.

Priority Actions:

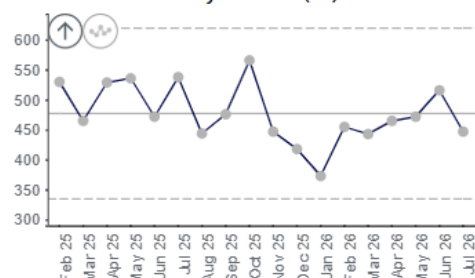
Consistent reporting of near miss and no harm. Good Catches and due diligence recognised at the weekly Patient Safety Meeting

Integrated Performance Report | August 2026

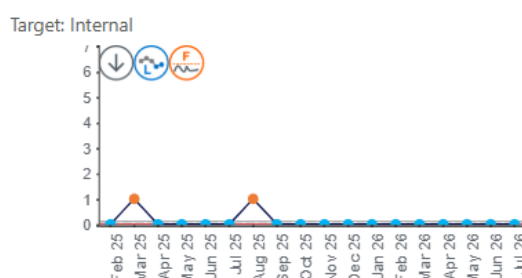
Outstanding Care and Experience – Safe & Caring - Watch Metrics

Watch Metrics

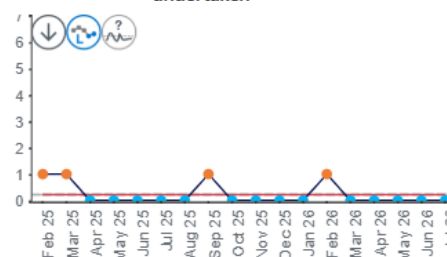
Patient Safety Incidents (All)



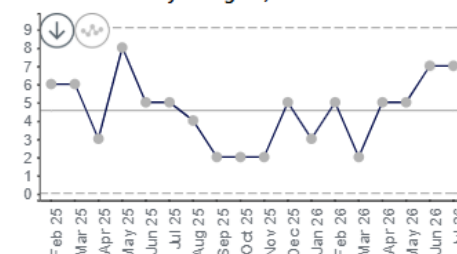
Severe or Fatal Incidents – Physical & Psychological



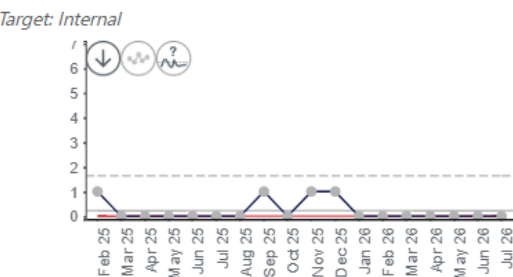
Number of PSIs (Patient safety incident investigation) undertaken



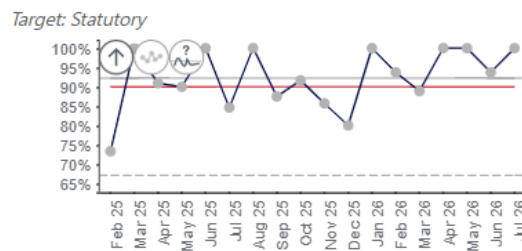
Medication Errors resulting in Harm (Physical and Psychological)



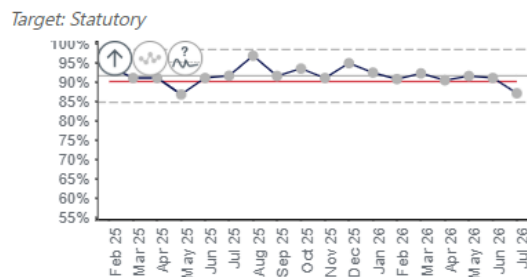
Number of Never Events



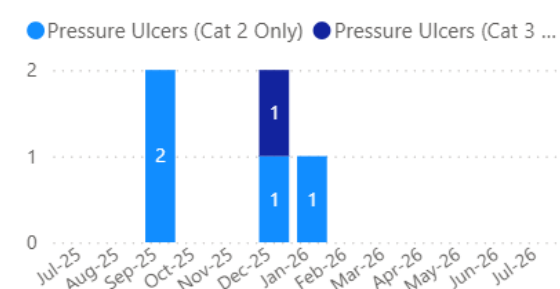
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



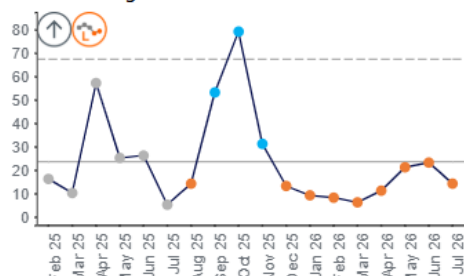
Sepsis % Patients receiving antibiotic within 60 mins for ED



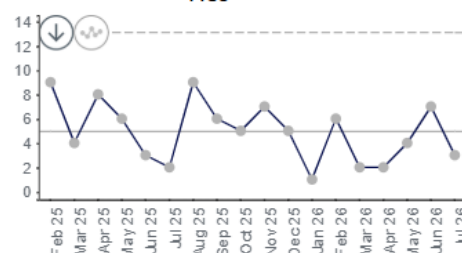
Pressure Ulcers Category 2-4



Recording of restrictive interventions



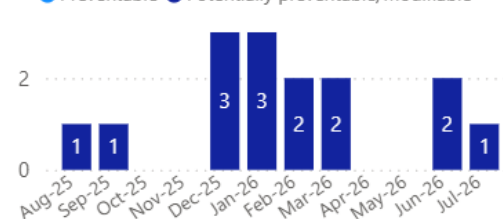
Number of patients deteriorating from HDU admitted to PICU



Predictable and preventable deteriorating patients

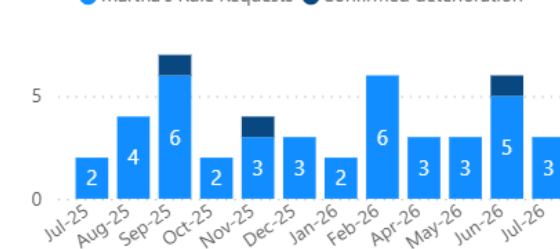
Not inclusive of all categories

Preventable Potentially preventable/modifiable



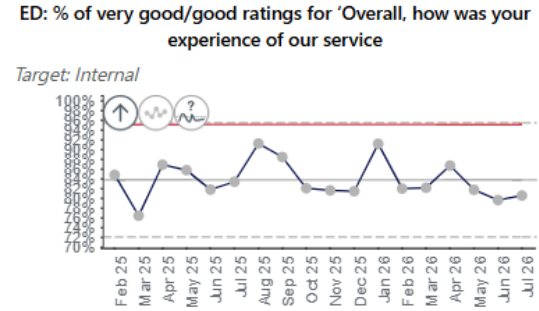
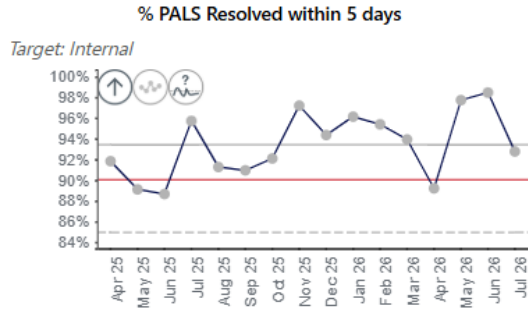
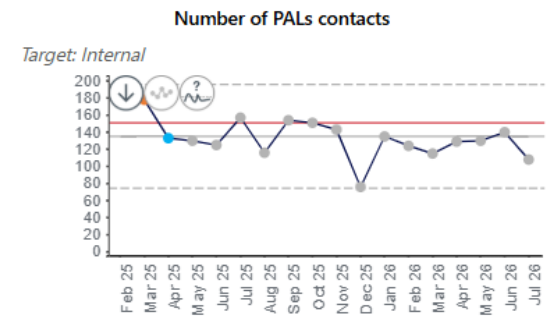
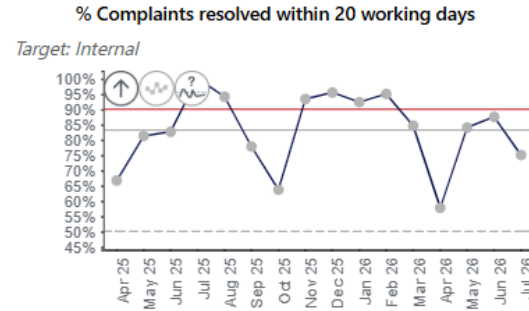
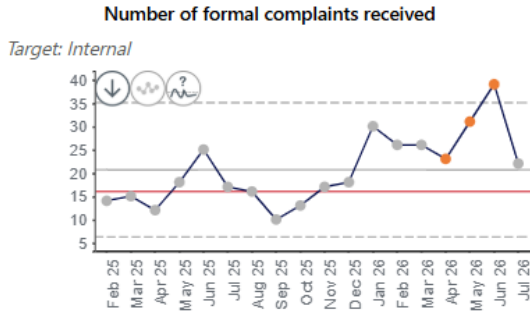
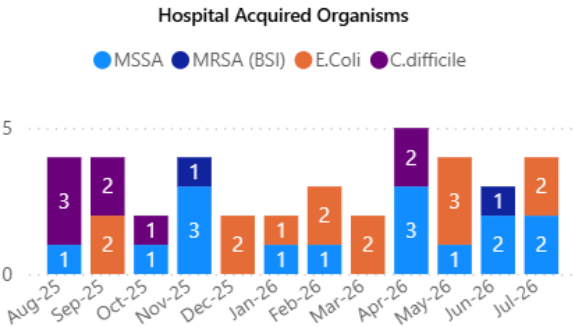
Martha's Rule

Martha's Rule Requests Confirmed deterioration



Outstanding Care and Experience - Safe & Caring - Watch Metrics

Watch Metrics



Revolutionise Care – Effective & Responsive

SRO:	Operational: Adam Bateman, Chief Operating Officer	2030 Transformation Programme: Kate Warriner, Chief Transformation and Digital Officer	Clinical: Alf Bass, Chief Medical Officer
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Highlights

- ED time to be seen and treated performance has improved in month and is above target in July at **89%**.
- Percentage of RTT patients waiting > 52 weeks in July reduced and achieved target of **1%**.
- **80%** of CYP on the waiting list for Community Services waiting 18 weeks or less.

Areas of Concern

- Reduction in DM01 performance due to reduced compliance within Endoscopy at **89%**.
- Cancer breach for **31 days** from urgent referral to first treatment.

Areas Requiring Attention

 DM01 / RTT performance

Reduction in DM01 at **89%** and RTT 18wk performance **67.6%**

 Cancer

Second in year cancer breach for **31 days** from urgent referral to first treatment. Both breaches primarily attribute to external pathway dependencies and diagnostic delays outside AH direct control, rather than delays within AH treatment processes.

 ND Assessment

ND assessment % triage within 12 weeks at **62%** following continued reduction in performance.

Forward Look (with actions)

- Ongoing forward planning to ensure year end delivery of zero 52-weeks by March 2027. Whilst achieved in month, compliance fluctuates and there are 6 areas of risk across sub-specialities. In depth modelling is currently underway to analyse compliance based on current run rates.
- Weekly DM01 recovery cell in place, additional short-term capacity in place with a view to complete a full capacity and demand review for the service by September.

Key Performance Indicators

1 ED: % treated within 4 Hours

Latest (July 2026)

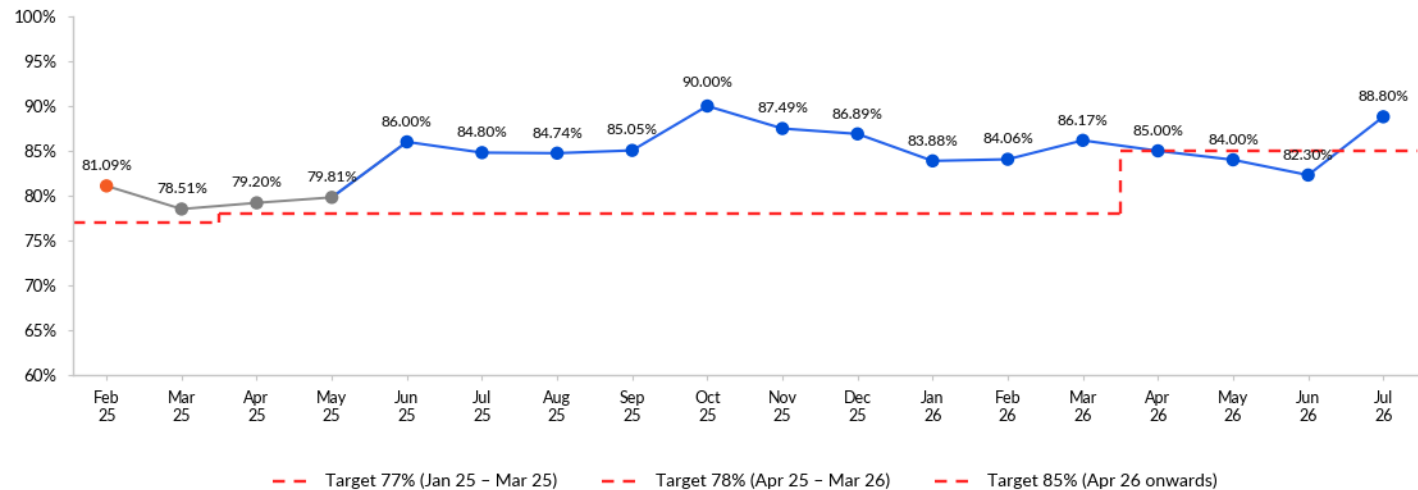
88.8%

Target (Statutory)

85%

↑ 6.50%

vs Jun 26
(82.3%)



2 RTT waiting list within 18 weeks

Latest (July 2026)

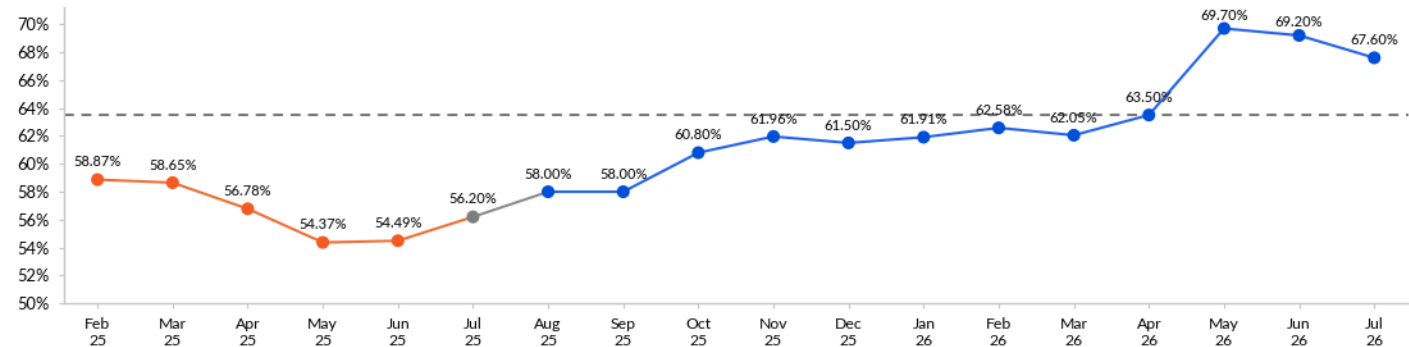
67.6%

Year-end target (Mar 2027)

75.1%

↓ 1.60%

vs Jun 26
(69.2%)



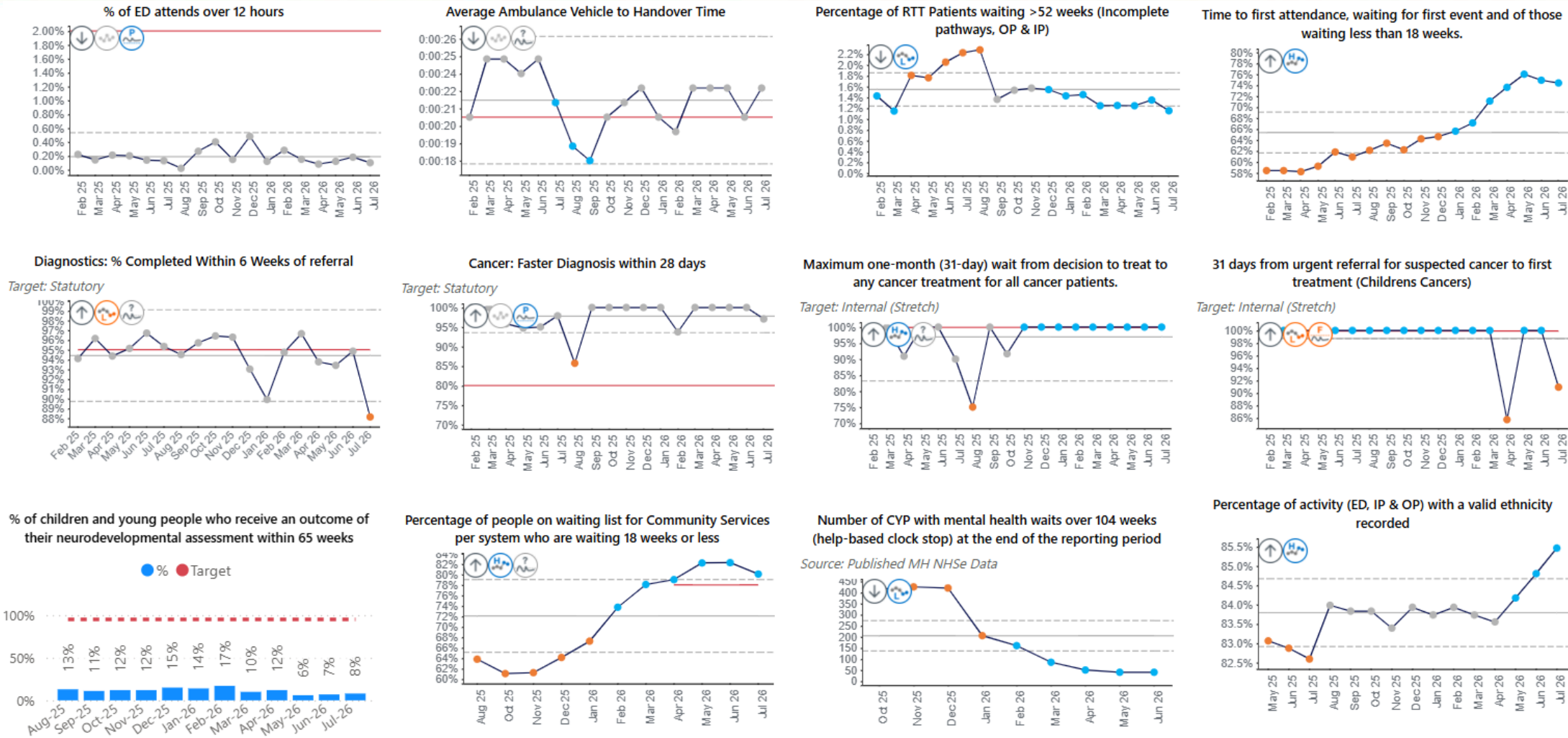
Technical Analysis

- Performance of 88.8% in Jul-26 exceeded our target of 85%, a significant increase from Jun-26 (82.3%). Jul-26 represents performance +3.8% compared to Jul-25 (85%), whilst Jul-26 experienced +410 extra attendances compared to Jul-25.
- Special cause variation with current performance of 67.6% against a revised year-end target of 75.1% by March 2027. This is a decrease from the June 2026 position of 69.2% and the 2nd consecutive month to decrease.

Priority Actions

- ED performance has improved for the 15th consecutive month above 80%. Plans are in progress to support achievement of the new 95% target.
- Reduction in month in performance for % patient waiting under 18 weeks for treatment at 68%. RTT trend review at speciality level to ensure plans are in place to achieve the year-end target of 75% RTT compliance. Additional capacity plans are in place for ENT to mitigate a workforce gap impacting OPNEW capacity.

Revolutionise Care – Effective & Responsive – Watch Metrics



Support Our People

Executive Summary



SRO

- Melissa Swindell, Chief People Officer

Highlights

- Mandatory training completion remains over 90%

Areas of Concern:

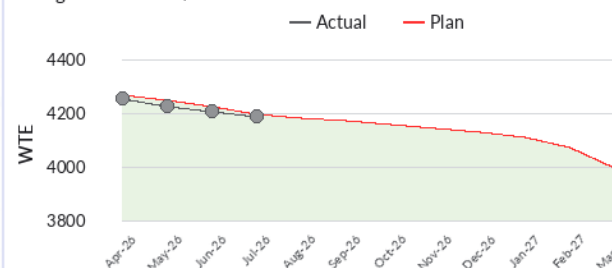
- A sickness update has been presented to Execs, with reporting continuing to the People & Culture Committee, which will include an overview of occupational health activity in September. A refreshed, detailed action plan is in place, including potential run rate savings that could be achieved through reduction in absence.

Forward Look (with actions)

- PDR completion has reduced as a significant number of PDRs were completed in this window 12 months ago. L&D colleagues continue to support managers to achieve PDR completion.

Total Workforce - WTE

Target: Internal 26/27



Target (Internal)	Actual (Jul 26)	vs Plan
4,199.18	4,189.36	↓ 9.8 WTE

Technical Analysis:

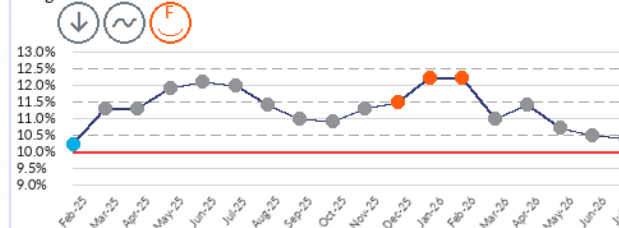
Total workforce for the end of July 2026 was 9.8 WTE below plan. M4 Total workforce was 4189.36, against a plan of 4199.18

Actions:

For 2026/27 we are reporting below plan for Total Workforce, with continuing work to do across the year, primarily through the HWWTF programme.

Staff Turnover

Target: Internal



Target (Internal)	Jul 26	vs Target
10%	10.4%	↑ 0.4%

Technical Analysis:

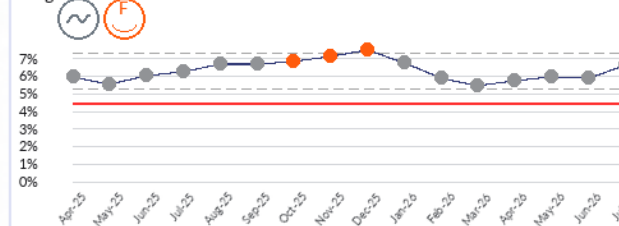
Common cause variation observed with performance of 10.4% in July 2026 against an internal target of 10%. Minor increase from 10.5% the previous month however a consistently failing metric.

Actions:

Diving deeper into turnover data, 4.70% of turnover is involuntary (FTC end dates, VR etc) and 6.10% is truly voluntary which has seen a slow reduction from 7.39% in April 2025, and 6.45% in April 2026.

Sickness Absence Overall

Target: Internal



Target (Internal)	Jul 26	vs Target
4.5%	6.62%	↑ 2.12%

Technical Analysis:

Common cause variation observed. Total sickness absence in July 2026 is 6.62% which is above the monthly target of 4.5%. July-26 is a 0.68% increase from June-2026 and the highest rate since January 2026. July 2026 performance comprises STS at 2.61% and LTS at 4.02%. Monthly sickness target is set at 4.5% in 2026/2027.

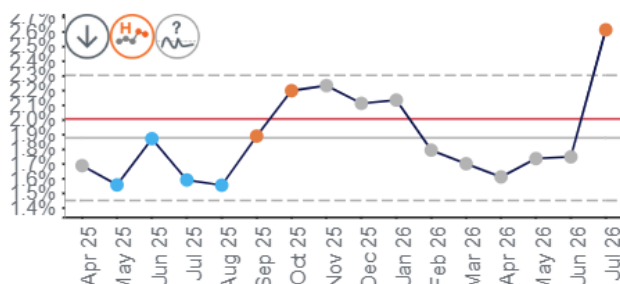
Actions:

A sickness update has been presented to Execs, with reporting continuing to the People & Culture Committee. A refreshed, detailed action plan is in place, focusing on manager support, automation, and targeted, data driven, support, and focusing on enhancing both support and challenge and accountability.

Supporting Our People - Watch Metrics

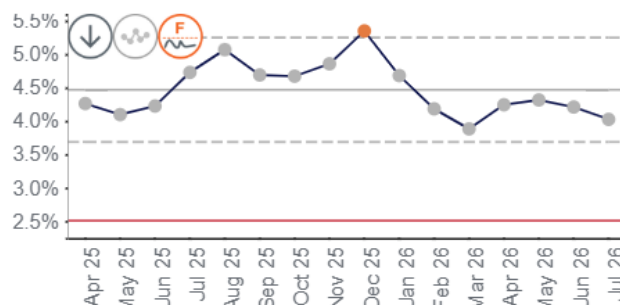
Short Term Sickness

Target: Internal

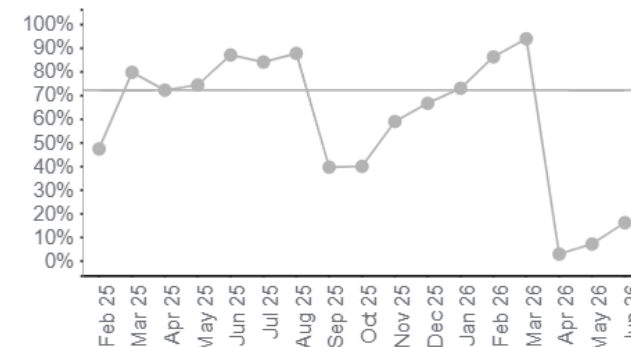


Long Term Sickness

Target: Internal

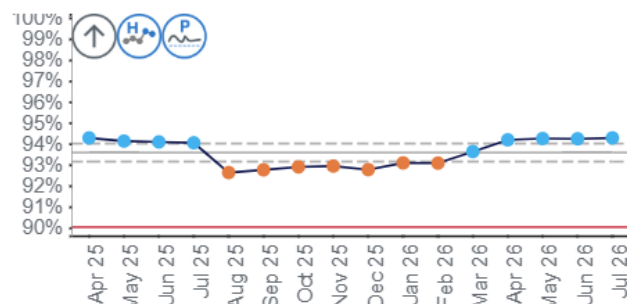


Medical Appraisal



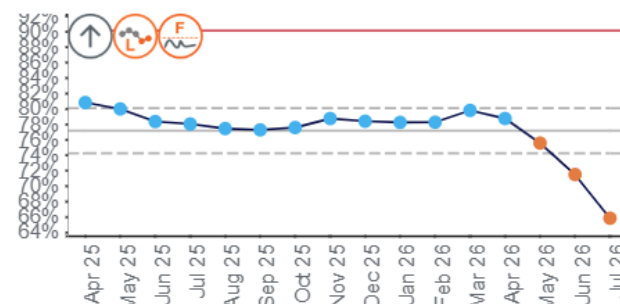
Mandatory Training

Target: Internal



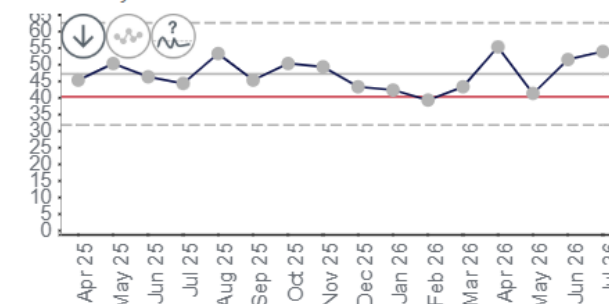
PDR's Completed

Target: Internal



Average Time to Hire

Target: Statutory



Pioneering Breakthroughs

Executive Summary

SRO
Kate Warriner
Chief Transformation and Digital Officer

Alf Bass
Chief Medical Officer

Highlights

- Director of Nursing and AHPs for the Bring me the Future System appointed.
- New BMFT multi-disciplinary senior leadership team of 12 established, with the operating model under development.
- New leadership model for innovation established.
- Rolling internal funding call launched to boost the potential to turn research ideas into external funding applications, with funding opportunities visible via My Alder Hey.
- Funding application submitted to the nine-only NIHR Accelerated Research Delivery Fund for £969,678.
- New research participants story published: Alder's Story – Alder Hey Children's Hospital Trust.

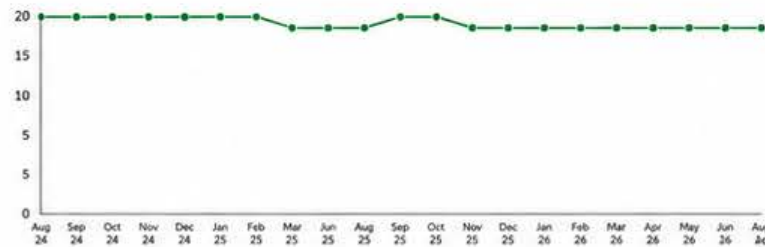
Areas of Concern

- Research financial position is off track, mainly driven by MRI and Paediatric Medicines Unit underachievement against the income target; a mitigation plan is in place.
- The 90-day site target for study set-up is off track; mitigation plans are in development and funding applications are under review to boost resource in this area.

Forward Look (with actions)

- Alder Hey CRF NIHR Public and Patient Involvement, Engagement and Participation Strategy developed and under internal review and review by Liverpool Health Partners for 31 August submission.
- Paediatric Open Innovation Zone challenge fund awards under review, with an 18 September deadline.
- Alder Hey innovation next phase in development under new leadership.

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



Current (Jul 26)	Previous Month (Jun 26)	vs Previous Month
19	19	0

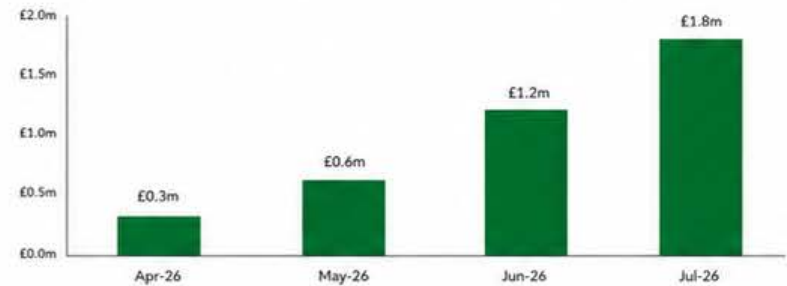
Technical Analysis:

Number of AH Chief Investigators leading NIHR portfolio studies (externally funded and peer reviewed).

Actions:

Remains stable. A new funding call is live to pump-prime new research ideas and external funding applications. Funding is available through My Alder Hey.

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



Current (Jul 26) YTD	vs Previous Year (Jul 25 YTD)	vs Previous Year (YTD)
£1.8m	—	—

Technical Analysis:

External income received by month across Research and Innovation.

Actions:

Innovation income and expenditure are balanced. Research income is underachieving, with mitigations identified and actioned.

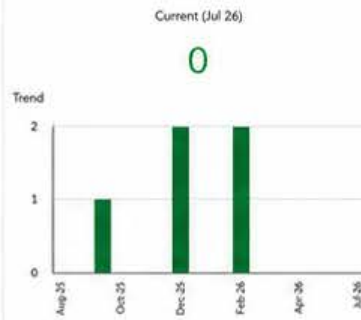
3. Number of participants recruited to all studies



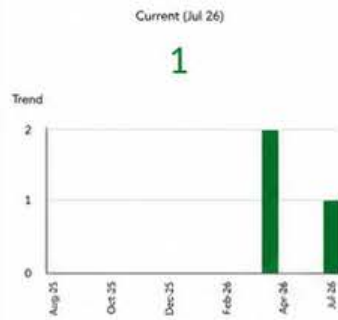
4. Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



5. Number of jobs created through new external funding (POIZ metric)



6. Number of businesses supported by POIZ



Financial Sustainability: Well Led



SRO: Rachel Lea, Chief Financial Officer



Highlights:

In July (M4), the Trust reported £0.2m deficit and £2.9m deficit YTD, which is in line with plan. The forecast at M4 showed an improvement of £1m at a system level based on mitigations included from the Acute & Specialist system but also a deterioration in other systems. Control total targets have been shared with each system to reduce their current forecast in line with the principles shared at FTPC last month. The improvement required from the current reported M4 forecast is £5m to mitigate overall risk of not delivering the £677k surplus. This includes further delivery of CIP, ERF recovery and reduction in run rate pressures. The external forecast remains in line with plan, subject to the successful delivery of targeted CIP actions and ERF recovery.

CIP performance remains broadly on track with delivery £0.4m ahead of plan in M4 and £0.1m behind YTD. In year £17.5m CIP has been transacted and the current risk adjusted forecast is £21.3m, leaving a gap of £3.3m. Recurrently £13.8m has been implemented with risk adjusted forecast at £19.8m, leaving a recurrent gap of £4.8m.

Cash has remained in line with plan & capital is behind plan due to phasing and awaiting approval of NHSE Strategic funding.



Areas of Concern:

The forecast gap highlights the continued importance of delivering further CIP and improving ERF performance during the remainder of the year. While the overall forecast position remains aligned to plan, there is a significant recurrent CIP challenge and ongoing cost pressures, particularly in relation to energy inflation.

Bank reduction remains a key priority, with the M4 forecast c.£0.3m above the NHSE cap.

Cash forecast is being kept under review as forecast assumes that most of the CIP programme would deliver cashable savings.



Forward Look (with actions):

Forecast mitigations are dependent upon both improved CIP delivery and recovery of ERF income therefore continued focus on recurrent efficiency delivery, run rate reduction and active management of temporary staffing is required to support achievement of the Trust's financial plan.

From September reporting will focus on recurrent CIP delivery as we enter into annual planning processes to understand the underlying position and ensure financial sustainability from April 27. Forecast targets have now been allocated to each System and delivery will be monitored through FPOG and FIP.

Cash will remain under close review to ensure emerging risks are identified and addressed promptly.

Finalisation of capital programme awaits updated forecast of NICU spend for the year, and approval of NHSE cases earmarked for PDC support, all of which will feed into final prioritisation decisions.

CIP	TRUST TOTAL
CIP Target	£24,587,000
CIP - In Year Risk Adjusted Forecast	£21,279,000
In Year Gap	-£3,308,000
Recurrent Risk Adjusted Forecast	£19,801,000
Recurrent Gap	-£4,786,000

I&E	TRUST TOTAL
I&E In Month Variance	£0
I&E Year End Forecast	£677,000
ERF YTD Variance	-£981,000
Cash in Bank	£31m

Temporary Spend Measures		
Measure	Target	Year End Forecast
30% reduction agency spend in 26/27	£350,000	£225,000
10% year on year reduction in spend on bank staffing	£4,500,000	£4,801,000

Risk Management: Well Led

Executive Summary



SRO
Erica Saunders, Chief Corporate
Affairs Officer

Highlights:

- 32 high risks on the risk register as of 31st July 2026, down from 35 at the end of June 2026.
- 100% of high risks were within review date in July 2026.
- Sixth consecutive month at 100% review-date compliance.

Areas of Concern:

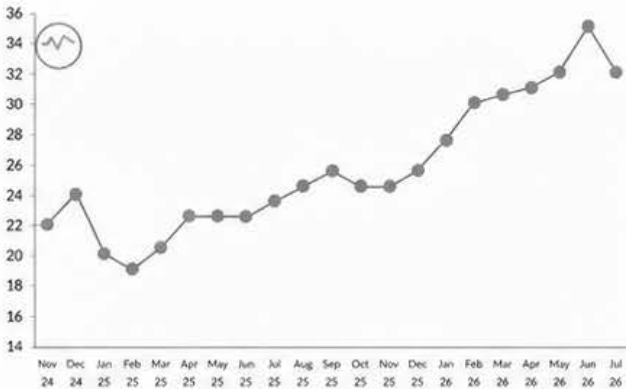
- Continued oversight is required to monitor the high-risk profile through engagement with systems.



Forward Look (with actions)

- Continue to monitor the number of high risks and review-date compliance through engagement with systems.

Number of High Risks (scored 15 and above)



Current (Jul 26)	Previous (Jun 26)	vs Last Month
32	35	↓ 3

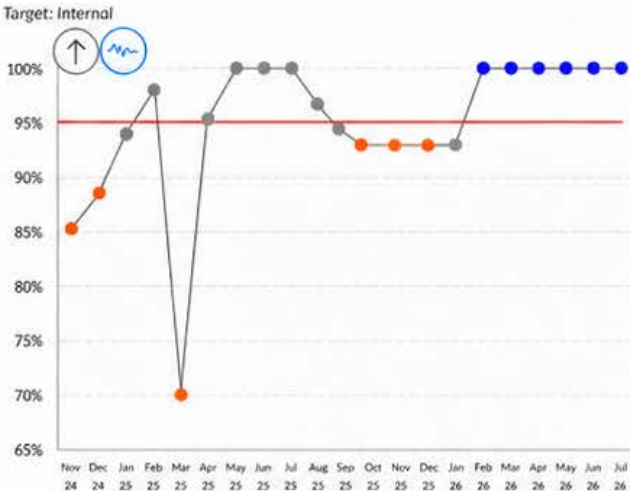
Technical Analysis:

32 high risks on the risk register as of 31st July 2026 following 35 at the end of June 2026.

Priority Actions:

Continue to monitor through engagement with systems.

% of High Risks within review date



Current (Jul 26)	Previous (Jun 26)	vs Last Month
100%	100%	→ 0

Technical Analysis:

Sustained performance of 100% of risks within review date for July 2026, 6th consecutive month at 100%.

Priority Actions:

Continue to monitor through engagement with systems.



SRO: Benedetta Pettorini, Medical Director



HIGHLIGHTS

- The number of patients waiting over 52 weeks continues to reduce. In the last 12 months this has reduced by 50% (approx. 400 patients)
- The number of 2 year overdue follow ups is decreasing gradually
- Long term sickness rate has reduced for the 3 month in a row
- Mandatory training remains above target at 93%
- The M4 SLAM refresh has resulted in an increase in income for OPN and OPROC. Current YTD performance is above plan.



AREAS OF CONCERN

- WNB increased to 10.5% which is consistent with attendance rates during the school holidays.
- DMO1 performance is below target at 70%. This is primarily driven by Gastroenterology who are struggling to meet demand within the 6 week timeframe
- ERF M4 YTD performance currently remains behind plan (£-1.4m). Main drivers are lack of demand in Cardiac (-640k), change in treatment provided by Respiratory Medicine (£-304k) and multiple factors impacting Neurosurgery, Paediatric Surgery and Nephrology (-750k)



FORWARD LOOK (WITH ACTIONS)

- Recovery plan developed and actions underway for fragile services (Cardiology, Chronic Pain & Dentistry) who do not currently have the capacity to eliminate 52-week breaches by March 27
- Continued focus on ED performance working towards 95% target
- Services who have no general new patients waiting are overbooking with overdue follow ups
- Offered mutual aid to other cardiac centres / spinal units to increase ERF delivery
- Included expected tariff as a factor in determining which services are reallocated theatre sessions
- Weekly DMO1 recovery cell commenced with Deputy COO to monitor patient level breaches and ensure delivery of specialty level recovery trajectories. Targeted actions for Gastroenterology and Sleep Studies to improve position & review long term capacity and demand

Acute and Specialist Care

Financial KPI Summary



1. KEY HIGHLIGHTS

- ↓ CIP risk adjusted forecast: £7.6m against target of £12.0m
- ↓ CIP in-year gap: -£4.4m
- ↓ ERF YTD actual: £29.5m vs target £31.0m (variance: -£1.5m)
- ↓ I&E in-month actual: -£8.1m vs plan -£6.6m (variance: -£1.5m)
- ↓ I&E year-end forecast: -£90.3m vs plan -£83.1m (variance: -£7.3m)
- 📅 Recurrent risk adjusted forecast: £8.6m
- ↓ Recurrent gap: -£3.4m



Temporary Spend Measures

👤 Agency Forecast	N/A
🎯 Agency Target	N/A
⚖️ Agency Variance	N/A
🏛️ Bank Forecast	£1,875,000
🎯 Bank Target	£2,201,000
⚖️ Bank Variance	-£326,000



CIP in Year

In Year Risk Adjusted Forecast	£7,615,000
Target	£12,000,000
In Year Gap	-£4,385,000



Recurrent CIP

Risk Adjusted Forecast	£8,634,000
Gap	-£3,366,000



ERF YTD

Actual	£29,457,000
Target	£30,987,000
Variance	-£1,530,000



I&E In Month

Actual	-£8,132,000
Plan	-£6,633,000
Variance	-£1,499,000



I&E Year End

Forecast Actual	-£90,341,000
Plan	-£83,064,000
Forecast Variance	-£7,277,000



Favourable

Favourable variance or better than plan/target

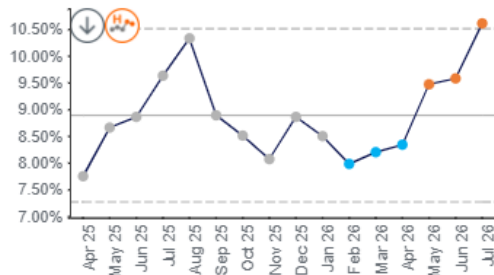


Adverse

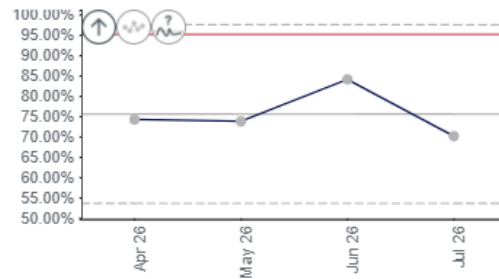
Unfavourable variance or worse than plan/target

System Performance Summary - Acute and Specialist Care

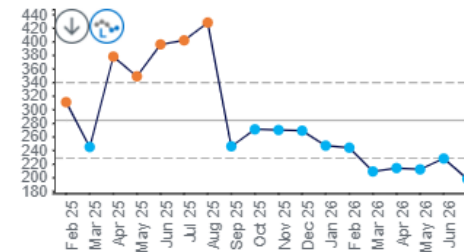
WNB Rate



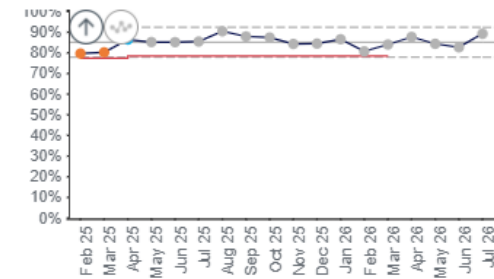
Diagnostic: % waits under six weeks



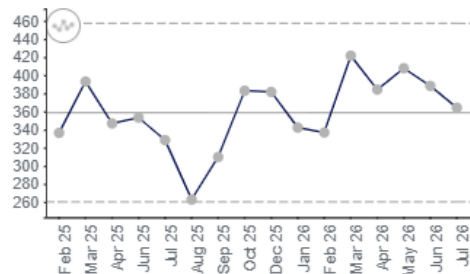
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



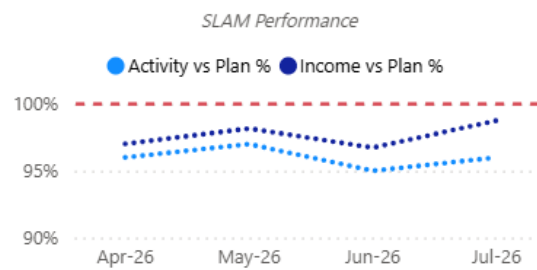
ED: % treated within 4 Hours



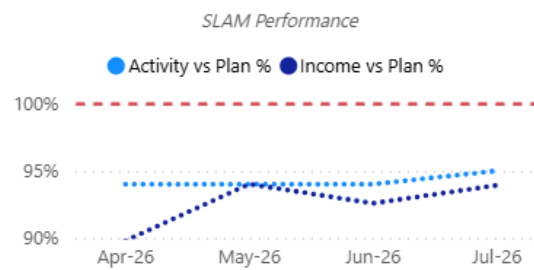
A&E Attendances per ED Consultant WTE



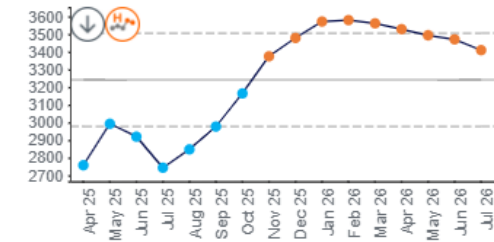
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)



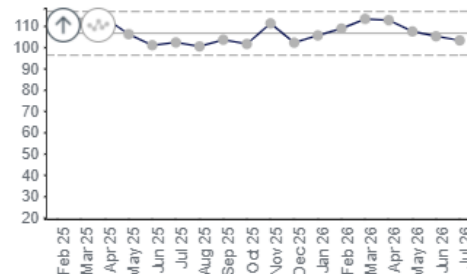
Elective & Daycase Income and Activity (Spells) vs Plan (YTD Position)



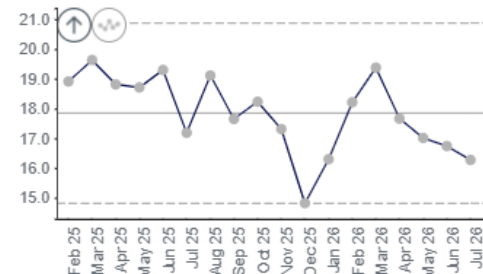
Volume of active outpatient follow up waits - 2 Years & Overdue



Day Cases per working day



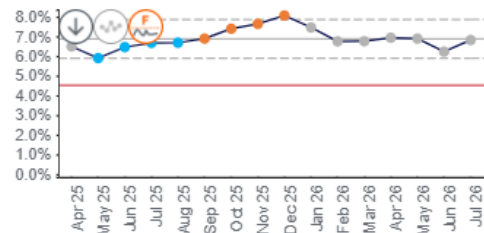
Electives per working day



System Performance Summary - Acute and Specialist Care

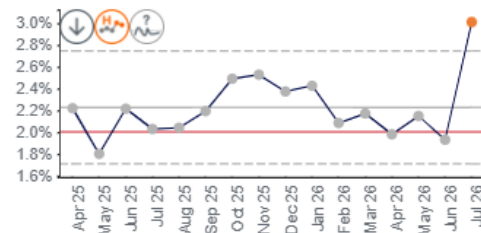
Sickness Absence Overall

Target: Internal



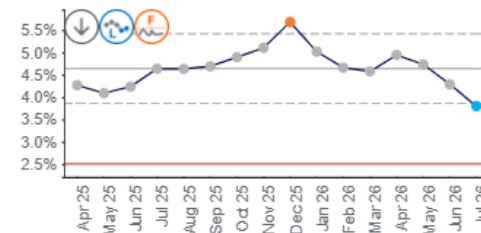
Short Term Sickness

Target: Internal



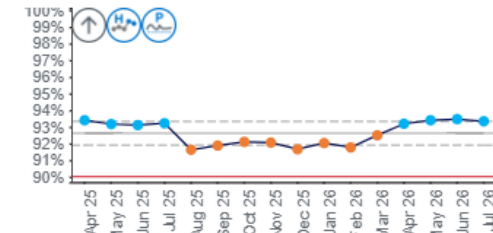
Long Term Sickness

Target: Internal



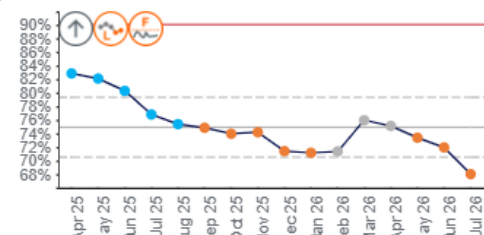
Mandatory Training

Target: Internal

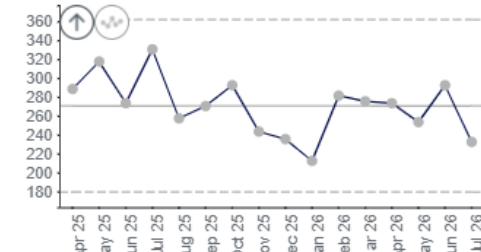


PDR's Completed

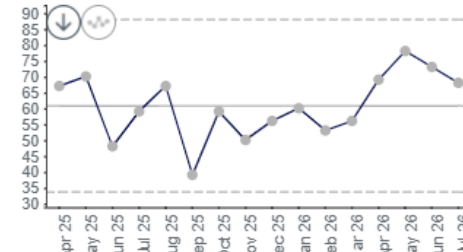
Target: Internal



No Harm Incidents

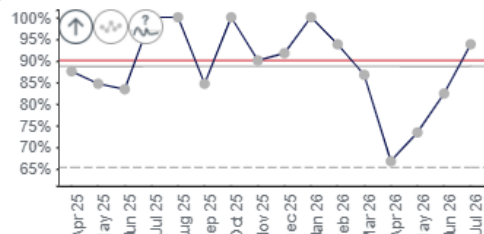


Incidents rated low harm and above



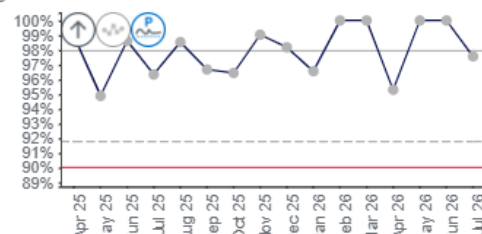
% Complaints resolved within 20 working days

Target: Internal



% PALS resolved within 5 days

Target: Internal





SRO: Lisa Cooper, Medical Director



HIGHLIGHTS

- Continued improvement in Community Paediatric waiting times with over 92% of children waiting less than 18 weeks from referral to treatment
- Appointment of Roald Dahl Rare Disease Nurse to support children and families navigate complex care and treatment pathways
- ICCNT received award from Airefest as their Unsung Hero 2026 following the transformation and innovation the team have been involved in over the last year.
- Continued reduction in CYP Mental Health 104 week wait clock stops following significant work to improve data quality and compliance with recording of data in EPR
- Go live for Phase 1 of EMIS to Meditech transformation for Community Physiotherapy and OT



AREAS OF CONCERN

- Waiting time for ND assessments continue to be a significant area of concern and time to triage has also deteriorated further in July (62%)
- Was Not Brought rates continue to be a challenge across a number of services (14%)
- Sickness absence rates have increased for a further month (7%)
- Rate of PDR compliance below level required



FORWARD LOOK (WITH ACTIONS)

- Complete capacity and demand bid for additional ND capacity as part of C&M ND Improvement programme (Aug 2026)
- Deep dive into areas with high levels of sickness absences, support managers with improvement actions and training where needed to ensure compliance with policies
- Monitor impact of Phase 1 EMIS to Meditech and plan for roll out to next service (Autumn 2026)

Neighbourhood, Public & Mental Health

Financial KPI Summary



1. KEY HIGHLIGHTS

- ✓ CIP risk adjusted forecast: £3.4m against target of £3.4m
- ↓ CIP in-year gap: -£25.0k
- ↑ ERF YTD actual: £835.0k vs target £673.0k (variance: +£162.0k)
- ↑ I&E in-month actual: -£2.7m vs plan -£3.0m (variance: +£258.0k)
- ↑ I&E year-end forecast: -£31.9m vs plan -£33.9m (variance: +£2.0m)
- 📄 Recurrent risk adjusted forecast: £3.1m
- ↓ Recurrent gap: -£287.0k



Temporary Spend Measures

👤 Agency Forecast	N/A
🎯 Agency Target	N/A
⚖️ Agency Variance	N/A
🏛️ Bank Forecast	£1,133,000
🎯 Bank Target	£1,029,000
⚖️ Bank Variance	-£104,000



CIP in Year

In Year Risk Adjusted Forecast	£3,375,000
Target	£3,400,000
In Year Gap	-£25,000



Recurrent CIP

Risk Adjusted Forecast	£3,113,000
Gap	-£287,000



ERF YTD

Actual	£835,000
Target	£673,000
Variance	£162,000



I&E In Month

Actual	-£2,718,000
Plan	-£2,976,000
Variance	£258,000



I&E Year End

Forecast Actual	-£31,890,000
Plan	-£33,939,000
Forecast Variance	£2,049,000



Favourable

Positive variance or better than plan/target

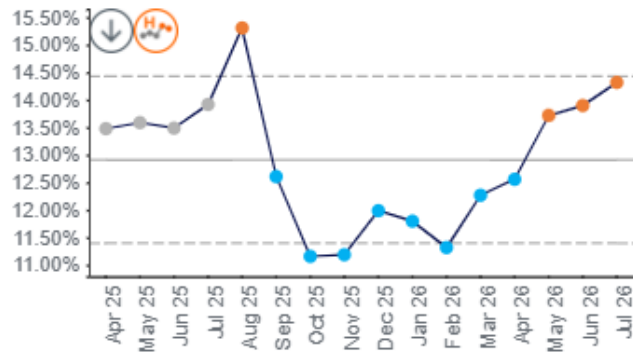


Adverse

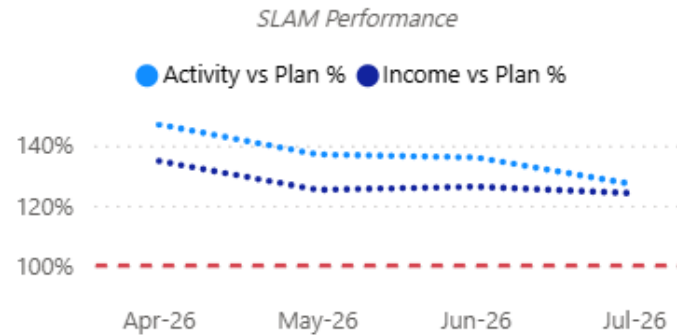
Negative variance or worse than plan/target

System Performance Summary - Neighbourhood, Public and Mental Health

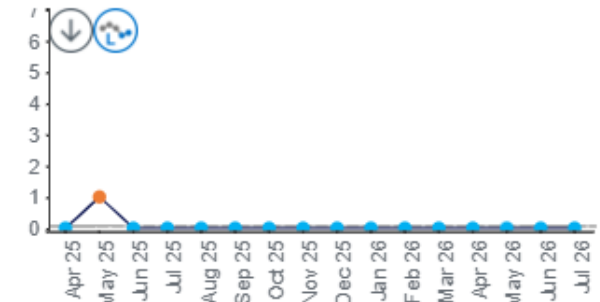
WNB Rate



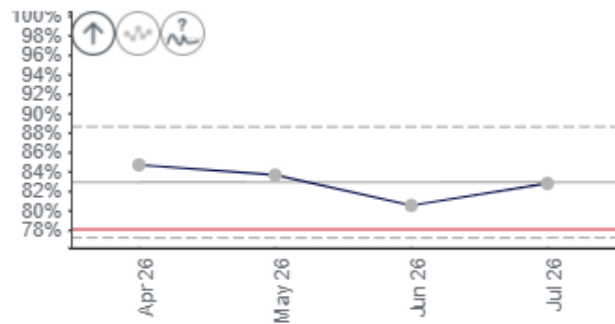
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)



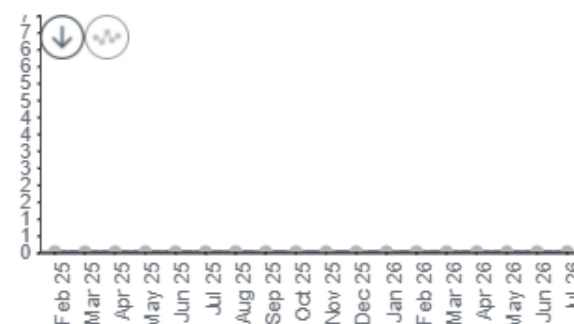
Volume of active outpatient follow up waits - 2 Years & Overdue



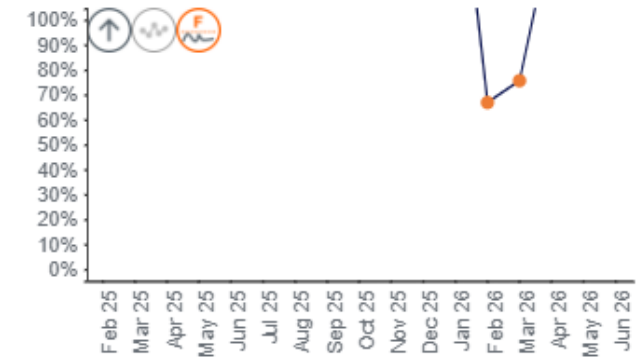
Percentage of patients waiting less than 18 weeks for Community Services



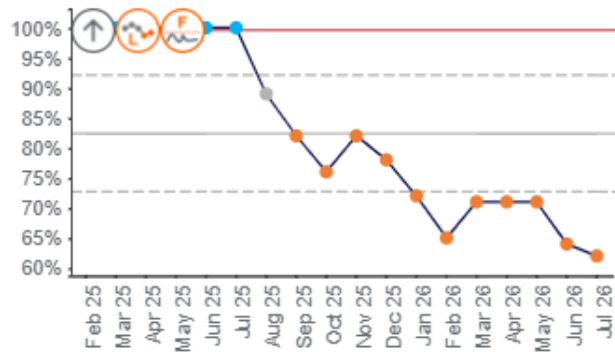
Number of Paediatric Community Patients waiting >52 weeks



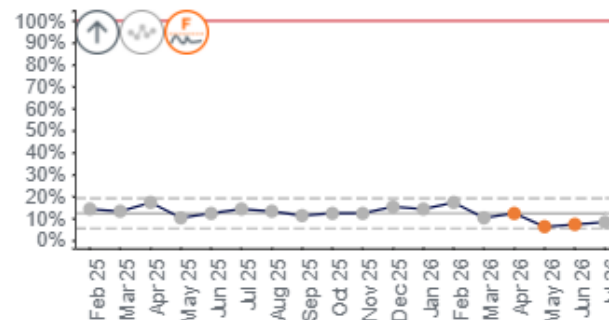
IHA: % complete within 20 days of referral to Alder Hey



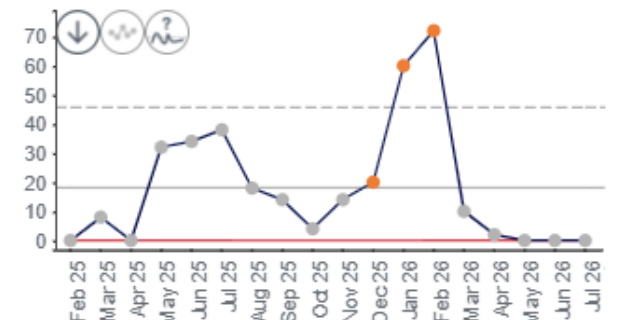
ND Assessment: % triage within 12 weeks



ND Assessment: % waiting <65 weeks for concluded diagnosis



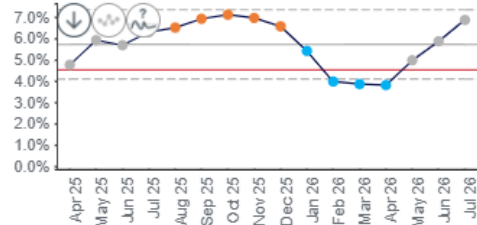
CAMHS: Number of children & young people waiting >52 weeks



System Performance Summary - Neighbourhood, Public and Mental Health

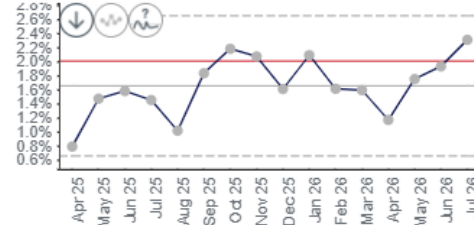
Sickness Absence Overall

Target: Internal



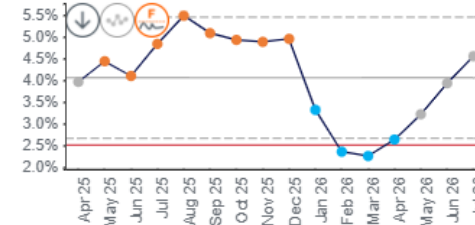
Short Term Sickness

Target: Internal



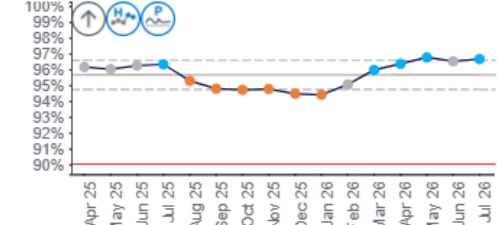
Long Term Sickness

Target: Internal



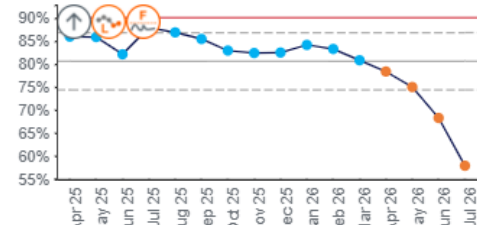
Mandatory Training

Target: Internal

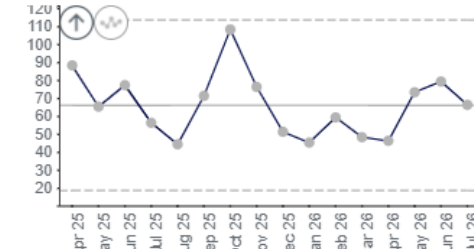


PDR's Completed

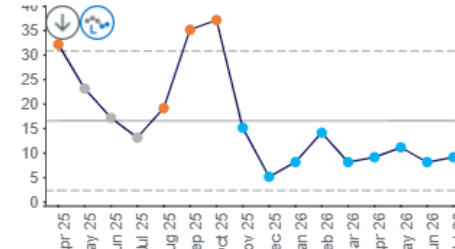
Target: Internal



No Harm Incidents

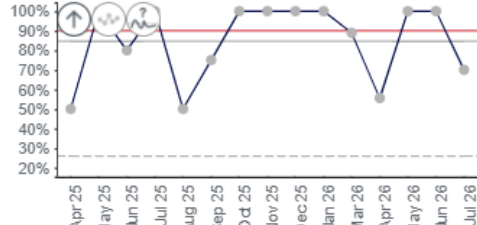


Incidents rated low harm and above



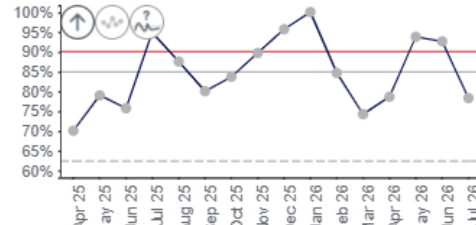
% Complaints resolved within 20 working days

Target: Internal



% PALS resolved within 5 days

Target: Internal





SRO: Urmi Das, Medical Director



HIGHLIGHTS

- Activity remains above plan YTD (+735), although activity mix continues to be reviewed.
- Strong Physiotherapy OPD New performance against plan.
- Long-term sickness continues to improve from the August 2025 peak.
- Diagnostic performance remains excellent, with 100% of patients waiting under six weeks, exceeding the 95% target.
- Outpatient New and OPPROC activity and income remain above plan, maintaining performance above 100%.
- Elective and Daycase activity and income are above plan, with income continuing to outperform activity.
- Mandatory training compliance has improved and is now close to target.
- PALS performance remains strong, with 100% of cases resolved within five days since March 2026.
- Complaints performance has improved in the most recent reporting periods following a dip in May.



AREAS OF CONCERN

- Forecast overspend of £2.1m against plan remains the key financial risk.
- Sickness absence remains above target, with an increase in short-term sickness during July.
- PDR compliance has reduced, reflecting the transition to the new system and line management structures.
- Incident reporting has increased, including both no-harm and low-harm-and-above incidents, requiring further analysis and learning.
- Workforce vacancies within the Booking & Scheduling Team are impacting outpatient capacity and activity delivery.
- Audiology remains a priority area, with a service review underway to address performance, capacity and financial sustainability challenges.



FORWARD LOOK (WITH ACTIONS)

- Continue embedding the new System operating model and performance framework, recognising this is the first reporting cycle under the new arrangements.
- Deliver financial recovery actions to improve the forecast £2.1m overspend position.
- Improve PDR compliance as new line management and reporting structures become established.
- Review sickness absence, workforce capacity and Booking & Scheduling vacancies to support activity delivery.
- Complete the Audiology service review and implement agreed improvement actions.
- Strengthen oversight of incidents, waiting lists and activity performance to support sustainable improvement and assurance.
- Work with Neighbourhoods system to ensure safe transition of services through EMIS to Meditech (Community SaLT).

Personalised Care, Therapeutics & Diagnostics

Financial KPI Summary



1. KEY HIGHLIGHTS

- ↓ CIP risk adjusted forecast: £3.2m against target of £4.6m
- ↓ CIP in-year gap: -£1.4m
- ↑ ERF YTD actual: £3.7m vs target £3.6m (variance: +£87.0k)
- ↓ I&E in-month actual: -£3.9m vs plan -£3.8m (variance: -£132.0k)
- ↓ I&E year-end forecast: -£48.3m vs plan -£46.1m (variance: -£2.2m)
- 📄 Recurrent risk adjusted forecast: £3.7m
- ↓ Recurrent gap: -£892.0k



Temporary Spend Measures

👤 Agency Forecast	£210,000
🎯 Agency Target	£228,000
⚖️ Agency Variance	-£18,000
🏛️ Bank Forecast	£1,551,000
🎯 Bank Target	£1,085,000
⚖️ Bank Variance	£466,000



CIP in Year

In Year Risk Adjusted Forecast	£3,193,000
Target	£4,596,000
In Year Gap	-£1,403,000



Recurrent CIP

Risk Adjusted Forecast	£3,704,000
Gap	-£892,000



ERF YTD

Actual	£3,703,000
Target	£3,616,000
Variance	£87,000



I&E In Month

Actual	-£3,934,000
Plan	-£3,802,000
Variance	-£132,000



I&E Year End

Forecast Actual	-£48,283,000
Plan	-£46,110,000
Forecast Variance	-£2,173,000



Favourable

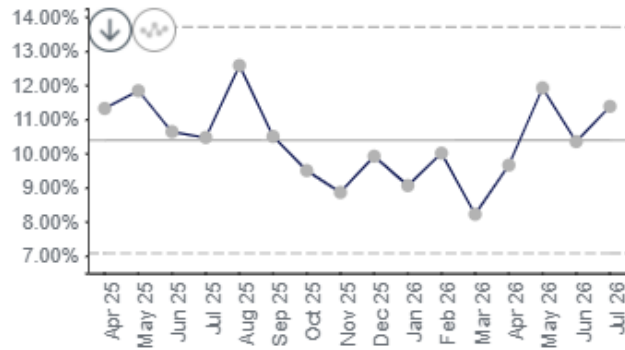
Favourable variance or better than plan/target



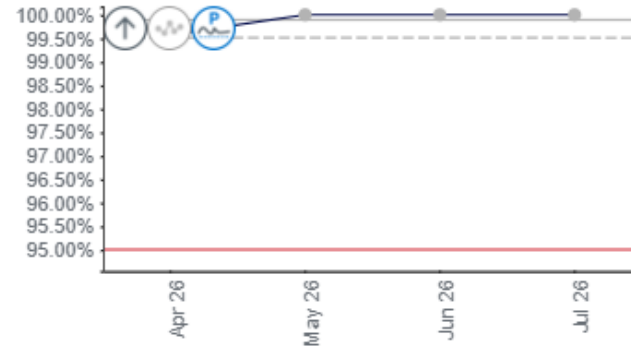
Adverse

Unfavourable variance or worse than plan/target

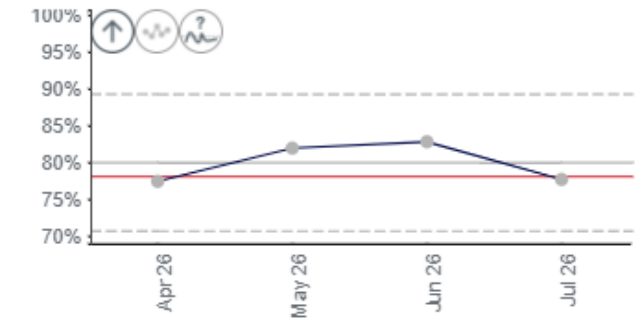
WNB Rate



Diagnostic: % waits under six weeks

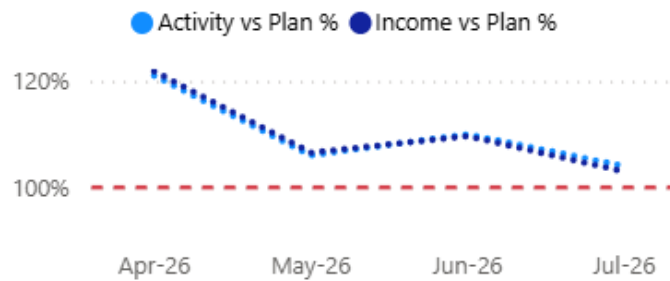


Percentage of patients waiting less than 18 weeks for Community Services



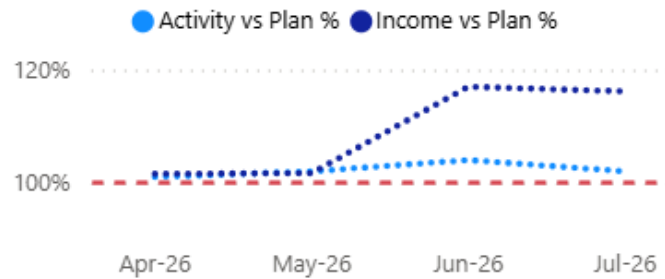
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

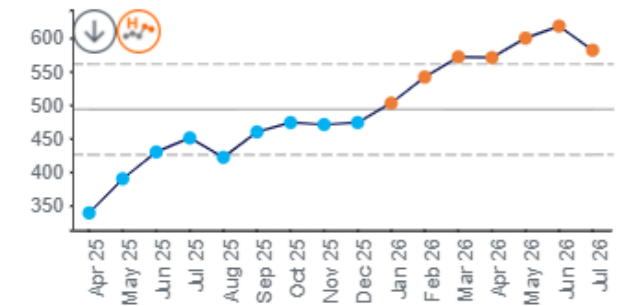


Elective & Daycase Income and Activity (Spells) vs Plan (YTD Position)

SLAM Performance



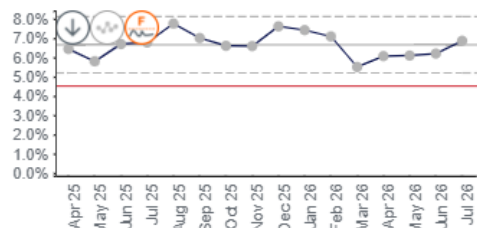
Volume of active outpatient follow up waits - 2 Years & Overdue



System Performance Summary - Personalised Care, Therapeutics and Diagnostics

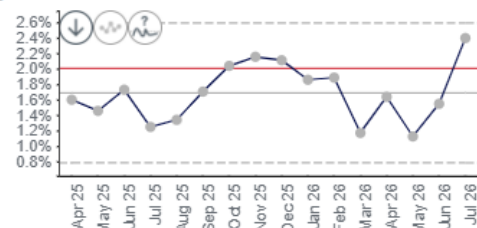
Sickness Absence Overall

Target: Internal



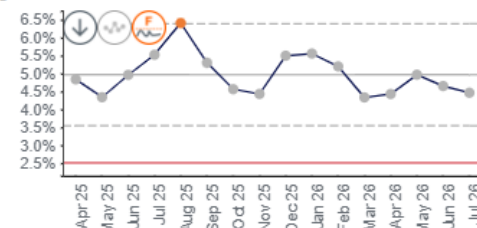
Short Term Sickness

Target: Internal



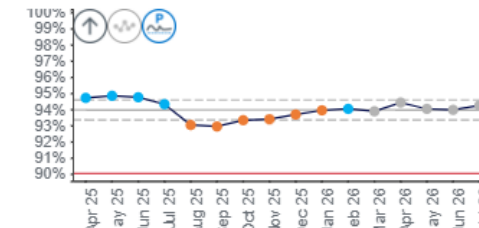
Long Term Sickness

Target: Internal



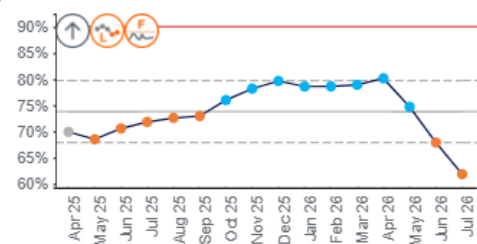
Mandatory Training

Target: Internal

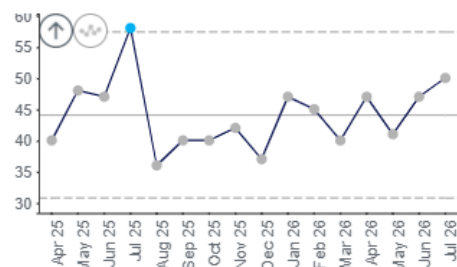


PDR's Completed

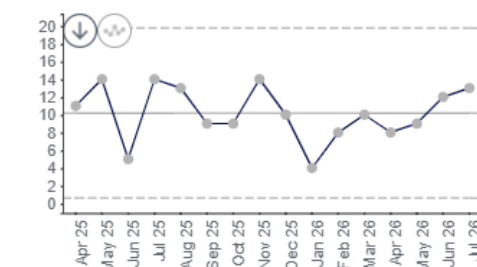
Target: Internal



No Harm Incidents

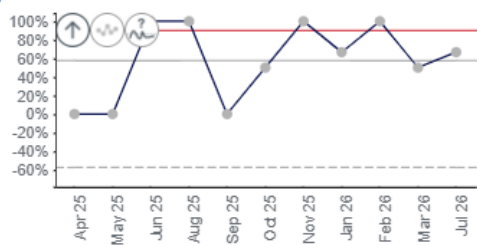


Incidents rated low harm and above



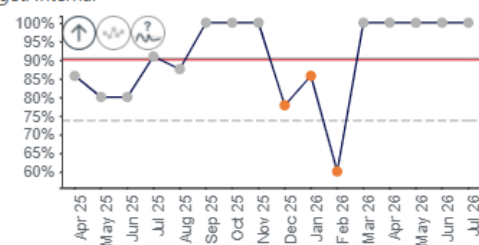
% Complaints resolved within 20 working days

Target: Internal



% PALS resolved within 5 days

Target: Internal



Q4 2025/26 NOF Segment Summary

Jun-26 Published

Trust rank

15 out of 134

Previous quarter's rank: 14 out of 134

OVERALL DOMAIN PERFORMANCE



Effectiveness &
Experience

1.00

HIGH PERFORMING

Overall Domain Segment

1



Finance &
Productivity

1.38

HIGH PERFORMING

Overall Domain Segment

1



Access to
Services

1.80

HIGH PERFORMING

Overall Domain Segment

1



Patient
Safety

2.24

ABOVE AVERAGE

Overall Domain Segment

2



People &
Workforce

2.47

ABOVE AVERAGE

Overall Domain Segment

2

PERFORMING WELL

	ED 4-hour performance % admitted, transferred or discharged within 4 hours	1.00
	Financial position Combined finance & planned surplus/deficit	1.00
	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	1.81

REQUIRES ATTENTION

	Sickness absence rate High absence impacting workforce capacity	3.57
	C. difficile infections (12 months) Above target	4.00
	Proportion of E. coli bacteraemia (12 months) Above target	3.85

PERFORMANCE BY DOMAIN – KEY METRICS

	DOMAIN & METRIC	JUN-26 PUBLISHED	MAR-26 PUBLISHED	DEC-25 PUBLISHED	TREND (vs MAR-26)	CURRENT RANK
Access to Services	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	1.81	2.11	2.27	↓	36/130
	Difference between planned and actual 18 week performance	1.00	1.00	1.00	→	11/130
	Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	2.33	2.61	2.10	↓	80/130
	Percentage of patients waiting over 52 weeks for community services	2.61	2.35	2.46	↑	39/78
	Percentage of emergency department attendances admitted, transferred or discharged within four hours	1.00	1.00	1.00	→	3/123
	Percentage of emergency department attendances spending over 12 hours in the department	1.07	1.07	1.00	→	4/122
	Annual change in the number of children and young people accessing NHS-funded MH services	2.74	2.39	1.96	↑	10/20
Effectiveness & Experience	Average number of days from discharge ready date to actual discharge date (including zero days)	1.00	1.00	1.00	→	1/128
	NHS Staff survey - raising concerns sub-score	1.20	1.05	1.05	→	10/134
Patient Safety	Number of MRSA bacteraemia cases (12 months)	2.00	2.28	2.00	↑	n/a
	Proportion of C. difficile infections (12 months)	4.00	4.00	4.00	→	n/a
	Proportion of E. coli bacteraemia (12 months)	3.85	3.70	3.68	↑	n/a
People & Workforce	Sickness absence rate	3.57	3.60	3.54	↓	130/134
	NHS Staff survey engagement theme sub-score	1.36	1.25	1.25	↑	17/134
Finance & Productivity	Combined finance	1.00	1.00	1.00	→	n/a
	Planned surplus/deficit	1.00	1.00	1.00	→	3/134
	Variance year-to-date to financial plan	1.00	1.00	1.00	→	73/134
	Implied productivity level	1.77	1.70	1.32	↑	35/134

Revolutionise Care

HWWWTIF

Digital Data, AI & Advancement

CYP System

Financial Improvement Programme

Key Messages: Oversight of the five programmes is continuing to mature, and consistency in reporting has been a priority. Digital and transformation teams are working towards standardising benefits and project documentation following FIP review. AVT Sprint group has been initiated, with feedback to COO expected in August.

Highlights

- ✓ Acute care standards have been shared across Cheshire & Merseyside
- ✓ Weekly FIP action plan reporting to Execs following assurance report
- ✓ Early conversations are positive relating to Single Point of Access for CAM. Internal SPOA engagement is required with clinical leads but key team members identified.

Areas of concern

- AVT productivity benefits realisation requires further review. Deep dive has highlighted discrepancies in delivery, and a working group has been set up to investigate.
- The outpatient department is a key stakeholder in several projects, risk to delivery due to team capacity.

Actions & Next Steps

- ❑ Standardisation between project teams underway relating to benefits realisation and project documentation
- ❑ Workshop planned for 1st September to focus on second half of 2026/27 and beyond
- ❑ Awaiting feedback from Transformation Unit. Update will come to next Transformation board, with a change in scope document.

Performance by Programme

Outcome	Prog.	Metric	Baseline	Target	July-26	Trend
Right Care, Right Time, Right Place – First Time	Revolutionise Care	% of A&E attendances who are admitted to an inpatient ward	7.3%	TBC	8.9%	↑
		% of admissions to an inpatient ward from A&E with LoS <1 day	20.9%	TBC	23.4%	↑
		Attendances to ED per 100,000 population	1,211	TBC	1,160	↓
		PCAS referrals for ages 0-5 which managed digital clinical service	TBC	TBC	TBC	TBC
		% Non-admitted RTT	73.1%	92%	73.2%	↓
		% PIFU	6.3%	10%	7.6%	↓
		% Advice & Guidance requests which do not result in an outpatient appointment	45.8%	TBC	46.8%	→
Thriving people delivering sustainable futures	HWWWTIF	WTE Position	4,215	4,000	4,189	↑
		Staff Engagement Score	7.10	7.30	N/A	→
		% of Teams who Receive Thriving Teams Data	28%	100%	28%	→

Outcome	Prog.	Metric	Baseline	Target	July-26	Trend
Advancing care for the next generation	Digital Data, AI & Advancement	% of Clinical Letters produced via AVT	80%	100%	97%	↑
		Number of AI Projects/pathways Live	5	20	5	→
		Patient Portal adoption	98.87%	70%	58.7% 56,048	↑
		Digitally enabled financial benefits	£0k	≥£500k	£45k	→
		Metrics to be scoped				
Delivering sustainable services	Financial Improvement Programme	CIP Delivery – Trust-wide	£0k	£24.6m	£17.6m	↑
		CIP – Bring me the Future	£0k	£193k	£0k	→
		CIP – Revolutionise Care	£0k	£4m	£3.15m	→
		CIP – HWWWTIF	£0k	£10.5m	£5.4m	↑
		CIP – Digital Data, AI & Advancement	£0k	£500k	£270k	→
		CIP – Financial Improvement Programme	£0k	£9.4m	£8.73m	↑

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Board Paper: NHS England Quality Strategy for NHS-Funded Care in England (July 2026)
Report of:	Nathan Askew , Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Nathan Askew

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☐
Summary / supporting information	This paper presents an overview of the recently published NHS England Quality Strategy. The new approach has implications across several functions of the trust and moves towards placing equal emphasis on safety, effectiveness and experience, reducing variation and a strong focus on reducing inequalities. The paper presents some high level implications for the organisation for the board to consider.
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:	Currently unknown

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

NHS England has published a new national Quality Strategy that establishes quality as the organising principle for all NHS-funded care over the next decade. The strategy aims to ensure consistently safe, effective and experience-led care while reducing inequalities and improving outcomes. It introduces a more systematic approach to quality management across providers, Integrated Care Boards (ICBs), regulators and national bodies.

The strategy defines quality through three interconnected domains:

- Safety
- Effectiveness
- Experience of care

and seeks to strengthen accountability, transparency, leadership capability, data utilisation, technological innovation and quality improvement methodologies.

For Alder Hey, the strategy provides significant opportunities to strengthen existing quality structures while also presenting challenges around leadership capability, quality governance, digital transformation, use of patient experience data, research participation and management of healthcare inequalities. The Board should consider how current arrangements align with the national direction and whether additional organisational investment is required to deliver the expectations set out.

The full strategy is available for board members [here](#)

2. Strategic Context

The strategy responds to findings from recent national reviews, including Lord Darzi's Independent Investigation and the Dash Review of Patient Safety, both of which identified persistent variation in quality, fragmented accountability arrangements and inconsistent use of quality data across the NHS.

Nationally, concerns remain regarding:

- Declining healthy life expectancy
- Persistent inequalities in outcomes
- Variation in management of long-term conditions
- Ongoing patient safety concerns
- Reduced public confidence in NHS services.

The strategy aligns with the NHS 10 Year Health Plan and reinforces the three major shifts:

1. Hospital to community
2. Analogue to digital
3. Sickness to prevention.

The document positions quality not as a separate assurance function but as a core organisational responsibility that must underpin planning, commissioning, operational management and service delivery. The strategy has implications across all functions including finance, access and performance, HR and OD and digital and transformation.

3. Key Quality Priorities

The strategy identifies several national priorities where the NHS should focus improvement efforts over the next decade. These include:

1. Improving Outcomes and Reducing Variation
2. National Modern Service Frameworks will be developed for:
 - Cardiovascular disease
 - Sepsis
 - Severe mental illness
 - Frailty and dementia
 - Palliative and end-of-life care
 - Children and young people's health.
3. Maternity and Neonatal Improvement
Applying recommendations from national reviews into maternity and neonatal services
4. Patient Safety

The NHS Patient Safety Strategy will be refreshed with greater emphasis on:
 - Real-time risk management
 - Early warning systems
 - Transparency
 - Learning culture
 - Risk management across care pathways.
5. Experience of Care

Patient experience will receive increased prominence through:

- Creation of a national Directorate of Patient Experience
- New complaints arrangements
- Standardised experience improvement methodologies
- Expansion of patient-reported measures.

6. Reducing Inequalities

Health inequalities are embedded across all quality domains, requiring organisations to adopt the Core20PLUS5 methodology and demonstrate improvement in access, outcomes and experience for disadvantaged groups.

4. The Ten Quality Enablers

The strategy identifies ten enabling conditions required to achieve sustainable quality improvement. These are:

1. Clear accountability
2. Prioritisation of quality improvement
3. Leadership and management capability
4. Patient and community involvement
5. Data-driven quality management
6. Transparency
7. Technology and digital maturity
8. Alignment of incentives
9. Research and innovation
10. Improvement-focused regulation.

For Boards, these enablers provide a useful framework against which local maturity can be assessed.

Of particular significance is the expectation that quality management becomes a core management discipline rather than solely a governance activity. Leaders are expected to actively monitor, improve and manage quality through robust systems and culture.

For Alder Hey, significant consideration is needed regarding the resourcing and focus of the quality improvement team, and their central role in delivering the quality enablers and overall strategic outcomes of this strategy.

The board should also note the intention to alter the incentivisation of quality through a review of current best practice tariffs (BPT's) and the creation of an additional 30 BPT's as a starting point.

The strategy provides an Annex of quality indicators. It should be noted that a significant number of these would not be appropriate for children and young people. There is potential for the Trust to help influence those indicators that would be more useful for CYP services.

As an example, the new strategy not only places a focus on the safety and effectiveness measures of those on planned waiting lists, but on the experience they have whilst waiting in terms of communication, clear information and contact from the organisation.

5. Leadership, Governance and Board Responsibilities

The strategy places significant emphasis on organisational leadership.

Boards, executives and clinical leaders are identified as being directly accountable for quality outcomes and quality management. This responsibility extends beyond assurance to include active oversight, intervention and continuous improvement.

National expectations include:

- Strong quality governance systems
- Data-driven decision-making
- Leadership development programmes
- Quality-focused organisational cultures
- Accountability frameworks linked to quality outcomes.

The new NHS Leadership and Management Framework will establish professional standards for leaders and is expected to become an important component of recruitment, development, appraisal and regulatory assessment.

Implications for Alder Hey

The Board may wish to consider:

- Alignment of Board development programmes with the NHS Leadership Framework.
- Strength of quality governance arrangements.
- Board oversight of inequalities and patient experience.
- Capability of leadership teams to utilise quality intelligence and data.
- Organisational quality culture and speaking-up arrangements.
- Organisational cultural shift in equitable emphasis across safety, effectiveness and experience.
- Strengthening whole organisation responsibility for delivering the quality strategy.

6. Implications for AlderHey: Key Areas for Focus

6.1 Quality Management Systems

A major policy shift is the introduction of Quality Management Systems (QMS) as the preferred organisational model for managing quality. The forthcoming NHS QMS Framework will encourage organisations to embed:

- Quality planning
- Quality assurance
- Quality control
- Quality improvement.

This represents an opportunity for Alder Hey to further integrate quality governance, improvement methodology and operational management.

6.2 Patient Experience and Co-Production

The strategy significantly elevates patient voice.

There is an expectation that providers use feedback, PROMs and PREMs systematically to influence service design, governance and improvement. Martha's Rule is cited as an exemplar demonstrating how patient voice improves safety outcomes.

Given Alder Hey's established commitment to family-centred care, there is an opportunity to position the Trust as a national leader in this area.

6.3 Data and Digital Transformation

The strategy commits to:

- Expanded use of AI
- Federated Data Platform adoption
- Predictive analytics
- Public transparency of outcomes
- Improved benchmarking and quality dashboards.

For Alder Hey, this supports continued investment in:

- Digital quality surveillance
- Predictive patient safety tools
- Clinical decision support
- Data-driven workforce planning
- Benchmarking of paediatric outcomes.
- Movement away from point prevalence audit to continuous real-time monitoring.

6.4 Research and Innovation

The strategy explicitly identifies research-active organisations as delivering better care and improved outcomes. Participation in research is positioned as a quality intervention rather than a discretionary activity.

This aligns strongly with Alder Hey's strategic ambition as a leading children's research organisation and provides an opportunity for further diversification of the research portfolio. This move also strengthens the need to continue to develop an organisation that is curious and seeks improvement through quality improvement, clinical audit and research.

7. Board Assurance and Recommendations

The NHS Quality Strategy represents one of the most significant developments in quality policy since Lord Darzi's original 2008 review. The emphasis moves beyond assurance and compliance towards quality management as a core organisational function.

The board should note that the strategy identifies further guidance and resources that will become available over the next 2 years relating to the specific requirements of this strategy.

For Alder Hey, the strategy is largely aligned with current priorities around patient safety, patient experience, digital transformation, health inequalities, research and workforce development. However, it also raises expectations regarding leadership accountability, use of data, quality management systems and public transparency.

Recommendations

The Board is asked to:

1. **Note** the publication of the NHS England Quality Strategy and its implications for NHS providers.
2. **Support** a gap analysis against the ten national quality enablers to assess Alder Hey's organisational maturity.
3. **Commission** a review of existing quality governance arrangements against the proposed national Quality Management System framework when released.
4. **Receive assurance** regarding the Trust's readiness in areas of patient experience, quality intelligence, digital transformation and healthcare inequalities.
5. **Consider** using the strategy as a framework for future Board quality development and organisational self-assessment.
6. **Undertake** a review of the Trust Quality Strategy and align it to the national strategy, to be reviewed by SQAC and approved at a future Trust Board.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Learning from the Nottingham Maternity Review and the National Maternity and Neonatal Investigation
Report of:	Nathan Askew, Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Nathan Askew.

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☐
Summary / supporting information	This report presents 5 overarching themes that have emerged from both the Independent review into maternity and neonatal services at Nottingham University NHS Trust and the National Independent review into maternity and neonatal services. Links to both reviews are provided in the summary and key learning for Alder Hey is presented.
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
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1. Executive Summary

The Nottingham Maternity Review and the Independent Investigation into Maternity and Neonatal Services in England identify recurring and systemic failures evident across multiple NHS reviews over many years. The reports conclude that serious harm rarely results from an isolated clinical error. Instead, harm occurs when weaknesses in organisational culture, leadership, governance, workforce planning and learning systems interact over prolonged periods.

Whilst Alder Hey does not provide maternity services, the themes identified are directly applicable to specialist paediatric services and to NHS boards more generally. Several of the failings described in the reports relate not to clinical practice itself but to the effectiveness of board oversight, organisational culture, assurance systems and the ability of organisations to hear and respond to concerns.

The purpose of this paper is therefore not to review maternity services but to consider the lessons for Alder Hey and the questions the Board should ask of itself.

Board members would be encouraged to read the executive summaries of both reports, which can be accessed at the following links:

[Nottingham Maternity Review](#)

[National Maternity Review](#)

2. Introduction

There is considerable learning and cross-cutting themes between the two reports, which are mirrored in other national investigations into maternity services. Below is a summary of 5 consistent themes for the board to consider.

a. Theme One: Listening as a Safety Intervention

A consistent finding across both reviews was that patients, families and staff repeatedly raised concerns which were either not heard, not believed, or not acted upon. Both reports conclude that the inability of organisations to listen effectively became a direct contributor to patient harm.

The Nottingham review opened with the experience of the Hawkins family whose daughter, Harriet, died before birth. The review describes almost ten years of delay, inadequate investigations, poor communication and failures by multiple organisations to provide honest answers following an avoidable death. The review team specifically highlighted the family's experience because it illustrated how organisational failure can continue long after the original clinical incident.

More than 2,000 families contributed evidence to the review. Common themes included women feeling unheard, excluded from decision-making, inadequately informed and unsupported when raising concerns about reduced foetal movements, emerging complications or deterioration. Families repeatedly reported that they knew something was wrong but felt their concerns had been dismissed.

The national investigation identified the same issue nationally and concluded that listening to women and families should be treated as a patient safety intervention rather than solely an experience measure. It recommended that information relating to patient voice should be considered safety intelligence and reviewed through board governance structures.

Learning for Alder Hey Board

The reports suggest that:

- Complaints may represent early warning indicators of safety concerns.
- Patient experience data should be viewed alongside other quality and safety intelligence.
- Organisations must be able to demonstrate not only that concerns are heard, but that action follows.
- Strengthening alternative routes of feedback such as Martha's Rule would allow for increased responsiveness to families' concerns in real time.

b. Theme Two: Evidence-Based Assurance Rather Than Reassurance

One of the most significant findings from the Nottingham review was that many concerns were known for years but failed to generate meaningful organisational action. Six external reviews between 2015 and 2022 raised concerns regarding culture, governance and safety, yet many of the same issues remained evident in 2026.

The review found incidents that were not investigated appropriately, delays in reporting serious events, repeated failures in Duty of Candour and recurring examples where lessons were identified but not embedded into practice. Board papers frequently provided reassurance that actions were underway, yet there was limited evidence that risk had reduced.

The review specifically criticised insufficient board curiosity and challenge, highlighting examples where serious concerns remained within committees and were never escalated effectively to the Board. Executive leaders sometimes provided reassurance rather than evidence-based assurance.

The national review identified similar concerns, describing fragmented governance, unclear accountability and an inability of existing structures to identify deteriorating performance early enough.

Learning for Alder Hey Board

The reports challenge Boards to ask:

- *"What evidence demonstrates improvement?"*, rather than: *"Has the action plan been completed?"*
- Assurance should be evidenced through measurable improvement in outcomes, culture and experience.
- The effectiveness of committees to explore and escalate issues where there remain gaps in assurance.

c. Theme Three: Culture is a Safety Issue

The Nottingham review concluded that culture was not simply a workforce issue but a principal cause of unsafe care. More than 40% of staff reported witnessing or personally experiencing bullying, while staff described fear of speaking up, intimidation, poor psychological safety and concerns being ignored by leaders.

The review found examples of intimidating cliques, long-standing conflict within teams and a perception that inappropriate behaviours were known but not addressed. Staff described managers as invisible, unapproachable and unresponsive to concerns.

The national investigation echoed these findings. Staff reported feeling blamed when things went wrong, experiencing racism and discrimination, lacking visible leadership and feeling unable to influence decisions regarding safety and service delivery.

A particularly powerful conclusion from the Nottingham review was that workforce shortages alone did not explain poor outcomes. Rather, unsafe outcomes occurred when workforce pressures operated within a culture that prevented people from speaking up and escalating concerns.

Learning for Alder Hey Board

The reports reinforce that:

- Psychological safety is a patient safety control.
- Speaking up culture influences organisational learning.
- Staff experience and patient outcomes are closely connected.

d. Theme Four: Learning Systems Must Demonstrate Impact

Perhaps the most concerning finding from Nottingham was the recurrence of similar incidents over many years. The review found examples where investigations were delayed, poorly executed or failed to result in sustained improvements. Families were repeatedly told that lessons had been learned, yet similar harms continued to occur.

The review described multiple examples of:

- Incident under-reporting.
- Incident misclassification.
- Delayed investigations.
- Failure to learn from previous reviews.
- Failure to translate recommendations into practice.

The national investigation identified similar weaknesses nationally and recommended stronger investigation standards, specialist investigator training and clearer oversight of recommendation implementation.

The reports collectively argue that organisations often measure activity instead of learning. Investigations alone do not improve safety unless they result in demonstrable change.

Learning for Alder Hey Board

The key question is whether learning systems can demonstrate impact.

Examples include:

- Has recurrence reduced?
- Have outcomes improved?
- Can teams evidence behavioural and practice changes following investigations?

e. Theme Five: Workforce Pressures and Organisational Resilience

Workforce pressures were central to both reports. In Nottingham, only 11% of staff believed staffing levels were sufficient to meet demand safely. Staff described routinely working beyond safe capacity and having insufficient time for training, supervision and improvement activity.

The review linked staffing pressures to missed observations, delayed escalation, poor monitoring, reduced oversight and workforce burnout. In neonatal services, shortages resulted in staff prioritising essential tasks over comprehensive care.

The national review similarly described chronic staffing shortages, rota gaps, high absence levels and insufficient protected learning time. It highlighted workforce models that had not kept pace with increasing patient complexity and demand.

Importantly, neither review suggested workforce numbers alone were responsible. Rather, workforce pressures became dangerous when combined with poor governance, inadequate leadership and ineffective cultures.

Learning for Alder Hey Board

Workforce reviews should not focus on establishment reviews alone and increasingly need to consider:

- Safety indicators and the effectiveness of the care given
- Staff wellbeing and morale.
- Training capacity.
- Leadership capability.
- Future service demand.

3. Concluding Reflection for the Board

The strongest lesson from both reports is that the warning signs were visible long before the adverse outcomes became nationally recognised. Families complained. Staff raised concerns. Investigations highlighted weaknesses. External reviews identified recurring themes. Yet organisations were insufficiently curious, escalation was inconsistent, and assurance often focused on process rather than impact.

Boards have been asked to reflect on the overarching themes of the report and consider where oversight and governance could be strengthened in their organisations.

4. Next Steps

- The recommendations in both reports are undergoing an assessment process to align relevance to Alder Hey.
- Relevant actions will be compiled into a Trust-wide action plan.
- The action plan will be presented to SQAC where progress can be monitored.
- Consideration will be given to how the Trust adapts its approach to Quality oversight in line with the recently published NHS Quality Strategy.

5. Recommendations

The board are asked to:

- Note the content of this report
- Approve the next steps and indicate any future reporting requirements to the board
- Invite the board to discuss the themes and any areas where oversight could be strengthened.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Safeguarding Children and Adults at Risk Annual Report 2025-26
Report of:	Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Director of 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 2025 to 31 March 2026, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk. Trust Board is requested to ratify the report, note the key risks requiring continued oversight and support the proposed safeguarding priorities for 2026/27.
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		12
271	Safeguarding Nursing Team Capacity		15
288	CAMHS Planned Safeguarding Supervision		15
529	Named Doctor for Safeguarding		20
539	Multi-Agency Partnership Working		15
540	Safeguarding Admin Capacity		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

Safeguarding Children and Adults at Risk Annual Report 2025-2026

Safeguarding and Statutory Services



Contents	Page Number
Executive Summary	4
Introduction	6
Alder Hey and Safeguarding Commissioning Arrangements	6
Legislative Frameworks for Children, Young People and Adults at Risk • Legislation, statutory and recommended guidance for all ages • Safeguarding Legislation Specific to Children and Children in Care • Safeguarding Legislation Specific to Adults	7
Alder Hey Safeguarding Governance Arrangements • Named Professionals for Safeguarding • Internal and External Assurance Reporting Arrangements	10
Safeguarding Service Structure • Safeguarding Child Protection Peer Review • Child Sexual Abuse Peer Review	13
Safer Recruitment Practices and Managing Allegations Against Staff	16
Safeguarding Training	17
Multi-Agency Safeguarding Processes Multi-Agency Safeguarding Hub (MASH)	21
Statutory Safeguarding Inquiries and Reviews • Domestic Abuse Related Death Review (DARDR), • Safeguarding Adult Reviews (SARs) • Safeguarding Rapid Reviews & Local Child Safeguarding Practice Reviews (LCSPRs)	23
Channel Panel	26
Safeguarding Team Meditech Orders	26
Successes During 2025/26 • Safeguarding Digital Project • Safeguarding Supervision Review • Improving Child Death Statutory Processes	28
Challenges During 2025/26 • Workforce Sustainability and Capacity • Balancing Operational Delivery and Service Improvement • Contributions to Local Safeguarding Adult Boards (LSABs), Local Safeguarding Children's Partnership (LSCPs) and Local Authorities Families First Reforms	30
Safeguarding Priorities for 2026/27 • Workforce Sustainability and Statutory Leadership • Governance, Partnerships and System Interfaces • Digital Transformation, Intelligence and Assurance • Implementation of Fuller Inquiry Phase 2 Recommendations	31
Conclusion	31
Appendix 1 – Alder Hey Children's NHS Foundation Trust Safeguarding and Statutory Services Governance Chart	33

This annual report provides assurance to the Safety and Quality Assurance Committee and Trust Board regarding Alder Hey Children's NHS Foundation Trust's safeguarding arrangements for children, young people and adults at risk for the period 01 April 2025 to 31 March 2026. It summarises the work completed by the Safeguarding Team within Safeguarding and Statutory Services and demonstrates how the Trust has continued to discharge its statutory safeguarding responsibilities through established governance, specialist leadership, multi-agency working, training, supervision, audit and continuous improvement activity.

The report draws on the quarterly safeguarding assurance reports received by the Safeguarding and Statutory Services Assurance Group (SASSAG) and the Safety and Quality Assurance Committee (SQAC). It therefore provides a consolidated annual position, rather than a detailed repetition of quarterly activity, with a focus on the key areas of assurance, progress, risk and forward priorities for 2026/27.

Key areas of progress and strengthened assurance during 2025/26 include:

- **Digital transformation of safeguarding processes**, including the move from manual spreadsheets to Meditech-based recording for key safeguarding activity, improving data quality, visibility and the ability to use intelligence to support assurance.
- **Review and strengthening of safeguarding supervision**, supporting staff to access advice, reflection and professional challenge in relation to complex safeguarding decision making.
- **Improvement of statutory child death processes**, including work to strengthen Trust-wide policy, internal coordination and statutory notification arrangements.

The report also identifies a number of challenges that require continued senior leadership oversight and action:

- **Workforce sustainability and capacity**, including the requirement to maintain statutory safeguarding leadership and specialist capacity during periods of vacancy, sickness and increasing demand.
- **Balancing operational delivery and service improvement**, as the team continues to respond to high-volume safeguarding activity while progressing improvement work, audit, digitalisation and assurance requirements.
- **Increasing external partnership and statutory reform requirements**, including contributions to Local Safeguarding Children Partnerships, Local Safeguarding Adult Boards, Local Authorities and Families First reforms.

Overall, the report provides **partial assurance**. There is evidence of established safeguarding governance, clear reporting routes, specialist advice and multi-agency engagement, alongside demonstrable improvement activity during the year. However, assurance is moderated by ongoing workforce risks, below target Level 3 safeguarding training compliance, the requirement to sustain improvement alongside operational demand, and the need to maintain pace in response to evolving local and national safeguarding expectations.

The Safeguarding Team continues to ensure that safeguarding remains visible across the Trust and that children, young people and adults at risk are supported through clear processes,

specialist oversight and partnership working. The report highlights that safeguarding practice continues to evolve in complexity and scope, including in relation to contextual safeguarding, child death processes, statutory review activity, domestic abuse, Prevent, serious youth violence and emerging expectations following national inquiries and reforms.

The safeguarding priorities for 2026/27 are therefore focused on strengthening resilience, improving assurance and ensuring the Trust remains responsive to statutory, regulatory and partnership requirements. These priorities are:

- Workforce Sustainability and Statutory Leadership
- Governance, Partnerships and System Interfaces
- Digital Transformation, Intelligence and Assurance
- Implementation of Fuller Inquiry Phase 2 Recommendations

SQAC is asked to approve the report and note the areas of assurance, the key risks requiring continued oversight, and the proposed safeguarding priorities for 2026/27.

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 2025 to 31 March 2026, 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 2025/2026 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. The Safeguarding Accountability and Assurance Framework (SAAF) (NHS England, 2026) clearly states that *"Every NHS-funded organisation, and each individual employee, contractor, trainee, volunteer and healthcare professional working in the NHS, has a responsibility to ensure that the principles and duties of safeguarding children and adults are applied holistically, consistently and conscientiously. These principles and duties should extend to unborn children as per the Child Protection Information System, and deceased people as recommended in the Independent Inquiry into the issues raised by the David Fuller Phase 2 report. **The wellbeing of children and adults remains at the heart of everything we do**"* (page 3).

Alder Hey and Safeguarding Commissioning Arrangements

7. Alder Hey Children's NHS Foundation Trust 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.
8. Alder Hey employs a workforce of over 4000 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.

9. 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).
10. 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

11. Safeguarding children and young people and promoting their welfare is outlined in Working Together (2026) as:
 - Providing help and support to meet the needs of children as soon as problems emerge.
 - Protecting children from maltreatment, whether that is within or outside the home, including online.
 - Preventing impairment of children's mental and physical health or development.
 - Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
 - Promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
 - Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework:
 - Outcome 1 - Children, young people and families stay together and get the help they need
 - Outcome 2 - Children and young people are safe in and outside their homes
 - Outcome 3 - Children and young people are supported by their family network
 - Outcome 4 - Children in care and care leavers have stable, loving homes

12. Child protection is part of safeguarding and promoting the welfare of children. It is defined by Working Together (2026) *"as activity that is undertaken to protect specific children who are suspected to be suffering, or likely to suffer, significant harm. This includes harm that occurs inside or outside the home, including in foster care and residential care, as well as online"* (page 6).
13. Working Together (2026) clearly outlines that effective safeguarding is anti-discriminatory and anti-racist. It is vital that those working with children, young people and their families understand and are sensitive to factors, including economic and social circumstances, ethnicity and disability, which can impact children and families' lives.
14. It is acknowledged that successful outcomes for children are dependent on strong partnership working between parents and carers and the practitioners working with them. It is vital that practitioners adopt a child-centred approach to meeting the needs of the whole family when engaging in safeguarding work.

Safeguarding Adults at Risk

15. 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.
16. 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.
17. 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.

18. Regardless of the developing context, all health organisations are required to adhere to the following arrangements and legislation (NHS England, 2026):

Legislation, statutory and recommended guidance for all ages	
• European Convention on Human Rights • Mental Health Act 1983 • Human Rights Act 1998 • The Crime and Disorder Act 1998 • Female Genital Mutilation Act 2003 • Sexual Offences Act 2003 • Mental Capacity Act 2005 • UN Convention on the Rights of Persons with Disabilities 2006 • Equality Act 2010 • Children and Families Act 2014 • Modern Slavery Act 2015 • Serious Crime Act 2015 • NHS Constitution and Values (updated Jan 2021) • Domestic Abuse Act 2021 • Multi-agency statutory guidance for dealing with forced marriage and multi-agency practice guidelines. • Health and Care Act 2022 • Serious Violence Duty 2023 • Prevent Duty 2023 • Online Safety Act 2023 • Victims and Prisoners Act 2024	
Safeguarding Legislation Specific to Children and Children in Care	
• United Nations Convention on the Rights of the Child 1989 • Children Act 1989 • Children Act 2004 • Children and Social Work Act 2017 • Child Death Review – Statutory and Operational Guidance 2018 • Marriage and Civil Partnership (Minimum Age) Act 2022 • Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff • Working Together to Safeguard Children 2026 • Safeguarding and child protection in the Children and Young People Secure Estate 2023 • Children Social Care Reforms	
Safeguarding Legislation Specific to Adults	
• The Care Act 2014 • Care and Support Statutory Guidance- Section 14 Safeguarding • Adult Safeguarding: Roles and Competencies for Health Care Staff 2024	

19. 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.
20. The Chief Nursing, Allied Health Professionals (AHP) & Experience Officer is the identified Trust Board Executive Lead for safeguarding children and safeguarding adults at risk, with the Chief Executive retaining overall statutory responsibility.
21. 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 (SAAF) and the Safeguarding Children, Adults and Children in Care Intercollegiate Documents. This includes executive responsibility in relation to:
 - Prevent Duty
 - Modern Slavery
 - Child Protection Information Sharing System (CP-IS)
 - Domestic Violence Duty
 - Serious Violence Duty
22. The Chief Nursing, AHP & Experience Officer acts as the Executive Strategic Lead for Domestic Abuse and Sexual Violence (DASV) and leads the Trust in the delivery of all the principles in the Sexual Safety in Healthcare Organisation Charter.
23. In addition, the Chief Nursing, AHP & Experience Officer assumes executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores in line with the recommendations of Independent Inquiry into the issues raised by the David Fuller case Phase 2 Report published on 15 July 2025.
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 (SOG) was established 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 is required to have an identified Named Nurse and Named Doctor for Safeguarding in line with the requirements of all NHS Providers as set out on page 8 of the NHS Safeguarding Accountability and Assurance Framework (SAAF) (NHS England, 2026).
33. The Associate Director for Safeguarding and Statutory Services leads the Named Professionals in their statutory responsibilities to ensure Trust safeguarding arrangements are robust.
34. 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.
35. In May 2025 the Trust recruited an additional Named Nurse for Safeguarding following investment with a specific remit to support the Northwest Children and Young People Gender Service (CYPGS) in line with contractual requirements for this service. This post whilst primarily supporting the CYPGS also has a wider role to support Community and Mental Health Services across the Trust.
36. In August 2025 a new Named Nurse for Safeguarding joined the service following the promotion of the previous post holder.
37. Both Named Nurses for Safeguarding work collaboratively to ensure the Named Nurse statutory functions are fulfilled on behalf of the Trust.
38. The Named Doctor for Safeguarding left the Trust in Quarter 4 of 2025-26 and this statutory role will go out to recruitment in Quarter 1 of 2026/27. The gap in this statutory role has been added to the service risk register.

39. 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

40. Health Providers are required under statute and regulations 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.
41. Providers must demonstrate that safeguarding is embedded at every level in their organisation, with effective governance processes evident. In addition, providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working (NHS England, 2026).
42. A Safeguarding Annual Report is provided to Trust Board following approval at SQAC. The Safeguarding Quarterly Reports are provided to SASSAG, and SQAC for scrutiny and oversight as part of our safeguarding governance arrangements.
43. 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

44. Data and quality analysis are provided quarterly to Designated Safeguarding Professionals at Sefton Place who act as 'Lead Commissioner' in line with commissioning arrangements and safeguarding contractual standards. Regular feedback regarding the level of assurance and quality of key performance indicator (KPI) submissions are provided by Designated Safeguarding Professionals at quarterly Business Meetings with the Associate Director for Safeguarding & Statutory Services and Named Safeguarding Professionals.
45. Designated Nurses for Safeguarding at C&M ICB are invited to attend SASSAG where there is discussion regarding the quality of KPI submissions. Their attendance supports openness, transparency and good working relationships between the Trust and our Commissioners.

Cheshire & Merseyside ICB Commissioning Standards

46. 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*'.
47. 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 2014.

48. The Safeguarding Team populated the audit tool with the support of relevant corporate and divisional colleagues to gather the appropriate evidence.
49. 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
50. The Safeguarding Team completed an audit tool in Quarter 4 of 2025/26 with scrutiny meetings with Designated Safeguarding Professionals subsequently taking place where evidence was reviewed against all standards. Feedback from C&M ICB will be provided in Quarter 1 2026/27 and an action plan will be developed by the Safeguarding Team to address any 'red' or 'amber' rated standards.
51. The Commissioning Standards Action Plan will be 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

52. 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.
53. The Safeguarding Team works from the Rainbow Centre and is known widely across the Trust as the 'Rainbow Team'.
54. 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.
55. The Safeguarding Team supports the training and development of our workforce in respect of safeguarding to recognise and respond to abuse and safeguard children, young people, and adults at risk in the Trust's care at the earliest opportunity. They also provide a range of support and safeguarding supervision to enable safe decision making.
56. 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 works collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

57. 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.
58. 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. There are two dedicated examination suites, one child protection medical examination suite with a dedicated waiting room and a SARC forensic examination pod with dedicated waiting room along with office space and multi-agency meeting areas. The Rainbow Centre provides a calm, caring environment where children who are suspected of being abused can be medically and forensically examined and supported.
59. The Rainbow Centre is a dedicated examination centre and child protection service. Our doctors are supported by health care assistants and nurses, who 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.
60. 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.
61. The Safeguarding Team works closely with Unscheduled Care, Burns and Plastics, Critical Care, Major Trauma, Gastroenterology, Orthopaedics, Paediatric Surgery, Neurosurgery, Oncology, Ophthalmology, Radiology, Community Specialist Mental Health Services and Medical Photography colleagues in the management of some of the most complex child protection investigations within the region.
62. 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.
63. By arrangement with these Boroughs, Police and Children's Social Care, any children requiring medical examination, are referred to the Rainbow Centre at Alder Hey, to be seen by a member of the specialist safeguarding medical team.
64. For those children and young people who are hospital 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 safeguarding.
65. The specialist safeguarding medical 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 is led by the SARC Clinical Director. The SARC Clinical Director along with the SARC Nurse Manager ensures the highest standards are maintained, and that existing staff have regular training updates.

66. 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.
67. 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 in safeguarding investigations.
68. The safeguarding nurses and practitioners within the team provide safeguarding supervision to nursing and allied health professional groups on all aspects of safeguarding. They also provide support should staff be required to produce a court report or attend court.
69. The team also delivers all face-to-face Level 3 safeguarding mandatory training across the Trust.
70. The Safeguarding Team follows the good practice principles highlighted in Working Together to Safeguard Children (2026), 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

71. 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.
72. 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. Practice in line with this has been embedded throughout 2025/26.
73. 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).
74. 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.
75. 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."

76. In addition, safeguarding clinicians attend 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

77. The Sexual Assault Referral Centre (SARC) Child Sexual Abuse (CSA) Peer Review provides a proactive culture of learning where forensic health professionals, paediatricians and clinical SARC staff can review cases, discuss procedures, processes and the evidence base underpinning diagnosis and management.
78. CSA Peer Reviews are held bi-monthly with the safeguarding clinical team and the Forensic Medical Examiners (FMEs).

Safer Recruitment Practices and Managing Allegations Against Staff

79. 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.
80. 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.
81. 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.
82. Once employed, all staff are subject to DBS checks every three years during their employment with the Trust.
83. 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 (2026), LSCPs and LSABs policies and procedures.
84. 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.
85. 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.

86. 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 offence 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.

87. The above-named procedures are overseen and managed by the Director of Safeguarding and Statutory Services in collaboration with the Deputy Chief People Officer, with relevant senior leaders informed in the event of a concern.

88. Senior leaders then decide 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 Position of Trust (PiPoT) with adults with care and support needs protocol.

89. The senior nursing team for Safeguarding and Statutory Services attend LADO meetings along with senior HR colleagues on behalf of the Trust. This can include LADO processes for staff who are employed by other NHS providers but have worked on the Alder Hey site. The senior nursing team for Safeguarding and Statutory Services contributed to 20 LADO processes in 2025-26.

Safeguarding Training

90. 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.

91. The Trust is required to maintain safeguarding training compliance for all staff at 90% and this forms part of safeguarding KPIs set by C&M ICB.

92. The NHS England SAAF (2026) 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:

- Intercollegiate document: Safeguarding children and young people & children and young people in care: Competencies for health care staff (2025)

- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).

93. 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 contribute to the delivery of the Trust face-to-face induction day for all new staff.
94. 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 (2026).
95. The Intercollegiate Documents provide a comprehensive framework to indicate the level of safeguarding training required for individual staff groups.
96. Level 1 and 2 safeguarding children training and safeguarding adult 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 3 safeguarding adults are offered training face to face in person to maintain their compliance.
97. Compliance for safeguarding training has been as follows throughout 2025/2026:

Alder Hey Children's NHS Foundation Trust Overall Safeguarding Training Percentage % Compliance Rates				
Training Level (Target Compliance 90%)	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Level 1 Safeguarding Adults (Every year)	92.23%	94.10%	95.0%	95.8%
Level 2 Safeguarding Adults (Every 3 years)	92.75%	93.25%	90.6%	92.2%
Level 1 Safeguarding Children (Every year)	88.86%	92.71%	93.8%	95%
Level 2 Safeguarding Children (Every 3 Years)	93.03%	93.46%	86.7%	88.7%
Level 3 Safeguarding Children & Adults (Every 3 Years)	85.79%	84.32%	85.1%	84.0%

98. The overall Trust compliance figure for Level 1 and Level 2 safeguarding adult training remained well within the required compliance range of **90%** for the entirety of the year.
99. Level 1 safeguarding children training compliance demonstrates a positive improvement trajectory, increasing from 88.86% in Quarter 1 to 95% in Quarter 4. This indicates that actions to improve compliance have had a positive impact and that the Trust moved from a below-target position to a position of stronger assurance by year end.
100. Level 2 safeguarding children compliance reduced significantly in Quarter 3, falling from 93.46% in Quarter 2 to 86.7% in Quarter 3. Although there was some improvement in Quarter 4 to 88.7%, compliance remained below the Trust target. This is attributed to work completed to ensure all staff across the Trust are aligned to the correct

safeguarding training modules. It is anticipated that Level 2 safeguarding children training will be back within the target compliance by Quarter 1 of 2026-27.

101. Level 3 safeguarding training remains below the 90% compliance target and currently sits at **84%**. Work completed to improve this position is outlined below.
102. Safeguarding Level 3 Training Delivery in 2025/26 (see table below):

Safeguarding Training 2025/26	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	3	2	2	2	3	0	3	2	2	2	2
Total number of staff trained per month	76	99	68	60	74	121	-	115	53	76	73	67
Total number of cancelled places	9	34	24	21	22	30	-	20	21	12	12	21
Total number of did not attend on the day of training	17	32	18	24	16	20	-	27	24	13	14	17
Total number of staff trained per quarter	243			255			168			216		
Total number of staff trained	882											
Total number of cancelled places	226											
Total number of 'did not attend' on the day of training	139											

103. During 2025/26, Level 3 safeguarding training was delivered across 25 sessions, with 882 staff trained. Attendance was broadly maintained across the year, with the highest quarterly attendance in Quarter 2, when 255 staff were trained, and the lowest in Quarter 3, when 168 staff were trained.
104. Quarter 3 was affected by no training sessions being delivered in October, however additional sessions were planned in September and November to offset the impact.
105. Average attendance per session remained relatively consistent across the year, ranging from approximately 34 to 36 staff per session, suggesting that when sessions were delivered, uptake remained stable.

Improvements - Safeguarding Training Booking Process

106. The Safeguarding Team worked closely with the Learning and Development Team in 2025/26 to modernise the safeguarding training booking process. All staff can now book onto Level 3 safeguarding training directly via their Electronic Staff Record (ESR). Full instructions are outlined on the Trust intranet.

107. This has reduced the workload of both teams by reducing the manual administration for training bookings and allowing staff to choose dates that are most suitable for them.
108. Improvements have been made to the safeguarding training compliance reports by Learning and Development colleagues. The reports can now be filtered to provide information regarding which staff are:
- Due to become non-compliant (can be filtered by month)
 - Compliant
 - Non-compliant and booked onto a safeguarding training session (date provided)
 - Non-compliant
109. These improvements have allowed the Safeguarding Team and divisional leaders to quickly identify which staff are not compliant and haven't booked onto a training date.

Improvements - Safeguarding Training Delivery

110. In 2025/26 882 staff were trained in Level 3 safeguarding compared to 805 staff in 2024/25.
111. The Safeguarding Team have had significantly reduced capacity due to sickness, maternity leave and vacancies. Despite this the team have continued to prioritise delivery of Level 3 safeguarding training with no sessions being cancelled within the year.
112. To try and maximise each Level 3 safeguarding training course it was agreed with Learning and Development Team colleagues that whilst each Level 3 safeguarding training session has 40 places, the system would allow up to 50 staff to book places. It was hoped that allowing overbooking of places would help to minimise the impact of cancellations and non-attendance of staff.
113. Despite this positive change, 226 places were cancelled and 139 staff did not attend (DNA) on the day of training. This resulted in 365 places lost, which is a significant level of lost training capacity. This represents an increase in cancellations and DNAs compared with 2024/25, when there were 200 cancelled places and 95 DNAs on the day of training.
114. The Safeguarding Team have continued to highlight the reduction in staff compliance with senior leads, service leads, team leaders and individual staff. Safeguarding training compliance remains a standardised agenda item at the bi-monthly Safeguarding Operational Group (SOG).
115. Training compliance continues to be shared with Designated Professionals at Sefton as part of the KPI quarterly reporting submission and 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.

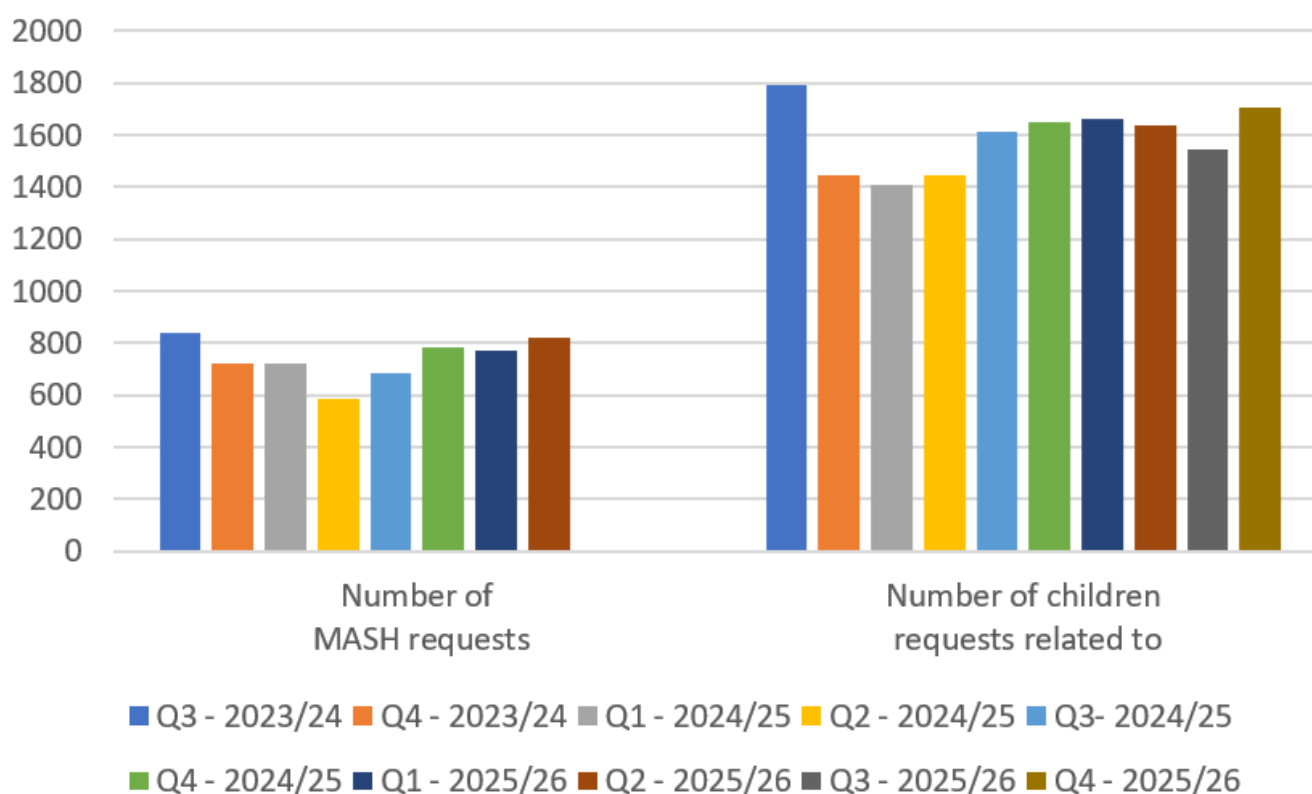
Multi-Agency Safeguarding Hub (MASH) Requests

116. 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.
117. The MASH is the front door to Children's Social Care for all child protection and immediate safeguarding concerns which bring together agencies (and their information) to identify risks to children at the earliest possible point and respond with the most effective interventions.
118. A summary of the data collated to date is outlined in the table below:

Quarter	2022/23		2023/24		2024/25		2025/26	
	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	Number of MASH Requests	Number of children requests related to
Quarter 1	-	-	730	1497	721	1409	771	1662
Quarter 2	-	-	753	1437	547	1447	823	1640
Quarter 3	503	1067	838	1792	685	1612	-	1545
Quarter 4	665	1401	719	1448	786	1652	-	1705
Total	1168*	2468*	3040	6174	2739	6120	1594*	6552

*denotes incomplete data

119. In 2025/26 the Safeguarding Team responded to **6552** MASH requests, relating to children from Liverpool, Sefton, Knowsley, Wirral and St Helens (see graph below):



125. A MASH Health Meeting is held quarterly and chaired by Designated Professionals for Safeguarding at Cheshire and Merseyside ICB to enable wider discussion with multi-agency partners.

Statutory Safeguarding Inquiries and Reviews

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

Domestic Abuse Related Death Review (DARDR)

127. A Domestic Abuse Related Death Review (DARDR), formerly known as a Domestic Homicide Review (DHR), is carried out where a person has died as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household.
128. DARDRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).
129. DARDRs are carried out by Community Safety Partnerships to ensure that lessons are learnt when a person has died as a result of domestic abuse, either by homicide or suicide. The purpose of a DARDR is to:
- Establish what lessons can be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
 - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
 - Apply those lessons to service responses including changes to policies and procedures as appropriate.
 - Prevent domestic abuse and domestic homicides and suicides and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.
130. In 2025/26 the Safeguarding Team was asked to contribute to one DARDR.

Safeguarding Adult Reviews (SARs)

131. A Safeguarding Adults Review (SAR) is a multi-agency review which seeks to determine what relevant agencies and individuals involved could have done differently, that could have prevented serious abuse or neglect or a death from taking place.
132. The Care Act 2014 requires that Local Safeguarding Adults Boards (LSABs) must arrange a Safeguarding Adults Review when:
- An adult in its area dies either as a result of abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult

- Or if an adult has not died, but the LSAB knows or suspects that the adult has experienced serious abuse or neglect

133. In 2025/26 the Safeguarding Team have not been asked to contribute to any SARs.

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

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

- a child has died or been seriously harmed
- and abuse or neglect of the child is known or suspected.

135. This may include cases where a child has caused serious harm to someone else.

136. The Rapid Review should:

- Assemble the facts of the case.
- Establish any immediate action needed to ensure a child's safety.
- Consider the potential for practice learning.
- Understand the context of the children's and families' lives, including how any inequalities related to protected characteristics may have influenced their experiences and professional practice.

137. A Rapid Review will determine whether a Local Child Safeguarding Practice Review (LCSPR) should be commissioned using the criteria set out in Working Together (2026).

138. A LCSPR is a multi-agency safeguarding review to identify improvements needed to local practice and wider systems.

139. The table below outlines the Rapid Review requests from LSCPs in 2024/25 and 2025/26:

Place Area	2024/25				2025/26			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Liverpool	3	1	4	1	2	3	2	4
Sefton	1	1	-	4	1	2	3	4
Knowsley	-	2	-	1	2	2	1	1
Cheshire West & Chester	1	-	-	-	1	-	1	0
Halton	-	1	-	-	-	-	1	0
Lancashire	-	1	-	-	-	-	-	0
Shropshire	-	-	-	1	-	-	-	0
St Helens	-	-	-	-	-	-	2	1
Tameside	-	-	-	-	-	1	-	0
Wigan	1	-	-	-	-	-	-	0
Wirral	-	-	1	-	1	-	-	0
Total by Quarter	6	6	5	7	7	8	10	10
Total by Year	24				35			

140. In 2025/26 the Safeguarding Senior Leadership Team have completed 35 Rapid Review submissions requested from Local Safeguarding Children Partnerships (LSCPs)
141. The table below shows the significant increase in the number of Rapid Review requests when the data is compared between 2023/24 and 2025/26:

Financial Year	Number of LSCPs Rapid Review Requests	% Increase/Decrease % between 2023/24 & 2025/26
2023/24	15	-
2024/25	24	↑ 60%
2025/26	35	↑ 40%

142. It is unclear why there has been a significant increase in Rapid review requests. This could be related to delivery of training across the LSCPs to increase awareness of the criteria for referral into LSCPs for Rapid Review.
143. 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 Senior Leadership Team.
144. 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.
145. 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.
146. 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.
147. In 2025/26 the Safeguarding Team have contributed to **11** ongoing LCSPRs.
148. Themes in respect of safeguarding children reviews included children living with complex and cumulative vulnerability, exploitation, need for earlier recognition and escalation of risk, information sharing and multi-agency coordination, family context and hidden harm, child sexual exploitation (CSE), serious youth violence and child criminal exploitation (CCE).
149. 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 2025/26 however most LSCPs have made significant progress in commencing LCSPRs which have been delayed.
150. 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.

151. 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

152. 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.
153. 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.
154. 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.
155. 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

156. 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.
157. The Safeguarding Team has a Meditech data dashboard which provides an overview of the demands in respect of Meditech safeguarding orders being reviewed and managed by the Safeguarding Specialist Nurses.
158. 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

159. 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.
160. In 2023/24 when **1759** Safeguarding Meditech Orders were classified as '**routine**' and **1932** were classified as '**urgent**'.
161. As part of the digital improvement work across Safeguarding and Statutory Services Safeguarding Meditech Orders were reclassified as follows:

Classification	Action Required
Stat	Requires immediate action
Urgent	Requires action within two working days
Routine	within two working days

162. The number of Safeguarding Meditech Orders received by the Safeguarding Specialist Nursing Team is outlined in the tables and graphs below:

Year	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
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
Total 2025/26	319	304	312	252	232	275	316	318	281	297	260	277	3443

163. The Safeguarding Specialist Nursing Team received 3,443 Meditech Orders during 2025/26. This represents a small increase of 28 orders (0.8%) compared with 2024/25, indicating that demand has stabilised following the reduction seen in 2024/25.
164. Activity was strongest during April to June and again during October and November, while July and August recorded the lowest volumes this is likely to be due to the school summer holidays during July and August. Although overall activity remains below the 2023/24 peak, the latest year demonstrates a sustained level of demand with reduced variation across the reporting period
165. The classification of Safeguarding Meditech Orders has been outlined in the tables and graphs below. This data is only available from July 2025 due to the Business Intelligence Data Warehouse upgrade:

Priority	Apr 25	May 25	June 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Total
Stat	-	-	-	5	5	8	10	7	6	10	6	8	65
Urgent	-	-	-	131	108	137	144	169	143	156	125	138	1251
Routine	-	-	-	116	119	130	162	142	132	131	129	131	1192
Total	319	304	312	252	232	275	316	318	281	297	260	277	3443

166. Priority classification data available from July 2025 demonstrates that almost half (49.0%) of Safeguarding Meditech Orders were categorised as 'urgent', with a similar proportion (47.5%) categorised as 'routine'. 'Stat' requests accounted for only 2.6% of activity.
167. The highest volume of 'urgent' orders was recorded in November 2025, coinciding with the highest overall level of safeguarding activity. These findings indicate that a substantial proportion of referrals require timely assessment and highlight the importance of maintaining sufficient capacity during periods of increased demand, particularly between October and January.
168. 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 2025/2026

Safeguarding Digital Project

169. Following the Safeguarding Team Quality Assurance Round (QAR) presentation in 2024 support was secured for the team to progress much needed digitalisation of Safeguarding and Statutory Services.
170. Extensive work was completed to review and update existing service paper templates (such as the Child Protection Medical Examination proformas) and create new digital templates to support improved record keeping and ensure lessons learned were embedded following Child Safeguarding Practice Reviews and incidents.
171. The Safeguarding and Statutory Services digital project went live in Meditech on 01 July 2025. During Quarter 3 revisions were made to the safeguarding templates following staff feedback.
172. This work has made a significant improvement to record keeping ensuring key information is captured. The new templates support data to be captured without the need for manual population of spreadsheets and inform business intelligence dashboards.
173. Phase 2 of the digital project commenced in Quarter 3 to review and update existing documentation relating to statutory child death processes and the Sexual Assault Referral Centre (SARC) Clinical Psychology Service. It is anticipated child death will now go live in Quarter 1, and SARC Clinical Psychology will go live in Quarter 2 or 3 of 2026/27.

Safeguarding Supervision Review

174. Work was completed in 2025/26 to review safeguarding supervision arrangements across the Trust. This review aimed to determine the resources required within the Safeguarding Team to deliver a comprehensive safeguarding supervision offer.
175. As part of the safeguarding supervision review a standalone Trust wide Safeguarding Supervision Policy (RM81) was developed and approved at SQAC in February 2026.

176. The policy provides a clear framework for safeguarding supervision for all relevant Alder Hey colleagues, depending on their role. It sets out the appropriate level, type and frequency of safeguarding supervision that staff should access, when working with children, adults at risk and families and where there are safeguarding concerns.
177. In addition, a comprehensive safeguarding supervision template has been developed and went live in Meditech in February 2026. The introduction of the safeguarding supervision template has significantly strengthened safeguarding governance, quality assurance and professional practice across Alder Hey.
178. The template standardises the recording of safeguarding supervision, improves the quality and consistency of documentation, creates a clear audit trail of professional decision-making and supports greater accountability through supervisee review and sign-off.
179. Integration within the electronic patient record enables enhanced organisational oversight, facilitates development of a Business Intelligence dashboard and supports routine audit and compliance monitoring.
180. The development of standardised safeguarding supervision digital template, a supervision matrix and associated governance arrangements were identified as key actions arising from safeguarding learning reviews and assurance work.
181. Collectively, these improvements provide stronger assurance that safeguarding supervision is delivered consistently, learning is captured effectively and safeguarding risks are identified, managed and monitored appropriately across the Trust.

Improving Child Death Statutory Processes

182. During 2025/26, significant work was undertaken to strengthen Alder Hey's statutory child death governance arrangements and improve compliance with national Child Death Review requirements.
183. The Safeguarding Team has worked with colleagues from palliative care, the Hospital Mortality Review Group (HMRG), Bereavement Team and Mortuary Team to improve statutory child death processes across the Trust.
184. This work has included:
- Established a Trust-wide Child Death and Bereavement Policy (C5) providing a single framework for child death, bereavement and sudden unexpected death in childhood (SUDIC) processes.
 - Redesigned the Meditech Child Death Notification Order Set to improve statutory notifications, safeguarding escalation and multidisciplinary communication.
 - Developed a digital morbidity and mortality module within InPhase to strengthen governance, reporting and assurance of HMRG processes.
 - Improved organisational assurance regarding compliance with national Child Death Review and Working Together requirements.
 - Responsibility for coordinating and monitoring statutory child death notifications to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

across the UK (MBRRACE-UK) and the Strategic Executive Network (SEN) was transferred to the Safeguarding Team from the Quality Team. This improved compliance, reduced the risk of missed notifications and strengthened the Trust's ability to demonstrate effective governance of statutory child death review processes.

185. This programme of improvement focused on standardising processes, enhancing digital systems, strengthening organisational oversight and improving assurance across the child death pathway

Challenges During 2025/26

Workforce Sustainability and Capacity

186. Maintaining resilience within the safeguarding workforce remained a significant challenge throughout 2025/26. Capacity pressures within a specialist service, coupled with the challenges of recruitment, retention and succession planning for statutory safeguarding roles, placed sustained pressure on service delivery. This was particularly important given the requirement to provide expert safeguarding advice, professional leadership, safeguarding supervision, training, quality assurance and partnership representation across the organisation.
187. Despite these pressures, statutory safeguarding responsibilities were maintained throughout the year.

Balancing Operational Delivery and Service Improvement

188. A significant challenge during 2025/26 was balancing increasing operational safeguarding demands with the delivery of strategic improvement programmes. Whilst maintaining day-to-day safeguarding responsibilities, the service also progressed major developments in supervision, governance, quality assurance, digitalisation and learning from reviews. Delivering sustainable improvement whilst responding to daily operational pressures required careful prioritisation of limited specialist resources.

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

189. The increasing demand for safeguarding leadership across Local Safeguarding Children Partnerships (LSCPs), Local Safeguarding Adult Boards (LSABs), multi-agency audits, Child Safeguarding Practice Reviews and the implementation of Families First significantly increased pressure on the Safeguarding Senior Leadership Team during 2025/26.
190. Whilst this strengthened Alder Hey's contribution to multi-agency safeguarding arrangements and system-wide improvement activity, it created ongoing capacity challenges within the safeguarding service. The requirement to support multiple partnership forums across several local authority areas further increased demands on senior safeguarding leadership capacity.

Workforce Sustainability and Statutory Leadership

191. Develop a sustainable, resilient and appropriately skilled safeguarding workforce, ensuring statutory leadership roles are maintained, succession planning is strengthened and the service has sufficient capacity and capability to respond to increasing demand and complexity.

Governance, Partnerships and System Interfaces

192. Develop, implement and embed the Safeguarding and Statutory Services operating model within the 'How We Will Work Together in the Future' structure, establishing clear accountability, governance arrangements and system interfaces between the Neighbourhood, Public and Mental Health System and Professional Services System. This will support robust safeguarding assurance, effective partnership working, professional leadership and statutory compliance.

Digital Transformation, Intelligence and Assurance

193. Continue the digital transformation of Safeguarding and Statutory Services through the development of business intelligence, outcome reporting and assurance systems, enabling the Trust to demonstrate the quality, effectiveness and impact of safeguarding activity whilst supporting evidence-based decision making, assurance and continuous improvement.

Implementation of Fuller Inquiry Phase 2 Recommendations

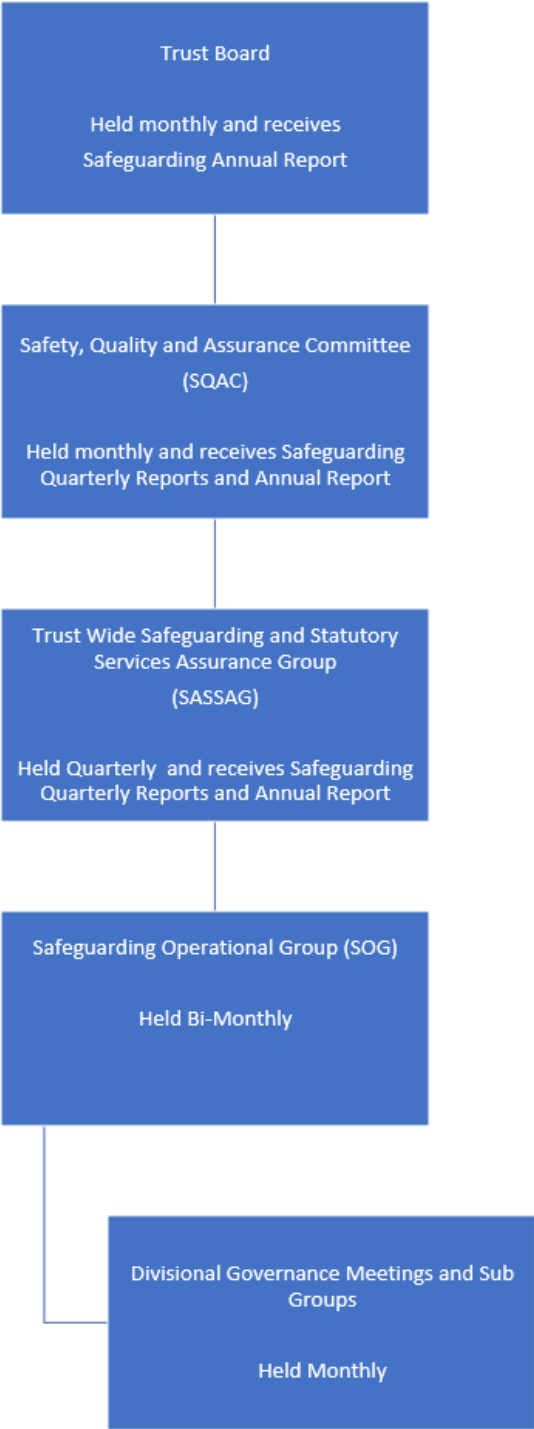
194. Complete and embed the Fuller Inquiry Phase 2 Action Plan, strengthening governance, assurance, security and oversight arrangements relating to the care of deceased children and young people. This work will ensure safeguarding considerations are fully integrated within Trust policies, training and assurance processes and provide sustainable assurance to the Trust Board that the recommendations of the Inquiry have been implemented and that the dignity, security and safeguarding of children and young people following death remain a core organisational responsibility.

Conclusion

195. This annual report demonstrates that Alder Hey has established safeguarding governance arrangements, clear reporting routes, specialist safeguarding leadership and active multi-agency engagement in place to support the Trust in meeting its statutory responsibilities for safeguarding children, young people and adults at risk.
196. During 2025/26, the Safeguarding Team has continued to provide visible specialist advice, supervision, training, audit and assurance activity across the organisation, while also progressing key improvement work including digitalisation of safeguarding processes, strengthening of safeguarding supervision arrangements and improvement of statutory child death processes.

197. The report provides partial assurance. There is clear evidence of effective infrastructure, committed leadership and continued improvement; however, assurance is moderated by ongoing workforce capacity risks, the requirement to recruit to the Named Doctor for Safeguarding role, below-target Level 3 safeguarding training compliance, increasing operational demand and the need to maintain pace with evolving statutory, regulatory and partnership expectations.
198. The priorities for 2026/27 are therefore appropriately focused on strengthening workforce resilience and statutory leadership, improving governance and system interfaces, developing digital intelligence and assurance, and implementing relevant recommendations arising from the Fuller Inquiry Phase 2 report.
199. These priorities are intended to ensure that safeguarding remains visible, responsive and embedded across the Trust, and that children, young people and adults at risk continue to receive safe, effective and coordinated care.
200. SQAC is asked to approve the report, note the partial assurance position and support continued senior oversight of the key risks and safeguarding priorities for 2026/27.

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



BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Compliments, Complaints and PALS report Q1 and Year End 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	To provide update and assurance on the performance against complaints and PALS targets in Q1 2026/27.
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 ☒

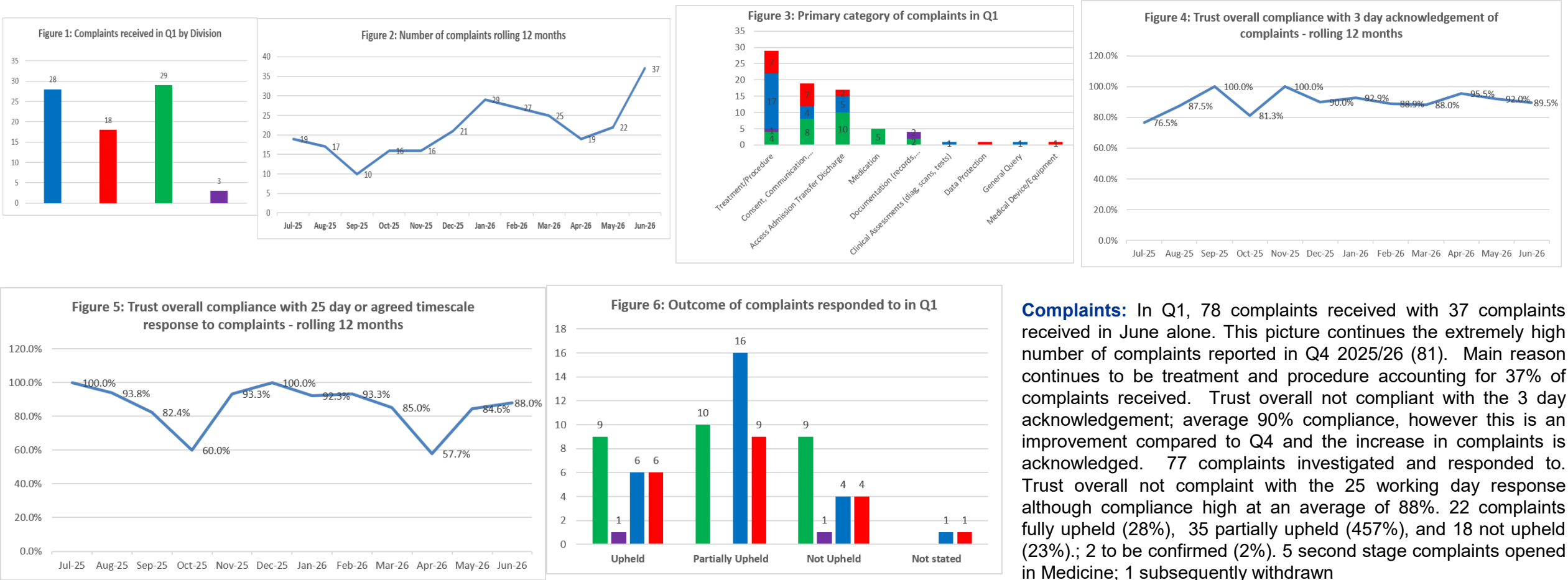
Risk number	Risk description	Score

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
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Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q1 2026/27 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



Complaints: In Q1, 78 complaints received with 37 complaints received in June alone. This picture continues the extremely high number of complaints reported in Q4 2025/26 (81). Main reason continues to be treatment and procedure accounting for 37% of complaints received. Trust overall not compliant with the 3 day acknowledgement; average 90% compliance, however this is an improvement compared to Q4 and the increase in complaints is acknowledged. 77 complaints investigated and responded to. Trust overall not complaint with the 25 working day response although compliance high at an average of 88%. 22 complaints fully upheld (28%), 35 partially upheld (457%), and 18 not upheld (23%); 2 to be confirmed (2%). 5 second stage complaints opened in Medicine; 1 subsequently withdrawn



Figure 7: PALS received in Q1 by Division

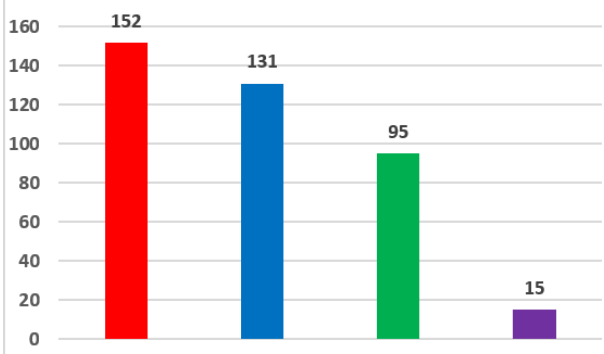
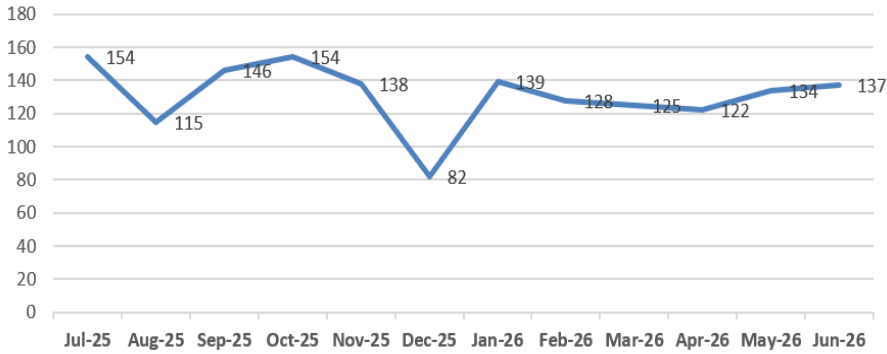


Figure 8: Total number of PALS - rolling 12 months



PHSO: No new PHSO cases opened in Q1. No open cases in Surgery or Community and Mental Health. Two new enquiries in Medicine: one regarding possible PHSO facilitated mediation however closed by PHSO no further action; one awaiting PHSO update

PALS: In Q1, 393 PALS concerns were received which is a comparable to Q4 25/26 (382). The main themes continue to be access to appointments accounting for 42% of the total in quarter. Compliance with the 5 working day response is very high with an average of 96% compliance.

Figure 9: Category of PALS - Q1

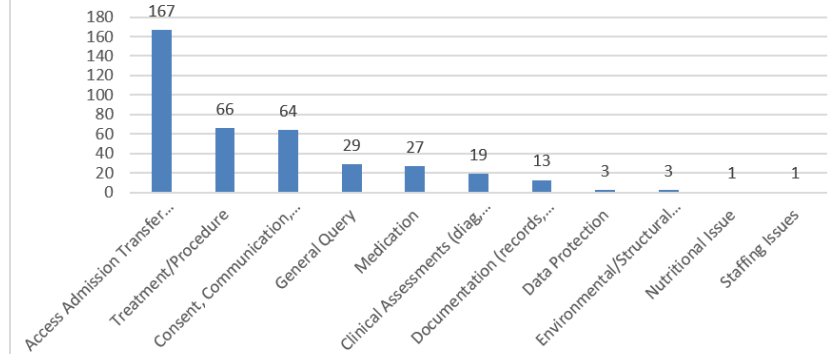


Figure 10: Trust overall compliance with 5 day response to PALS - rolling 12 months

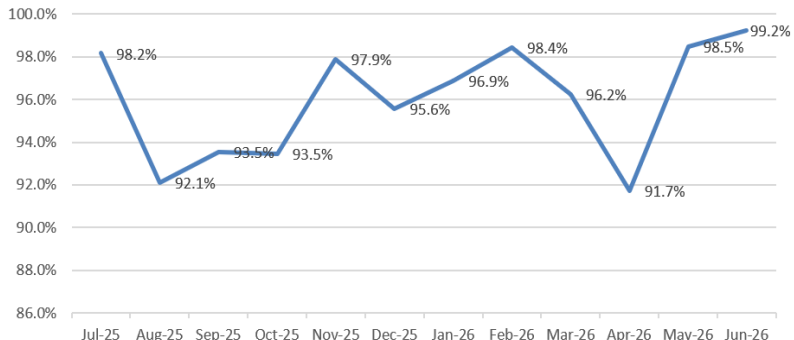
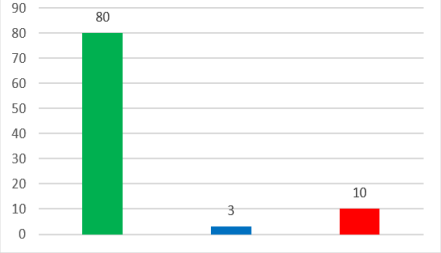


Figure 11: Compliments received in Q1 by Division



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

Success Highlights	96% of informal PALS concerns responded to within 5 working days 88% of formal complaints responded to within 25 working days despite the high volume of complaints received
Feedback and lessons learnt	Divisions capturing actions and sharing learning at the Patient Experience and Engagement Group Divisional governance leads involved in national work around complaint regulations in development for 2028
Escalation and Risks	Continued significant increase in formal complaints and in complaints associated with AI generation; this is in line with the national picture being seen. There is also a reported increase in the complexity of the complaints from across all Divisions. PHSO are also reporting a significant increase in complaints that they receive. Further workshop to be held to look at triage and risk stratification of complaints to inform new policy and process. Reporting of complaints will move into the new Trust systems in line with InPhase updating



Actions and Lessons Learned from Formal Complaints closed in Q1:

- Delay in producing final letter and referrals: Clinicians need to be aware of any clinic letters to be dictated / signed off and where possible ensure this is completed prior to taking planned annual leave to avoid delays. To prevent unnecessary delays in clinics, all investigation orders need to be made on the system in a timely way in advance
- Communication with children and families should balance the need for clear and direct clinical questioning with compassionate, patient centred communication. Clinical documentation should fully reflect the consideration of risk factors and the rationale for key decisions made during an assessment.
- When writing a clinical report, it is important to ensure that appropriate levels of detail and wider context are included, to ensure all parties are clear on the assessment, findings and future plans.
- Make the process of requesting a change of case manager easier for young people and their families.
- Importance of preparing the patient and family prior to having a blood test, particularly for parents attending direct from another Outpatient clinic.
- Ensure clear and consistent communication regarding treatment options, including eligibility criteria and expectations. Reinforce the importance of explaining that potential treatment discussions are conditional and subject to clinical criteria and multidisciplinary assessment.
- The need for earlier coordination, clearer communication, and timely follow up to ensure appropriate support is in place without unnecessary delay. Work ongoing to review job planning and capacity within the service
- To ensure confidentiality and avoid a data breach three points of verification should be used at all times. Staff members have received additional training regarding the importance of carrying out the appropriate verification checks before sharing any confidential patient information with a caller
- Ensure that relevant clinical details are consistently included within ED discharge communications. Ensure that management plans and safety-netting advice are communicated clearly, and that families have the opportunity to ask questions and confirm their understanding before discharge. Staff have been reminded through team huddles of the importance of ensuring that discharge summaries contain all relevant clinical information to support effective communication.
- Give clearer explanation to referrer and families regarding reasons for the referral rejection.
- To avoid families chasing appointments ensure that communication pathways in relation to last minute cancellations and scheduling of appointments is robust with early information to families.
- Ensure all discharge information is provided before the patient leaves the hospital.
- Consent conversations in advance of the day of surgery will enable families time to ask questions after thinking about the information provided. Conversations held too close to surgery can increase anxiety, even when clinically appropriate steps were followed.
- Communication with families should always be respectful and supportive
- Value of Specialist Support Services – timely involvement of specialist nursing teams improves families understanding, reassurance and overall experience.

Themes from PALS and complaints in Q1:

- Medication delays
- Communication failures admin / clinical
- Incorrect record information
- Rejected referrals
- Conflicting information
- Privacy and dignity

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Learning from Patient Safety Incidents Q1 April- June 2026
Report of:	Chief Nursing AHP and Experience Officer
Paper Prepared by:	Patient Safety Incident Investigation Lead Sarah Craigie

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 Patient Safety Board with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q1 2026/27 and next steps, noting that this is an iterative process as we continue to embed PSIRF.
Strategic Context This paper links to the following:	Outstanding care and experience ☒ Collaborate for children & young people ☒ Revolutionise care ☐ Support our people ☒ Pioneering breakthroughs ☐
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☒					
Risk Number	Risk Description				Score
Level of assurance (as defined against the risk in InPhase)	☐	Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ Not Assured Evidence indicates poor effectiveness of controls

1. Purpose

The purpose of this report is to provide Patient Safety Board with a summary of activity during Q1 April-June 2026 following the transition to the patient safety incident investigation framework (PSIRF) on 1 January 2024, highlighting any identified areas of system-wide learning and improvement and next steps.

2. Activity to date

2.1 Learning from Patient Safety Events (LFPSE)

The technical issues previously identified in Q4 2025/26 between InPhase and LfPSE V6 have now been resolved, enabling the Trust to recommence the transition to V6. Progress has resumed; however, due to organisational restructuring and the associated impact on InPhase, the implementation timeline has been revised. It is currently anticipated that the transition to LfPSE V6 will be completed during Q3 2026/27.

2.2 Commissioned Patient Safety Incident Investigations (PSIIs)

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

During Q1 2026/27, the Trust commissioned **0** PSII's.

2.2.1 Completed Patient Safety Incident Investigations.

1 PSII concluded in Q1 2026-27.

PSII: Never Event—Administration of Medication via the Wrong Route. InPhase ID:29369

This incident involved the administration of on oral medication mistakenly given via an intravenous route. The incident occurred in November 2025 and was reported approximately two weeks later in December 2025 within the Surgery Division and met the national Never Event definition of Administration of medication by the wrong route.

The IV medication had been prescribed correctly. The names of the two versions were very similar, and the medication chart also used technical potassium terms. Despite the wrong route administration, the patient experienced no physiological harm, supported by continuous monitoring, regular blood tests, and existing antibiotic therapy.

The investigation identified multiple interacting system factors that contributed to the error and delayed its detection. The PSII was presented at SQAC in May 2026.

2.2 Commissioned Learning Responses (excluding PSIIs).

During Q1 2026/27 there have been 1 learning responses (excluding PSIRIs) commissioned by the weekly PSIRI panel to investigate those incidents initially reported as moderate physical or psychological harm or above.

Table 1

Commissioned Learning Response Types Q1 2026/27	Number Commissioned	Number completed
After Action Review (AAR): A method of evaluation that is used to analyse what happened, why it happened, and how it can be done better by the participants, in the future. It is not an investigation process, but its purpose is to learn, support effective teamwork, motivation and implement improvements in a timely manner.	1	1
Learning Together Review (LTR): An LTR replaces previously named MDT and supports teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to obtain staff recollections of events either because of the passage of time or staff availability.	0	1
Thematic Review (TR): A thematic review can identify patterns in data to help answer questions, show links, or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.	0	0

2.3.1 Timescale Compliance for Learning Responses Q1 26/27

After Action Review (to be completed within 8 weeks of commissioned date and signed off at PSIRI Panel)

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

Commissioned Subject Matter Expert (SME) Review

Following the two Never Events involving retained swabs, occurring in different theatres and surgical specialties in September and October 2025, a proactive meeting with the ICB approved the Trust's approach to undertake a Subject Matter Expert (SME) review of the Trust's theatre Department.

The use of external and internal SMEs was agreed, and Terms of Reference approved, demonstrating the Trust's commitment to developing a deeper understanding of contributory factors and driving meaningful improvement.

The SME review plan was to be completed in stages, led by a combination of internal and external reviewers, selected to align with areas of expertise.

It was initially anticipated that the review would conclude in Q1 2026/27; however, this timescale was not met due to the withdrawal of external SME reviewers. The Trust has since

appointed an alternative external expert and the new deadline for completion and presentation is due in September 2026(Q2 2026/2027).

Completed Learn Together Review – 16661

Following the presentation and discussion at the PSIRI Panel on 19/06/2025, a Learn Together Review was commissioned due to involvement of external providers and the incident being cross divisional. Due to the complexity of the incident and to agree on the harm level, a Learn Together Review (LTR) was commissioned and led by the Patient Safety Incident Investigation Leads.

This case highlighted a series of interconnected clinical, operational, and communication challenges that collectively contributed to delays in diagnosis, decision-making, and the patient's outcome. Although individual clinical decisions were made with the information and presentations available at the time, the review identified multiple points where earlier coordination, clearer communication pathways, and more robust escalation processes may have facilitated timelier recognition of vascular compromise.

Uncertainty around Category 1 declaration timing, inconsistent adherence to Major Trauma policies, and gaps in communication between Radiology, ED, Orthopedics', Plastics, and Anaesthetics created avoidable delays, particularly in relation to imaging decisions and transfer to theatre. The limitations of existing systems, such as ELIS, further reduced the organisation's ability to audit and monitor trauma activity effectively. Additionally, the absence of key teams at critical decision points-such as during lower-limb imaging discussions-meant that opportunities to challenge or clarify decisions were missed.

The delayed recognition of the popliteal artery injury and the subsequent delay in CT angiography were compounded by a lack of consensus between specialties and a lack of clarity over who held responsibility for initiating advanced imaging. It is also noted that the incident occurred over the Christmas period where daily staff changes were noted in the M&M discussions. The vascular opinion obtained as part of the LTR reinforces that earlier suspicion, referral, and imaging may have improved opportunities for limb salvage, although it cannot be determined whether the outcome would have differed.

A further challenge throughout this review process was the difficulty in coordinating meetings with all key stakeholders. The complexity of the case, combined with the involvement of multiple specialties across different divisions and external partner organisations, resulted in delays in securing full multidisciplinary engagement. This limited the ability to explore certain decision-making sequences in depth and reflects a wider systemic issue regarding protected time and governance engagement for major trauma reviews.

Overall, this case demonstrated the need for strengthened communication frameworks, clearer escalation protocols, reinforced adherence to established trauma policies, and more structured multidisciplinary involvement-both during clinical care and during governance review processes. The actions arising from this review aim to address these issues and support safer, more coordinated management of complex paediatric trauma cases in the future.

A Discussion of Harm Level from the Attendee's Perspective dated 14/05/2026– No Harm

Rationale: This case offers significant opportunities for learning and reflection on current practice. However, even if all identified learning points and proposed practice improvements

had been in place at the time, there is no indication that the outcome for the patient would have been different. Therefore, the case is assessed as resulting in **no harm** from the attendee's perspective.

An action plan meeting is planned for September 2026.

Community & Mental Health Division Cluster

There has been a developing theme of increased overdose incidents being reported by CAMHS Sefton and CAMHS Liverpool, resulting in some young people requiring hospital admission; a cluster of the incidents was taken to PSIRI Panel in June to highlight the issue. These incidents highlighted the increasing complexity of contextual factors that make the management of such cases complex, for example: alcohol and drug use, trauma, sexual assault and children in care. It is a concern for the CAMHS clinical teams that long waiting time and lack of capacity within the CAMHS Teams (on the risk register: #543, #393, #461, #478, #499) is impacting on the ability of clinicians to meet the needs of young people in a timely way, and this has been escalated in the Division. The concerns raised regarding the risks relating to this cohort of patients was shared by the PSIRI Panel.

2.4 Training and Education

2.4.1 Patient Safety e-learning

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

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

2.4.2 Level 2 Patient safety syllabus training

55 (a 25% increase from 2022-2026) staff to date have completed Level 2 of the patient safety syllabus (not mandated for all staff, only a requirement for those in oversight, learning response and engagement lead roles) training available via ESR as outlined below:

- **Oversight roles** (*meeting PSIRF standards*): 6 (including CMO, CNO)
- **Learning response leads** (*meeting PSIRF standards*): 13 (6 Surgery, 1 Medicine, 2 C+MH, 4 Corporate, 0 Research)
- **Engagement leads** (*meeting PSIRF standards*): 10 (4 Surgery, 1 Medicine, 1 C+MH, 4 Corporate, 0 Research)

However, this figure does not currently reflect training undertaken by staff via the E learning for Health (ELfH) platform as this is not aligned with ESR and is currently outside of the Trusts' ability to resolve.

A planned programme of Continued Professional Development (CPD) days is being developed for September 2026 to enhance the knowledge, skills, and confidence of staff in Oversight, Response Lead, and Engagement Lead roles.

To support the implementation of the five newly established systems, the Patient Safety Team Co-Ordinator undertook a proactive mapping exercise to identify and define the roles of Learning Response Leads and Engagement Leads. The exercise aims to ensure staff have the necessary clarity, preparation, and support to undertake learning responses effectively and to facilitate meaningful engagement with patients, families, and colleagues throughout the response process.

2.5. Patient Safety Investigators

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

Both Patient Safety Investigation Leads successfully completed the Loughborough patient safety course (PSS Level 3 and 4) in June 2026.

2.6 Patient Safety Partners (PSPs) Update

Following the evaluation of the Patient Safety Partner (PSP) programme, Phase 2 commenced in April 2026 with an increased emphasis on strategic influence and governance. PSPs are now invited to attend the monthly Patient Safety Board meetings and receive the agenda and supporting papers in advance. In addition, dedicated pre-meetings are held with PSPs to review key agenda items, enabling them to reflect on the content and provide feedback in a format that best supports meaningful participation.

Two PSPs are now active members of the Restrictive Practice Forum, attending monthly meetings to represent the perspectives of patients and families. They have also begun contributing to the development of training materials to support improvements in restrictive practice.

Changes in member availability have resulted in a smaller but engaged and active PSP cohort.

Current Position

The programme currently has 12 active Patient Safety Partners:

- 7 members aged 18 years or under.
- 9 members are former Alder Hey patients.
- 2 members are parents or carers of children treated at Alder Hey.

PSP Involvement During Q1 2026/27

During Quarter 1, PSPs have:

- Become active members of the Restrictive Practice Forum.
- Regularly contributed to Patient Safety Board discussions through agenda review and feedback.
- Supported work relating to patient safety and health inequalities.

- Completed an audit of patient information leaflets.
- Visited the Paediatric Assessment Unit (PAU) on four occasions to gather feedback from children, young people and families about their experiences of care from a patient safety perspective.

A notable achievement of the programme is that one PSP has secured a paid role within Alder Hey. The individual reported that the confidence, skills, and experience gained through their PSP role contributed positively to their successful recruitment and employment.

Local and National Influence

The Trust's PSPs continue to participate in regional Patient Safety Partner network meetings, sharing learning and collaborating with PSPs from other organisations.

The Alder Hey PSP programme has also provided feedback to NHS England on the opportunities and challenges associated with embedding the PSP role within a children's hospital. This feedback was subsequently featured in an NHS England Patient Safety Partner bulletin, demonstrating national recognition of the Trust's contribution.

Next Steps for Q2

The Trust continues to embed the Patient Safety Incident Response Framework (PSIRF), maintaining a strong focus on shared learning, the implementation of improvement actions, and consideration of the resources required to maximise the benefits of the PSIRF approach.

During Q1 2026/27, priority was given to reviewing and updating the Patient Safety Plan, drawing on stakeholder feedback and insights from patient safety data. A revised draft of the plan has been developed and circulated to stakeholders for final review and comment prior to approval and implementation.

Review and update the PSIRF Policy to ensure it reflects organisational changes and revised processes.

Deliver the annual Continuing Professional Development (CPD) programme in accordance with PSIRF requirements.

Enhance and expand PSIRF-related content on SharePoint to provide staff with access to up-to-date guidance, resources and information.

Extend the audit measures within InPhase reporting to incorporate the PSIRF oversight principles outlined in the updated Patient Safety Incident Response Plan (PSIRP).

Recommendations

Patient Safety Board is asked to note the activity that has been undertaken during Q1 2026/27 following the Trust's transition to and embedding of PSIRF and next steps for Q2 2026/27.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Infection Prevention & Control Report April 2026 – June 2026
Report of:	Infection Prevention & Control
Paper Prepared by:	Dr Beatriz Larru, DIPC

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

Does this relate to a risk? Yes ☐ No ☒ If "No", is a new risk required? Yes ☐ No ☒				
Risk Number	Risk Description			Score
Level of assurance (as defined against the risk in InPhase)	☐ Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☒ Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ Not Assured Evidence indicates poor effectiveness of controls	



1. Executive Summary

The purpose of this report is to provide oversight of Infection Prevention Control (IPC) activity and reporting for the period 1st April – 30th June 2026 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.

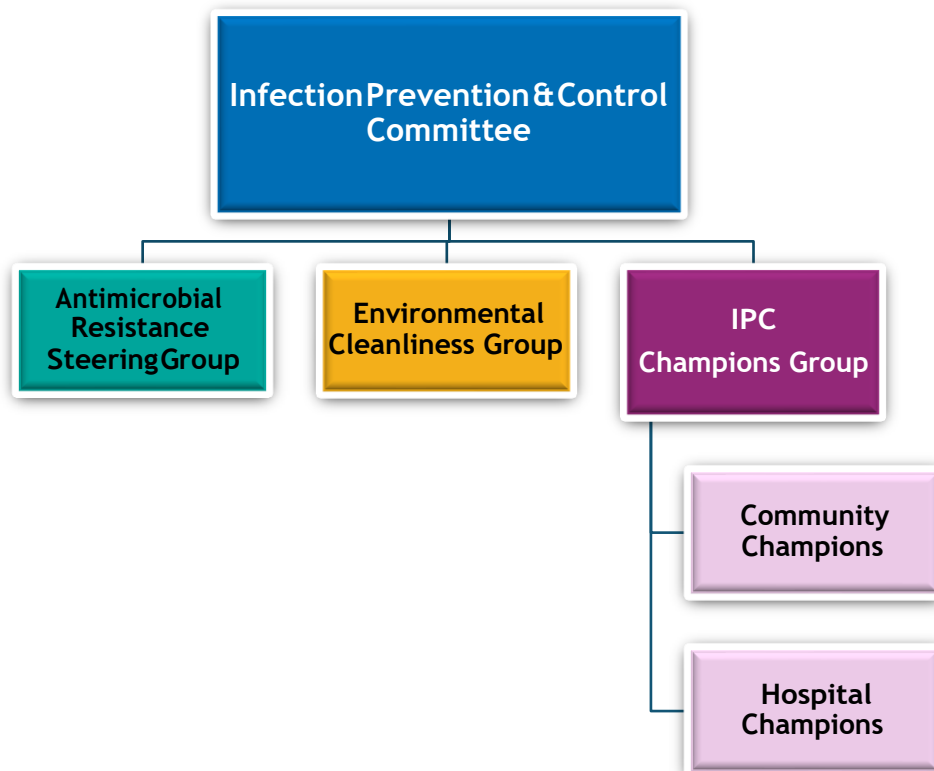
Effective prevention and control must be an integral part of everyday practice and applied consistently by everyone working directly with patients to ensure their safety. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control 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 has been based on the National IPC board assurance framework.

Governance has been strengthened through oversight of IPC policies and workplans, guiding operational groups and supporting assurance.

The IPC committee receives reports from the following subgroups:



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.

This group is currently on hold awaiting a review of the AMS governance.

Environmental Cleanliness Group

The group met on 21.04.26, 19.05.26 and 16.06.26

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

IPC Champions Group

The group continue to meet on a monthly basis and discuss infectious diseases where there is high transmission within the community.

There are now 2 groups with dedicated meetings for each:

- Hospital based IPC Champions
- Community based IPC Champions

We have continued to provide sessions in line with the NHSE IPC Educational Framework.

All IPC Champions have been advised that Hand Disinfection Audits will be completed via InPhase from January 2026.

The Clean Start Strategy has been launched in June 2026 to enhance cleaning standards and ensure a consistently high-quality environment.

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

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.

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:

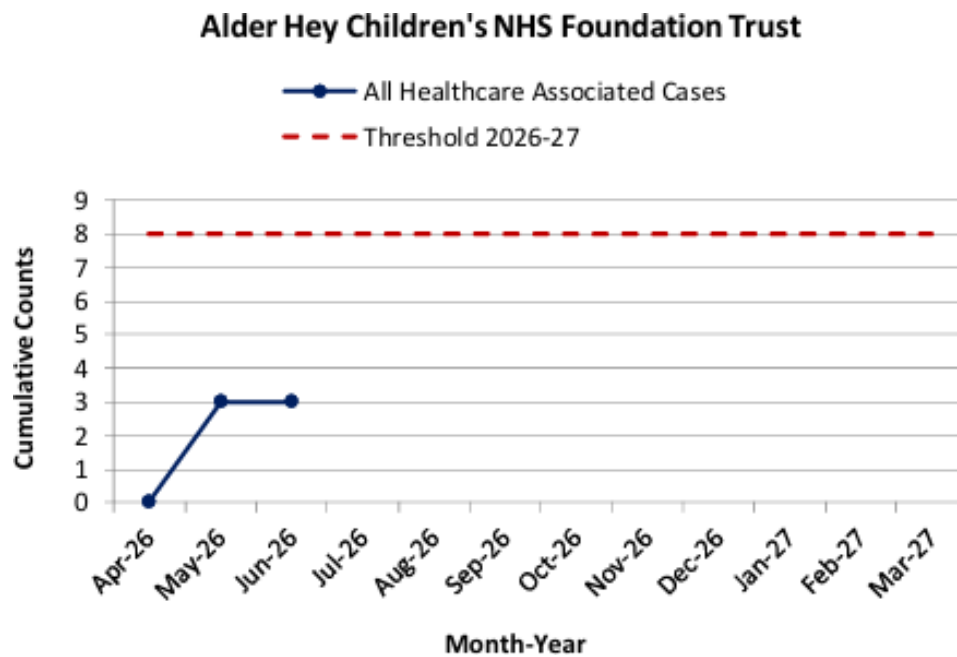
- 1) *Hospital Onset-Healthcare acquired (HOHA) (i.e., occurs in patients admitted >48Hr)*
- 2) *Community Onset-Healthcare acquired (COHA) (i.e., occurred in patients who have received healthcare in either the community or hospital in the previous 28 days).*

Healthcare-associated Gram-negative blood stream infections					
APRIL 2026		MAY 2026		JUNE 2026	
Cardiology	1 HOHA	Cardiology	1 HOHA	Oncology	1 COHA
		Critical Care	2 HOHA		
		Neurology	1 HOHA		
		Orthopaedic	1 HOHA		
		Specialist Medical	1 HOHA		

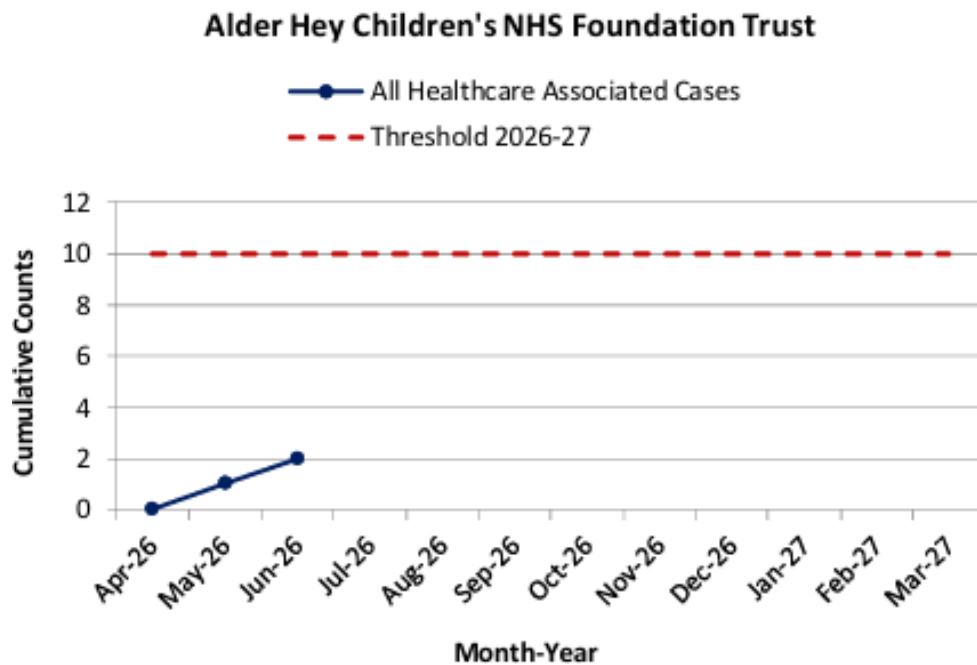
The post-infection reviews (PIR) of these cases identified:

- 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

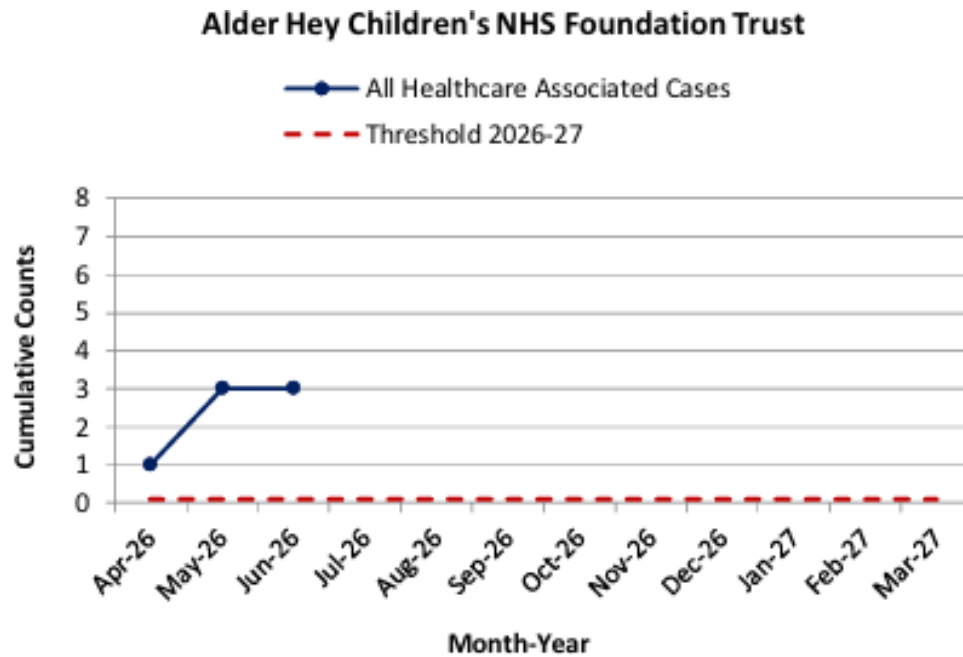
4. *E. coli* bloodstream infections



5. *Klebsiella spp.* bloodstream infection



6. *P. aeruginosa* bloodstream infections



7. Healthcare-associated *Staphylococcus aureus* bloodstream infections

Healthcare associated MSSA bloodstream Infections	
Medical	3
Surgical	4

Healthcare associated methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infections	
Medical	1
Surgical	0

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:

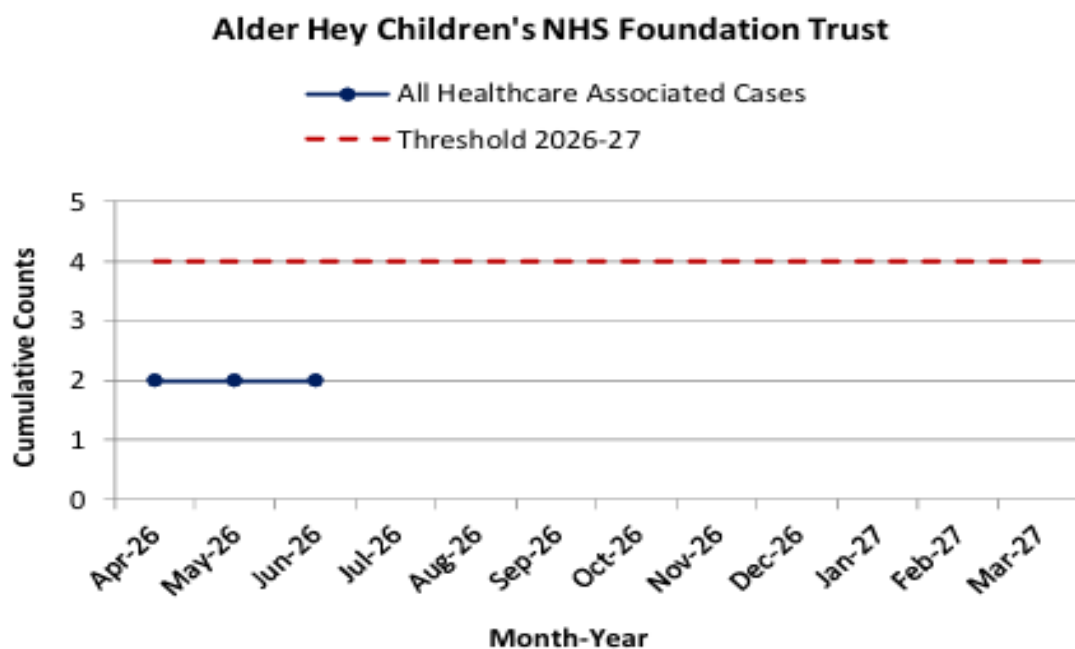
- Strengthen staff ANTT training
- Improve patient education
- Monitor practice
- Manage colonised patients proactively
- Adherence to surveillance policy
- Line bundles are added to patient's worklist

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

The workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued with a closer collaboration between IPC and the Microbiology laboratory to include in our PIRs *all significant blood stream infections 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.*)

9. *C. difficile* Infection



Healthcare-associated C.difficile infections			
APRIL 2026 - 2		MAY 2026 - 0	
Crit care	1 HOHA		
Oncology	1 HOHA		

Due to a recent increase in *C. difficile* cases, UKHSA visited Alder Hey to help identify opportunities for improvement.

The purpose of their visit was to observe and review current practices, tour the facilities, view different areas, and understand how we carry out cleaning procedures and documentation of stools in patient notes.

10. Healthcare acquired viral infections

Respiratory viral infections

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 and
- Lack of staff awareness of the burden of nosocomial viral infections in hospitalised paediatric patients
- Patients being frequently exposed to multiple visitors
- Previous visits from a friend or relative with symptoms
- Frequent contact outside the ward in families with long-term patients (particularly in 1C cardiac ward).
- 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.

Gastrointestinal viral infections

<i>Gastrointestinal Viral infections</i>		
April 2026	1	NOROVIRUS
May 2026	0	
June 2026	1	ROTAVIRUS

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, no outbreaks were declared.

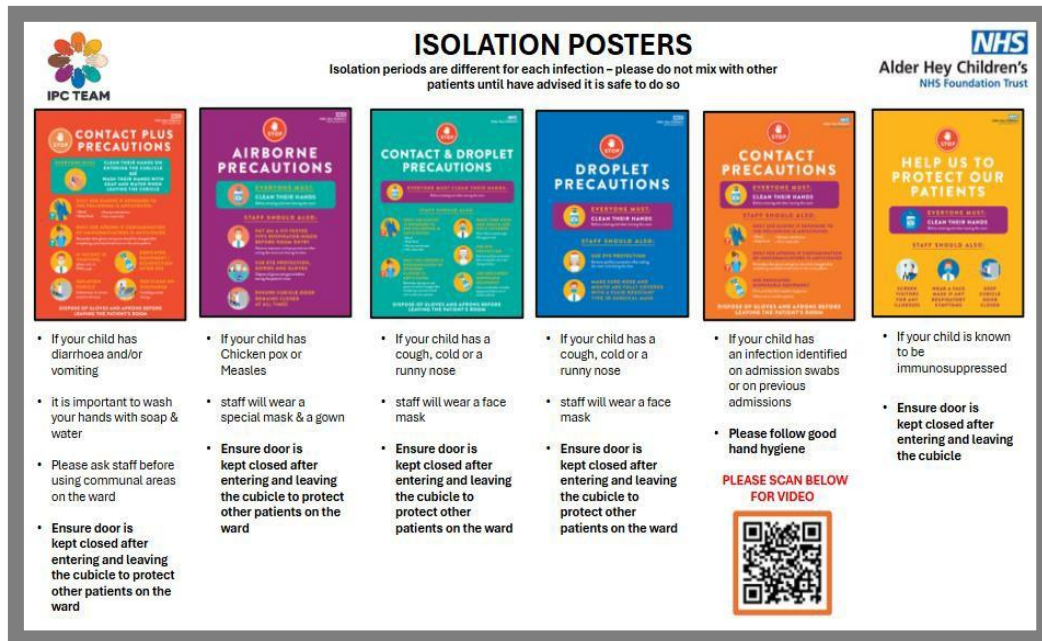
Efforts included enhanced infection control protocols, such as:

- **strict hand hygiene enforcement**
- **thorough environmental cleaning**
- **isolation precautions for affected individual**

11. Daily isolation walks

The IPC team conducts daily “isolation walks” across all areas of the Trust to reinforce appropriate infection prevention and control (IPC) transmission based precautions.

To support this, visual graphics have been developed to help identify contagious patients.



ISOLATION POSTERS
Isolation periods are different for each infection – please do not mix with other patients until have advised it is safe to do so

CONTACT PLUS PRECAUTIONS
If your child has diarrhoea and/or vomiting
It is important to wash your hands with soap & water
Please ask staff before using communal areas on the ward
Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward

AIRBORNE PRECAUTIONS
If your child has Chicken pox or Measles
Staff will wear a special mask & a gown
Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward

CONTACT & DROPLET PRECAUTIONS
If your child has a cough, cold or a runny nose
Staff will wear a face mask
Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward

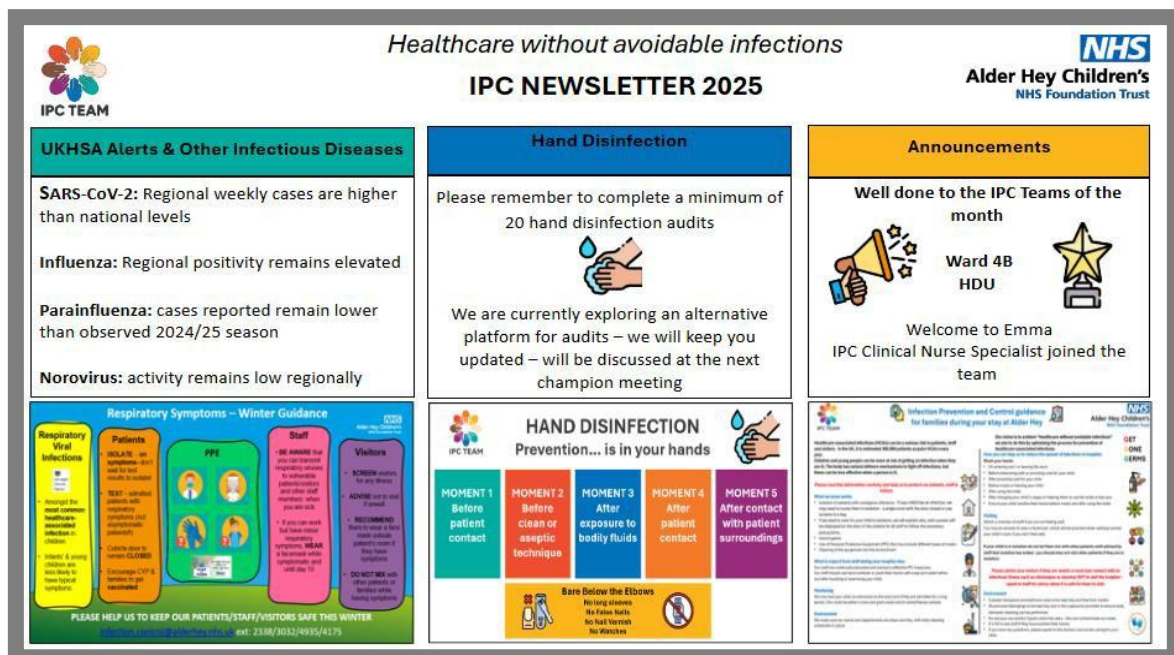
DROPLET PRECAUTIONS
If your child has a cough, cold or a runny nose
Staff will wear a face mask
Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward

CONTACT PRECAUTIONS
If your child has an infection identified on admission swabs or on previous admissions
Please follow good hand hygiene
PLEASE SCAN BELOW FOR VIDEO

HELP US TO PROTECT OUR PATIENTS
If your child is known to be immunosuppressed
Ensure door is kept closed after entering and leaving the cubicle

12. Newsletter Example

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



Healthcare without avoidable infections
IPC NEWSLETTER 2025

UKHSA Alerts & Other Infectious Diseases
SARS-CoV-2: Regional weekly cases are higher than national levels
Influenza: Regional positivity remains elevated
Parainfluenza: cases reported remain lower than observed 2024/25 season
Norovirus: activity remains low regionally

Hand Disinfection
Please remember to complete a minimum of 20 hand disinfection audits
We are currently exploring an alternative platform for audits – we will keep you updated – will be discussed at the next champion meeting

Announcements
Well done to the IPC Teams of the month
Ward 4B HDU
Welcome to Emma IPC Clinical Nurse Specialist joined the team

Respiratory Symptoms – Winter Guidance
Respiratory Viral Infections
Patients
PPE
Staff
Visitors

HAND DISINFECTION
Prevention... is in your hands
MOMENT 1 Before patient contact
MOMENT 2 Before clean or aseptic technique
MOMENT 3 After exposure to bodily fluids
MOMENT 4 After patient contact
MOMENT 5 After contact with patient surroundings
Safe Below the Elbows
No long sleeves
No loose buttons
No nail varnish
No Nails

13. 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



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





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



Healthcare-associated infections (HCAs) can be a serious risk to patients, staff and visitors. In the UK, it is estimated 300,000 patients acquire HCAs 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.

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.

GET ONE GERMS








14. Outbreak / Exposure Cases

April 2026					
Location	Exposure	Patients exposed	Prophylaxis required?	Staff exposed	Prophylaxis required?
EDU	SARS Cov-2	11	0	0	0
4C	CHICKENPOX	52	3	2	0
ED	MEASLES	28	2	0	0
3C	CHICKENPOX	4	0	0	0
ED	MEASLES	0	0	0	0
ED	MEASLES	0	0	0	0
OPD	CHICKENPOX	15	0	5	0

May 2026					
Location	Exposure	Patients exposed	Prophylaxis required?	Staff exposed	Prophylaxis required?
ED	MEASLES	0	0	0	0
ED	MEASLES	0	0	2	0
ED	MEASLES	0	0	2	0
OPD	CHICKENPOX	0	0	3	0

June 2026					
Location	Exposure	Patients exposed	Prophylaxis required?	Staff exposed	Prophylaxis required?
ED	CHICKENPOX	0	0	0	0
ED	CHICKENPOX	58	0	6	0
4A	CHICKENPOX	8	0	6	0

15. 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 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.

16. 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.

ICNet implementation discussions in progress.

17. 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.

18. Occupational Health Status Access

Healthcare workers whose Occupational Health provision is delivered by Aintree Occupational Health Service can independently check their Occupational Health status through the secure online self-service portal.

Staff can access their records by following the link below and completing the authentication process:

<https://liverpoolft.opasg2.com/selfreport/authenticate>

The self-service portal offers several benefits, including:

- 24/7 access to Occupational Health information at a time convenient to the employee.
- Immediate visibility of current Occupational Health status without needing to contact the Occupational Health team.

- Improved efficiency, reducing administrative queries and saving time for both staff and Occupational Health services.
- Enhanced accessibility, allowing staff to securely access information from any location with an internet connection.
- Greater employee empowerment, enabling individuals to manage and monitor their own Occupational Health records.

The portal provides a convenient, secure, and efficient way for staff to access Occupational Health information and verify their status when required.

The self-service portal supports the IPC team during occupational exposure incidents, as staff can quickly access and confirm their immunisation status, enabling timely risk assessment, management, and follow-up actions.

19. Clean Start Strategy

The clean start strategy has been launched to enhance cleaning standards across the Trust. As part of the initiative, all nursing and domestic cleaning staff have received new training focused on best practice cleaning techniques, infection prevention, and maintaining high standards of hygiene.

UKHSA colleagues have attended meetings to review the current strategy and provide specialist expertise and advice to support ongoing development of the programme.

The associated Moodle training module is now live and available for nursing staff to complete. The IPC team will monitor training uptake and completion rates to ensure compliance, identify areas requiring further support, and provide assurance that staff have received the necessary training.

In addition, a range of new cleaning product and terminal clean processes has been introduced to improve effectiveness, support safer cleaning practices, and help maintain a cleaner, healthier environment for everyone.

20. Conclusion

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.

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 24th June 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
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	JP
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Ava Killbride	Governor	AK
	Jill Preece	Governance Manager	JPr
	Veronica Greenwood	Director of Allied Health Professionals (AHPs)	VG
	Amy Tantom	Head of Nursing & Allied Health Professionals, Surgery Division	AT
26-27-68	Kelly Black	Deputy Head of Neonatal Nursing, LNP	KBL
26-27-71	Peter White	Chief Nursing Information Officer	PW
26-27-72	Dr. Matthew Neame	Consultant General Paediatrician, Chief Clinical Information Officer, Division of Medicine	MN
26-27-80	Julie Grice	Consultant in A&E & Mortality Lead	JG
26-27-81	Prof. Rachel Isba	Clinical Lead for Improve my Life Chances	RI
26-27-81	Pallavi Patel	ST5, Public Health Registrar	PP
Apologies:	Alfie Bass	Chief Medical Officer	AB
	Jenny Devine	Governor	JD
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Melissa Swindell	Chief People Officer	MS

- 26/27/63 Welcome and Apologies**
The Chair welcomed everyone to the meeting and apologies were NOTED.
- 26/27/65 Declarations of Interest** - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.
- 26/27/65 Minutes of the Previous Meeting**
The Committee members were content to **APPROVE** the minutes of the meeting held on 20th May 2026.
- 26/27/66 Matters Arising/Review of Action log**
The Action log was reviewed and updated.

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

- 26/27/67 Divisional Updates**
Division of Medicine
CW presented the Medicine Division update and drew attention to a few key points from the report including:-
Highlights:-
- SQAC noted the continued positive progress across safety, governance, and service delivery.
 - Patient safety performance remained stable with the majority of incidents resulting in low or no harm.
 - Sepsis compliance remained strong at 100% compliance for inpatients and >90% for ED.

- There is sustained compliance with audit and risk management processes, with no overdue audits or actions reported over the past 12 months.
- An improved position in business continuity planning was noted.

Challenges:-

- Challenges were noted in relation to complaints performance, which had reduced to 78%, attributed to the introduction of face-to-face engagement with families, alongside operational constraints in staff availability. Actions are in place to strengthen this process.
- SQAC noted that the primary focus for the division is the proposed Ward 4C reconfiguration, designed to align bed capacity and workforce with demand, supported by evidence of sustained unused inpatient capacity and increasing use of ambulatory pathways. The change is positioned as a service redesign rather than reduction, with continued investment in general paediatrics. SQAC noted that engagement activity had been extensive, including multidisciplinary staff workshops; however, this had generated significant staff concern and emotional response, which is being actively managed through continued engagement and support. Patient and family engagement had included individual discussions, with further targeted engagement planned with frequent attenders and long-term patients to update them regarding the future model.

FB sought assurance on patient and family experience, particularly for frequent users of the service, emphasising the importance of capturing and maintaining elements of care that are most valued. CW confirmed that there is ongoing and planned engagement to address this.

Discussion highlighted opportunities to strengthen evaluation and learning, including potential publication of the transformation work and alignment with research, audit, and virtual ward developments to support the future model of care.

SQAC acknowledged the positive trajectory and gained assurance from the report, noting the need for continued focus on staff engagement, complaints performance, and clear communication to patients and families as the reconfiguration progresses.

Division of Surgery

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

Highlights:-

- Sepsis performance remained strong, achieving 100% compliance for the fifth consecutive month.
- Infection rates remained low overall.
- Patient experience indicators were positive, with a notable improvement in access performance, with cardiac waiting lists which have reduced from 105 to 65 patients, with improved throughput and management of elective demand.
- Incident reporting remained high, with 281 incidents reported in-month, reflecting a positive reporting culture. Most incidents were classified as low harm or near miss.
- Moderate harm incident identified related to late identification of skin damage in critical care. Review has identified learning actions focused on balancing Neuroprotection; Tissue viability
- Overdue incidents have continued to reduce; however, 26 incidents remained open beyond 30 days, requiring continued monitoring and active management.

Key Risks and Challenges:-

- Challenges were noted regarding workforce pressures, within the AVAT (Acute Vascular Access Team) and the Major Trauma Team, resulting in a temporary reduction of the major trauma service to a five-day model. Mitigation is in progress through the induction and integration of supernumerary staff.
- Governance and audit compliance – there are 39 overdue audits identified, which requires focused improvement.
- Emergency Preparedness (EPRR) - Business continuity plans are not fully complete, with ongoing review and development. This remains an area of focus alongside workforce and audit compliance

AT advised that all key risk areas have action plans in place to support improvement.

GM commended the division for the strong and sustained sepsis performance, noting its importance given previous focus by SQAC.

FB noted that the performance data in Appendix 1 is omitted from the report and requested submission of the complete dataset. In response AT confirmed that the data would be circulated following the meeting.

Clinical Research Division

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

Highlights:-

- A notable success was achieved through the archiving of closed studies: A target had been set to archive 100 studies in May 2026, 103 studies had been successfully archived, exceeding expectations. Archived materials had now been transferred to off-site storage, representing a significant operational improvement and reduction in backlog.
- Significant progress in Standard Operating Procedures (SOP) review and compliance was noted, the original backlog of 48 SOPs requiring updates, this had reduced to 34 updated SOPs. The updated SOPs had been uploaded to iPassport for compliance monitoring and had been made accessible on the Document Management System (DMS) for wider organisational use.

Challenges:-

- Challenges were noted regarding the 150-Day Study targets, with continued pressure in meeting 150-day targets, particularly regarding dependencies on support services, with ongoing monitoring of progression across stages of study setup. Work is ongoing to track and manage delays, though this remains a persistent challenge.
- Historic archiving and data Integrity: A significant issue identified through a patient complaint relating to a study conducted approximately 20 years ago - an archived box retrieved did not contain expected study documentation; original consent form was ultimately located in the patient medical record, enabling response to the complaint. This prompted a wider review of historical archiving practices with a selected sample review of six studies (10–15 years old) undertaken. Findings shown that the required documents were generally retrievable, however there were inconsistencies in storage practices and content were identified, with variation noted in retention practices (e.g. mixing studies with differing retention requirements). The current off-site archive contains: 452 boxes, covering an estimated 1,000 studies, including 116 studies potentially still subject to regulatory audit (MHRA). Mitigation actions include immediate decision taken to implement a “no-destroy” policy for all archived materials, with further work required to assess archiving integrity and consistency and to develop a systematic approach to historical data management. LR confirmed that no escalation from SQAC is requested at this stage, however the issue is recognised as requiring further detailed review and corrective action.
- Re-opening of risk relating to CRF (Clinical Research Facility) door - there are ongoing operational issues requiring monitoring, which is being managed in conjunction with estates and operational teams.

Community and Mental Health Division

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

Highlights:-

- Through the Complex care support team, there has been a reduction in the number of clinically ready for discharge children experiencing delays. SQAC noted this as a significant achievement, supporting improved patient flow and a more efficient use of hospital capacity.
- Positive progress was noted in community Speech and Language Therapy services, including: development of an innovative app to support parents following assessment, this initiative supports improved parent experience and more effective post-assessment care pathways.

Key Risks and Challenges:-

- An incident relating to delayed genomic test results had prompted further review: Initially thought to align with wider system issues, however further factors identified increased complexity and time required for whole genome testing consent processes; loss of programme funding, impacting practitioner capacity and a lack of integration between systems (electronic ordering systems not aligned). Risks identified included delays in testing or reduced uptake due to complexity and potential impact on timely diagnosis and clinical decision-making. Mitigation actions include Business case submitted to address capacity gap, with ongoing work to improve system integration for genomic ordering.

- Preparing for Adulthood (PFA) Programme - Risk identified regarding sustainability of progress: small resource base within the team, and current operational changes are impacting capacity for data cleansing and programme continuation. Mitigation includes focus on enabling clinical teams to take greater ownership of data and processes; recognition of potential future pressure if capacity is not maintained.
- Concern raised regarding Sefton Mental Health Services: Operating at approximately 30% below required staffing levels due to sickness absence and vacancies. There are concurrent issues: Two incidents prompting review; evidence of increasing population complexity and demand. Key strategic concern: Current waiting time standards may no longer be clinically appropriate and even cases seen within target times may not meet patient need in the context of increased complexity.

FB referred to the lack of clarity in the report regarding which patient cohorts are affected, the scale and impact of the issue and how the incident review links to wider pathway/service redesign.

FB requested a more comprehensive, system-wide overview in future reporting. In response JP acknowledged that the summary had not sufficiently captured the complexity and committed to providing a clearer, more holistic update in the next report.

KB requested clarity on the governance route for transition work and the frequency and visibility of reporting to SQAC. KB highlighted the importance of understanding the impact on patient flow, waiting lists, and safety. In response JP advised that quarterly updates are currently provided to CEOB and offered to share reports directly with KB if helpful.

NA recommended for SQAC to receive six-monthly updates to maintain oversight and to receive assurance on progress.

AB referred to escalation of high-risk areas - ADHD medication and Sunflower House and expressed concern regarding the ADHD medication backlog (approx. 2,000 patients) and the Sunflower House risk. AB stated that both risks represent significant and high-impact risks and requested greater focus, oversight, and potential exploration of alternative or more radical solutions. In response JP stated that these are ongoing high-priority risks and that these risks had not been highlighted this month as focus was on new/emerging issues. JP agreed to include further detail and outputs in future reports.

NA proposed that there are dedicated agenda items for these risks at the next SQAC meeting.

FB emphasised the need to ensure continued momentum and visibility on long-standing high risks and noted the lack of recent evidence demonstrating progress or mitigation impact.

FB referred to a significant decline in initial health assessments completed within 20 days.

JP advised that this is likely to be linked to staffing pressures (e.g. maternity leave) and provided a commitment to provide further clarification outside the meeting.

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

26/27/68

Liverpool Neonatal Partnership Monthly update

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

Highlights:-

KBI acknowledged the delays with regards to the new build, however colleagues are expected to receive the keys towards the end of December 2026. KBI advised on the opportunity to access the site earlier to support commencement of simulation and familiarisation programme.

- Specialised commissioners have requested further detail on the impact of delays and workforce implications, with work underway to respond and provide assurance.
- Mindray had been selected as the provider for the new patient monitoring system, neonatal services will be the only department in the Trust using this system. Progress includes allocation of project support; development of training plans and establishment of a clinical configuration group. With ongoing work to ensure integration with BadgerNet and System C set up.
- There is continued focus on education and simulation (SIM) programme: 84 staff rotations had been completed, equating to 122 individual rotation instances. Rotations had maintained and enhanced specialist neonatal skills and enabled staff to now work clinically within staffing

numbers, rather than supernumerary. While the delay has presented challenges it has also resulted in a more skilled and flexible workforce.

- Significant external developments were noted, the Ockenden Report (maternity and neonatal services) is due to be released on 24.6.26, colleagues are also awaiting the AMOS report to be published this year and the Thirlwall Inquiry, KBI advised that there may be recommendations or learning within these reports that will impact both units across the partnership.
- There is ongoing engagement with the Operational Delivery Network (ODN) on regional escalation policies and development of improved cot capacity oversight and reduced transfers
- Changes in ROP (Retinopathy of Prematurity) screening model: transition from centralised screening to local screening within each unit; reduction in need for patient transfers across sites and only babies requiring treatment will transfer to specialist centres.
- High acuity levels reported across both sites (HDU/ITU cots). With effective workforce flexibility demonstrated: staff redeployed across sites without reliance on bank spend.
- Sickness rates had improved significantly and had reduced from >10% to 5% (Alder Hey) and 7.5% (Liverpool Women's).
- 111 incidents were reported in May 2026, majority of which were noted as no harm. One moderate harm incident was noted.
- KBI updated on the introduction of swarm huddles enabling immediate multidisciplinary reviews following incidents which are conducted in real time, including out of hours. Benefits include immediate learning and action, and improved staff support and reduced anxiety for staff. KBI proposed to extend this approach across both sites (subject to governance approval).
- KBI advised on a safeguarding incident on the Liverpool Women's site which had resulted in a required temporary workforce model adjustment, the impact was short-lived and was effectively managed with workforce flexibility and supported mitigation.
- Overall patient experience reported as positive, supported by PMRT feedback, low complaints, PALS activity and through parent engagement (events, forums, family support roles). However: discharge survey response rates remain low, despite multiple improvement effort, which is recognised as not fully reflective of the overall patient experience.

Key Risks and Challenges

- Data and Reporting Limitations
- Programme Delays - delays to new build: Potential implications for: workforce planning and service transition, mitigation includes continued oversight and engagement with commissioners

FB referred to the outdated data within the report, including mandatory training and sickness metrics, and recommended that further work is required with the BI team to ensure timely and accurate data reporting. FB stated that it would be beneficial for improved data/data refresh processes, to ensure improved alignment with current reporting periods.

GM referred to learning from national reviews and highlighted the importance of understanding governance failures in national cases (e.g. Nottingham) and requested focus on systemic learning, and not just clinical practice. In response FB advised that recommendations from national reports will be reviewed and any learning would be applied locally.

AB expressed concern regarding the interaction between NICU development and PICU capacity and stated that the original plan to reduce PICU beds may present strategic risk and suggested the ongoing discussion with specialised commissioners, with future reporting to reflect critical care capacity implications.

SQAC acknowledged the positive feedback on practice regarding the value of swarm huddles as a real-time learning model, with strong examples of workforce flexibility and continuous improvement in patient safety.

Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership Monthly update. SQAC welcomed improvements in future reports to improve BI and reporting processes to ensure data accuracy

---- Safe ----

26/27/69

Patient Safety Update

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

Highlights:-

- The Patient Safety Annual Report has been received and reviewed and is providing structured oversight of programme delivery and workstreams.
- HMRG performance had improved in Quarter 3 and Quarter 4: >96% of cases had been reviewed within 4 months, exceeding the 90% target, demonstrating strengthened timeliness and robustness of mortality review processes.
- Medical Device and Radiation Safety reporting for Quarter 4 indicated that there were no moderate or above harm medical device incidents and no CQC-reportable radiation incidents.
- Key gaps and risks identified Medical Device Training and Off-Label Use, with limited assurance identified in medical device training compliance and monitoring of off-label device use.

Challenges:-

- Difficulty measuring compliance against the 90% target and ongoing concerns following Never Event recommendations. Mitigation includes work is progressing with education teams and theatre-based tracking project to improve oversight.
- Data Quality and Coding (HMRG / Mortality Data) - coding inaccuracies and data quality issues identified: Impacting national reporting and benchmarking accuracy Risk remains: Recorded on the risk register. Mitigation includes strengthened clinical oversight and implementation of revised pathways to improve accuracy.

LC raised a concern regarding the restrictive practice programme effectiveness and workforce capability and highlighted a recent case which required external support (Prometheus) due to staff lacking confidence to manage a child requiring restrictive intervention, which had resulted in a significant cost to the organisation. LC expressed concern that this was not aligned with expected capability following two years of programme delivery.

LC stated that there is a lack of clarity in the report regarding workforce capacity (number of trained staff), delivery against programme objectives and sustainability of training and cultural change. LC stated that her perception is that previous progress in staff confidence and culture may have regressed. LC requested detailed assurance and delivery plan, including workforce training numbers; barriers to training and actions required to ensure sustainable capability. In response VG agreed to provide further detail and to feed back comments raised to the programme leads

KB sought clarity regarding whether a comparable process exists for monitoring off-label medication use, in addition to devices.

KB referred to the organisational redesign on systems and governance and queried whether there is a comprehensive mapping of systems and processes impacted by organisational redesign, specifically, regarding tracking of mandatory training and governance data. In response AB confirmed the existence of a transition plan covering all systems. AB advised on the complexity of system changes and the varying timelines for implementation

SQAC acknowledged potential risks during transition and the need for close oversight of system changes and reporting continuity.

Resolved: SQAC requested a detailed update on restrictive practice programme, including workforce capability and training plan.

SQAC acknowledged the need to strengthen assurance on off-label use (devices and medicines) and training compliance monitoring.

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

26/27/70

Infection Prevention Control Annual Report

VG presented the Infection Prevention Control Annual Report

- There is continued development of IPC governance structures, including enhanced IPC Committee oversight, establishment of operational sub-groups and work programmes. Increased visibility and engagement through daily isolation ward rounds and education and outbreak response activity.
- The IPC team demonstrate robust and responsive management of Infection incidents, outbreaks and exposure events. There is effective collaboration observed with internal clinical teams and external agencies which had contributed to timely intervention and risk mitigation, supporting overall patient safety.

- Evidence of focused improvement in environmental cleanliness and water safety: With updated cleaning policies; introduction of discharge cleaning standards, product rationalisation and staff training packages.
 - IPC Team delivery supported by Clean Start Week, reinforcing visible improvements and engagement across clinical areas.
 - Clinical Water Safety Group has relaunched to strengthen infrastructure-related IPC controls.
 - VG referred to data quality and surveillance limitations given the current reliance on manual reporting processes, due to delay in implementation of ICNET system resulting in reduced reliability and efficiency of surveillance data. VG advised that progress is underway toward user acceptance testing, there had been some technical issues (“bugs”) which are currently being resolved prior to full implementation.
 - Post Infection Reviews (PIRs) continue to identify recurrent gaps in frontline practice, including: Hand hygiene compliance, ANTT (Aseptic Non-Touch Technique) adherence and appropriate use of PPE.
- VG advised on Key priorities to strengthen IPC assurance which include implementation of ICNET system to improve data capture and surveillance and a more systematic approach to translating PIR findings into targeted preventative interventions at ward level, with the use of Clean Start Week as a sustained improvement mechanism, including ongoing audits and feedback loops to maintain compliance and standards.
- FB provided positive feedback on the report’s clarity and noted the strong narrative on external engagement and system working and highlighted this as a key strength of the IPC programme.

Resolved: SQAC received and **NOTED** the Infection Prevention Control Annual Report

26/27/71

Trust Wide recovery plan regarding clinical letters

PW presented the Trust Wide recovery plan for clinical letter production and sign-off, noting a positive improvement in performance. The introduction of ambient voice technology (Lyrebird) had significantly enhanced workflow, with approximately 76% of letters now processed through this system, resulting in improved timeliness, consistency, and efficiency of clinical correspondence.

SQAC noted that early feedback from patients and families has been positive, with letters described as clearer, more accessible, and timelier. No increase in complaints or incidents had been identified to date, although further review will continue to ensure that no unintended consequences arise.

SQAC acknowledged that while progress is evident, elements of the workflow remain in transition, with ongoing monitoring in place to ensure compliance and long-term sustainability of improvements across services.

FB sought assurance regarding the impact of the new approach on patient experience and safety. Assurance was provided that feedback had been positive, with a commitment to follow up on any emerging issues.

FB requested confirmation on future trajectory and sustainability. It was noted that further progress is expected over the coming months, and a follow-up update was agreed in three months to assess sustained improvement and inform transition to routine divisional oversight.

SQAC recognised the significant improvement achieved and gained assurance, noting the importance of embedding the new processes and maintaining performance over time.

Resolved: SQAC received and **NOTED** the Trust Wide recovery plan regarding clinical letters and welcomed a further update at the September 2026 SQAC meeting

26/27/72

Diagnostics notification update

MN presented the Diagnostics notification update and drew attention to a few key points within the report:-

- Diagnostics notifications performance remains broadly stable, with approximately 78% of results acknowledged within the recommended timeframe. However, it was highlighted that a cohort of clinicians continue not to utilise the Trust-wide system as intended, instead relying on existing processes.

SQAC noted that whilst the system is technically capable, there are ongoing behavioural and process challenges impacting full adoption, alongside known system limitations (including risks relating to leaver processes and incomplete result capture). MN updated SQAC on the ongoing work to identify clinicians who are not using the system and updated on proposals to strengthen oversight of unacknowledged results, including development of a revised SOP to allow auto-acknowledgement of older results and the introduction of alternative reporting mechanisms to ensure clinical teams maintain visibility and follow-up of outstanding investigations. These developments are expected to be supported by the forthcoming Meditech upgrade.

FB sought assurance on patient safety, particularly how timely review and action of diagnostic results would be maintained where system compliance is inconsistent. It was acknowledged that driving consistent clinician engagement remains challenging, with ongoing work to identify and address non-compliance.

SQAC expressed concern that operating outside a Trust-wide system presents a significant patient safety risk, and that clearer expectations and accountability are required.

PW confirmed that a formal risk had been recorded on InPhase to reflect system and behavioural challenges, and that benchmarking with other organisations is underway to identify best practice and inform improvement.

SQAC recognised the significant residual risk and emphasised the need for strengthened clinical leadership and compliance, noting that further work is required to ensure safe, consistent and reliable management of diagnostic results across the Trust.

LC sought clarity on whether the proposed system changes would simplify reporting for clinical teams. In response MN confirmed that the new approach would enable clearer, consolidated reporting.

LC and AB expressed concern that it is not acceptable for clinicians to operate outside a Trust-wide system, highlighting that this as a patient safety and performance issue and emphasised the need to address this through clear standards, accountability, and leadership action.

AB highlighted continued discomfort with the residual risk associated with inconsistent system use and suggested exploring clearer risk stratification, stronger expectations and standards for compliance and the potential use of innovation (including AI) to support workflow efficiency.

Resolved: SQAC agreed that an offline discussion would be held with the Chief Medical Officer, Chair of SQAC, Divisional Director for Community & Mental Health and the Chief Operating Officer.

26/27/73

SBARD - Inphase Transition How We Will Work in the Future

VG presented the SBARD - Inphase Transition How We Will Work in the Future noting the risks and mitigation plan associated with moving from a divisional to a systems-based structure. It was highlighted that the InPhase system does not support parallel running of old and new structures, requiring a live transition approach, which introduces operational and governance risks.

SQAC noted the proposed transition timeline, with a planned go-live date of 1 September 2026, supported by a structured programme of activity over the summer period. This includes system reconfiguration, data migration, and alignment of organisational structures and permissions.

Key Transition Approach: -

- Introduction of an amnesty process during July to close down historical incidents and actions where appropriate and ensure focus on live and relevant records only.
- System reconfiguration and data migration (July–August) - Building new organisational structures within the live system and backdating and transferring open records to align with the new structure.
- SQAC noted the temporary limitations in reporting: - During August, reporting will be restricted to Trust-level data only due to transition activity.
- Governance and oversight arrangements - central oversight of transition progress, Ongoing monitoring and escalation of risks and rebuilding of dashboards and reports ahead of

Quarter 3 (October).

- Key Risks Identified - risk associated with transitioning within a live system environment, potential disruption to data quality; reporting accuracy and notification routing.
- Dependency on Divisional governance teams to support manual data updates and validation, accurate alignment of roles, permissions, and notification pathway.

FB sought clarification on the “amnesty” process, specifically regarding when it would be appropriate to close records and emphasised the need to ensure that active or complex incidents are not closed prematurely. In response NA confirmed that most records should be capable of closure and that there will be a small number of complex or ongoing cases which will be retained and transferred appropriately.

KB sought assurance regarding the continuity of notifications during the transition, the risk of notifications being misrouted, missed or ignored. In response VG confirmed that there is a forensic approach to system configuration and alignment.

NA added that assurance will not rely solely on the system, existing governance processes (e.g. review meetings) will provide additional safeguards.

KB queried whether all system-wide changes (beyond InPhase) had been identified and planned. Confirmation was received that a wider transition plan exists, covering IT systems, HR and finance systems and is managed through the programme steering group, with varying timelines depending on system complexity. PW provided assurance on the robustness of the approach and commended the detailed and systematic planning, particularly the role of the InPhase developer.

SQAC supported the proposed approach and gained assurance, acknowledging the complexity of the transition and the need for careful management, while approving the implementation timeline, including the amnesty process and transition plan.

Resolved: SQAC received and **NOTED** the SBARD - Inphase Transition How We Will Work in the Future update

26/26/74

Oncology Outliers report

CW presented the Oncology outliers report and drew attention to a few key points in the report: -

- SQAC noted the improvement in the overall position and ongoing systemic challenges. Outlier numbers had reduced, with current levels typically between one to three patients, compared to previous peaks of up to nine, with an average of approximately two patients per day. SQAC noted that demand and capacity remain inherently variable, driven by the unpredictable nature of oncology diagnosis and treatment requirements. While overall demand had not significantly increased, there has been a shift toward more complex treatment pathways, contributing to sustained pressure on inpatient capacity. Average occupancy remains above 110%, with peak demand typically occurring midweek.

SQAC recognised that outliers present risks to patient safety and experience, including reduced specialist oversight, fragmented care, and increased workforce pressure. Mitigations are in place, include daily specialist review, improved cohorting, outreach support, and enhanced bed management, alongside expansion of ambulatory and care closer to home pathways.

SQAC acknowledged that these mitigations alone are unlikely to deliver a sustained reduction, and that a more strategic approach is required. Proposed actions include increasing inpatient capacity (including potential ward reconfiguration to create additional beds), strengthening cohorting models, enhancing workforce and pathway design, improving data and analytics to better understand demand and trends.

FB stated that the issue extends beyond bed capacity, raising broader questions regarding patient experience and service ambition and the need for a more strategic, longer-term approach to service design.

NA highlighted the growing complexity of oncology treatments and associated inpatient needs noting that whilst some treatments may move to outpatient settings over time, future demand remains uncertain. NA suggested exploring alternative models (e.g. accommodation solutions such as Ronald McDonald House) to reduce inpatient reliance.

GM requested whether there is evidence of differences in clinical outcomes for outlier patients and emphasised the importance of understanding outcome impact to strengthen the case for change. In response CW confirmed that while complaints data does not indicate significant concerns, families express a preference to be cared for within the specialist oncology unit. CW acknowledged that further work is required to evaluate outcomes and patient experience more systematically.

LR highlighted opportunities to improve predictive modelling, particularly linked to clinical trials activity and emerging treatments and suggested closer collaboration between clinical and research teams to address workforce and capacity challenges.

JP highlighted the importance of including environmental and holistic care factors when considering outcomes and patient experience.

SQAC recognised this as a complex and system-wide issue requiring strategic consideration, and noted that while performance had improved, a sustained reduction in outliers will require investment and service redesign.

Resolved: SQAC agreed that a comprehensive update would be presented to SQAC at the December 2026 meeting to include an assessment of patient outcomes and experience, update on national work and modelling and an update on progress on capacity and pathway solutions

Resolved: SQAC received and **NOTED** the Oncology Outliers Report

26/27/75

Sefton SEND Inspection report and outcome

LC presented the Sefton SEND Inspection report and outcome and drew attention to a few key points within the report: -

- SQAC noted that whilst progress has been made since the previous 2019 inspection, the overall outcome identified that partnership arrangements continue to result in inconsistent experiences and outcomes for children and young people with SEND.
- The inspection acknowledged strong leadership and system commitment, with positive feedback on the contribution of Alder Hey services, including engagement initiatives such as the Youth Forum. However, further improvement is required across the local partnership, particularly in the context of forthcoming SEND reforms.
- Key areas for improvement highlighted within the inspection included: ongoing challenges with waiting times, particularly in neurodevelopmental and mental health services, absence of a local educational psychology service, representing a significant system gap, issues relating to the timeliness and quality of Education, Health and Care Plans (EHCPs)
- Report highlighted the need to strengthen support for transition to adulthood pathways
- Requirement to improve the use of data to inform service planning and delivery

SQAC noted that a partnership-wide action plan is being developed, with Alder Hey contributing through system governance structures. A corresponding internal action plan will be established and monitored at divisional level, with particular focus on waiting times for mental health and neurodevelopmental services.

FB emphasised the importance of continued focus on partnership working and system-wide collaboration to address the identified gaps.

GM stated that in the context of national comparisons, the inspection outcome is relatively positive, with more severe findings commonly seen elsewhere and highlighted that SEND inspections are typically challenging and resource-intensive and emphasised the importance of continued focus on partnership working, which remains a recurring theme across national reviews.

SQAC acknowledged the importance of supporting the Local Authority and system partners to address identified gaps and that similar inspections are ongoing across neighbouring areas (e.g. Knowsley and Liverpool), with implications for system-wide learning.

Resolved: SQAC received and **NOTED** the Sefton SEND Inspection report and outcome and gained assurance, recognising the progress made to date, whilst highlighting the need for

---- Caring ----

---- Effective ----

- 26/27/76 Southport Learning Review**
NA presented the Southport Learning Review and drew attention to a few key points within the report: -
SQAC noted the significant progress in delivery of the agreed actions. The number of outstanding actions have reduced from 39 to 37, the two outstanding actions remain on trajectory for completion.
SQAC noted that overall progress remains on trajectory, including Phase 1 recommendations. NA advised of a minor correction required within the report, confirming that one recommendation remains on trajectory for completion by October.
- GM sought clarification on previous requested actions relating to a demonstration of the digital system supporting the review and queried how lead agency is recorded - identified as a key issue arising from the review. In response NA clarified that the digital system demonstration is scheduled to be presented at Trust Board, and not at SQAC and that this remains in progress and will be followed up as appropriate. NA confirmed that actions relating to governance and system development continue to be progressed.
- SQAC acknowledged the importance of ensuring visibility of progress on key recommendations and maintaining oversight of system and governance improvements arising from the review.
- SQAC noted that Phase 2 of the inquiry is expected to commence in September and that ongoing monitoring and learning will continue as part of the wider programme.
- Resolved:** SQAC received and **NOTED** the Southport Learning Review
- 26/27/77 Clinical Effectiveness and Outcomes Board Chairs Highlight report**
VG presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report and advised on the continued requirement for oversight of (Risk 247), which remains under review through CEOB governance structures. VG advised that there are no significant new risks or areas of concern to update the committee on.
- Resolved:** SQAC received and **NOTED** the Clinical Effectiveness & Outcomes Board Chairs Highlight report
- 26/27/78 Board Assurance Framework**
SQAC **NOTED** the Board Assurance Framework report.
- Resolved:** SQAC received and **NOTED** the Board Assurance Framework
- 26/27/79 Board Assurance Framework – Deep dive of Risk 1.1**
NA presented the Board Assurance Framework – Deep dive of Risk 1.1 noting that overall, a high level of assurance can be taken from both the controls in place and the actions identified to address gaps. The deep dive was structured in line with the Trust's established approach and reflected continued progress in strengthening the alignment between risks, controls, and mitigating actions.
SQAC noted that the BAF has been updated to better reflect current internal and external challenges, with reference to wider system pressures, including financial constraints. The framework was considered to provide a more accurate and up-to-date representation of the Trust's risk profile.
- NA highlighted that the deep dive demonstrates good progress in both risk articulation and control effectiveness and confirmed that the framework reflects current operational and strategic challenges.

FB stated that the deep dive provided useful triangulation with issues regularly discussed at SQAC and noted the strengthened confidence that the key risks are appropriately identified and managed within the Board Assurance Framework, with ongoing focus regarding continued refinement of risks to reflect emerging pressures and maintaining strong alignment between the BAF and operational delivery.

Resolved: SQAC received and **NOTED** the deep dive of Risk 1.1 and gained assurance, recognising the strengthened position of the Board Assurance Framework and its alignment with the Trust's key risks and priorities.

26/27/80

Mortality Annual Report

JG presented the Mortality Report and drew attention to a few key points within the report: - JG advised that there is overall reassuring performance and evidence of learning and improvement.

- Mortality levels remained lower than expected compared to historical trends, with recent months showing a gradual return toward more typical levels. It was noted that this variation is likely attributable to data recording changes rather than a material shift in clinical practice.
- SQAC noted that external benchmarking showed observed deaths below expected levels -(8 vs 11.7). JG reported that previously identified coding issues had now been addressed through revised processes and strengthened oversight.
- Neonatal Mortality accounted for 35% of total deaths, most of these deaths related to congenital/genetic conditions (67%), Perinatal causes (33%). 66% of cases were palliative, reflecting high complexity and limited treatment options.
- Learning Disability Deep Dive - No significant concerns identified, cases characterised by high complexity, some sudden deaths (awaiting coroner outcomes) and cases involving incurable conditions.
- Coding and Data Quality: Previous issues impacting benchmarking had been resolved and there is strengthened processes which now include Senior clinical review of submitted data.
- Clinical Learning identified a need for holistic antenatal counselling, ensuring full consideration of comorbidities, requirement for availability of neonatal equipment in ED for rare but critical scenarios, importance of early advanced care planning discussions in complex respiratory cases, improved focus on bone health in long-stay PICU patients, use of appropriate antibiotics in complex transport cases and evidence of learning being embedded, with similar subsequent cases demonstrating improved management.
- Patient and Family Experience – There is continued focus on timely and consistent feedback to families, notable that some positive feedback from families has been received, indicating improvements in communication and care.

FB noted the report provided strong assurance, particularly in relation to the resolution of the data quality issues and clear evidence of organisational learning. FB acknowledged the value of demonstrated learning from incidents and improved confidence in data accuracy and benchmarking.

Resolved: SQAC received and **NOTED** the Mortality Annual Report and gained assurance, recognising both the improved data accuracy and the strong evidence of learning and quality improvement across the organisation.

26/27/81

Health Inequalities Report

RI presented the Health Inequalities Report and drew attention to a few key points within the report: -

Highlights: -

- SQAC noted the ongoing progress across a range of programmes aimed at improving outcomes and reducing inequalities. The report highlighted continued delivery of key initiatives, including vaccination work, which is gaining national recognition, alongside successful securing of external funding for the current financial year.
- RG advised on the Trust's designation as a Marmot organisation, reflecting a strengthened organisational commitment to addressing health inequalities and aligning with wider city ambitions.

- SQAC recognised the contribution of the Academy and broader public health initiatives, although it was noted that these are not always sufficiently visible within reports.

RI referred to the emerging work on weight management and wider prevention activity, although it was acknowledged that further data and evaluation are required to fully evidence impact.

Challenges: -

- Data and Metrics: Current limitations in accessing data to support the agreed metrics for the programme, work is ongoing with the digital teams to improve data availability and reporting capability.
- Recognition that meaningful metrics will be critical for future assurance
- SQAC welcomed the proposal to receive quarterly Health Inequality update reports to strengthen oversight and alignment with wider organisational changes

FB highlighted the need for a clearer reporting framework, including what information SQAC would like to receive, how reporting should be structured across the year and noted that the move to quarterly reporting should support greater focus on prevention and population health and align with broader organisational priorities.

SQAC discussion emphasised the importance of strengthening the public health and prevention agenda, and the need to ensure clarity on roles and responsibilities across public health, health inequalities, system partners and requirement for improved data, metrics, and impact measurement to support assurance.

SQAC noted the update, whilst recognising the need to strengthen reporting, data, and clarity of impact to support future oversight of the health inequalities agenda.

Resolved: SQAC and **NOTED** the Health Inequalities Report

26/27/82

Cheshire & Merseyside Mental Health Transformation Plan

LC presented the Cheshire & Merseyside Mental Health Transformation Plan noting the report was presented for information. LC highlighted that the current plan covers a 12-month period, rather than the usual two to three years, reflecting ongoing changes within the Integrated Care Board (ICB) and evolving national funding arrangements for mental health services.

SQAC noted that Alder Hey remains a key contributor to the system-wide plan, with a requirement to provide quarterly progress updates to the Cheshire & Merseyside ICB. The plan reflects a period of transition within the wider system, with future direction expected to be shaped by changes in commissioning structures and funding models.

SQAC acknowledged that the development of a 12-month plan is pragmatic given the current system uncertainty and it is positive that a plan remains in place during a period of change.

FB noted that the plan reflects the current position and system constraints and recognised that short-term planning is appropriate in the context of ongoing structural and funding changes.

SQAC noted the update and gained assurance, recognising the pragmatic approach to planning during a period of system transition and the importance of maintaining oversight through regular reporting.

Resolved: SQAC received and **NOTED** the Cheshire & Merseyside Mental Health Transformation Plan

---- *Well Led* ----

26/27/83

Discharge Planning Policy

SQAC received, **NOTED** and ratified the Discharge Planning Policy

26/27/84

Debriefing Guidance document

SQAC received, **NOTED** and ratified the Debriefing Guidance document

26/27/85 Environmental Risk Assessment and Management Guideline (Self-Harm) guideline
 SQAC considered the Environmental Risk Assessment and Management Guideline for ratification and noted several significant concerns requiring further review. Whilst the policy had progressed through prior governance routes, KB identified issues relating to clarity, accuracy, and alignment with existing risk management processes.

KB raised several substantive concerns regarding the content and structure of the guideline: The document contained incorrect references to the Trust’s overarching risk assessment policy, noting that environmental risk assessments are a distinct and specialised process and should not be conflated with general risk assessment frameworks; inaccurate statements regarding roles and responsibilities, particularly relating to the central risk team; references to divisional SQAC structures that were not considered appropriate or accurate within the context of the guideline; the scope of the document did not fully reflect all relevant groups, highlighting that reference is made to patients, carers, visitors, and staff, however, members of the public are not explicitly included, which was considered a gap, particularly in light of recent incidents. KB advised that the guideline requires a comprehensive review and discussion with the central risk team to ensure accuracy and alignment with governance arrangements. JP confirmed ownership of the guideline and agreed to take forward the feedback and review

SQAC agreed that the guideline is required to be revised and strengthened, addressing the issues raised and should be subject to further scrutiny prior to resubmission to SQAC for ratifying.

26/27/86 RM49 – Hospital Cleaning Policy
 SQAC received, **NOTED** and ratified RM49 – Hospital Cleaning Policy

Any Other Business

26/27/87 Any Other Business
 None received

Board Assurance

26/27/88 Review the key assurances and highlights to report to the Board
 The key assurances and highlights report was presented to the Board meeting held on 4th June 2026.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Sickness Absence Update
Report of:	Melissa Swindell, Chief People Officer
Paper Prepared by:	Kat Allsop, Associate Director of HR
Purpose of Paper:	Decision ☐ Assurance ☐ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☐
Summary / supporting information	To present to the Committee an update on sickness absence and the additional supportive measures that have been put in place to support wellbeing and reduce absence
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
#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
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	



Sickness Absence Overview: August 2026

1. Executive Summary

Sickness absence continues to be challenging, with the Trust's sickness absence % being scored 130 out of 134 for Q3 2025/26 in the National Oversight Framework, and around £2 million being spent through NHSP to cover sickness, and £12 million (salary cost only) on sick pay across 12 months (July – June). The approach to sickness absence management and support, cost, targeted action and recent audit results are outlined.

2. Background and Current State

Looking across the region, the Trust rates towards the bottom of local specialist hospitals, and low compared to other children's hospitals.

Trust (Q3 2025/26)	Sickness %	Rank
Alder Hey Children's NHS FT	7.08%	130 out of 134
Liverpool Heart and Chest Hospital NHS FT	5.76%	71 out of 134
The Clatterbridge Cancer Centre NHS FT	5.84%	77 out of 134
Liverpool Women's NHS FT	7.71%	134 out of 134
The Walton Centre NHS FT	6.86%	127 out of 134
Mersey and West Lancashire Teaching Hospitals NHS T	4.7%	22 out of 134
Manchester University NHS FT	6.44%	116 out of 134
Liverpool University Hospitals NHS FT	6.76%	124 out of 134
Birmingham Women's and Children's NHS FT	5.44%	60 out of 134
Great Ormond Street Hospital	4.43%	9 out of 134
Sheffield Children's NHS FT	5.78%	73 out of 134
Median (Acute trusts)	5.59%	
Cheshire & Wirral Partnership NHS FT	7.68%	56 out of 61
Mersey Care NHS FT	8.42%	60 out of 61
Median (Mental health and community trusts)	6.22%	

2.1 Proportion of Absence & Spend

Ten areas account for a third of the Trust absence percentage across 12 months (July to June), with all except Accident & Emergency and Ward 1C remaining in the top 10 in July 2026. Four of these areas, plus HDU account for **45% of the spend with NHSP** across the past 12 months booked as covering sickness absence. Opportunity for saving through sickness absence reduction is outlined below:

Department	July Sickness Absence %	Proportion of Trust Sickness	July Spend (Sick Pay £)*	July Spend NHSP (£)**	Last 12 months Spend NHSP**	Monthly saving if a sickness absence reduces by 1% (£)
Accident & Emergency	4.57%	2.09%	£19,975.97	£ 8,631.88	£ 64,249.80	£ 1,888.81
Domestic Cleaning Services	15.79%	5.26%	£28,173.95	£ 54,436.02	£ 610,727.91	£ 3,447.50
HDU Ward	7.58%	2.07%	£18,696.54	£ 13,814.35	£ 214,987.80	£ 1,822.47
Outpatients Level 2	9.66%	3.08%	£19,502.86	£ 4,811.00	£ 2,549.63	£ 498.03
PICU	5.48%	3.61%	£34,009.48	£ 25,310.14	£ 400,710.32	£ 4,618.64
Sunflower House	10.45%	1.71%	£16,272.56	£ 64,527.96	£ 447,112.73	£ 6,174.92
Ward 1C	3.89%	0.94%	£ 9,298.01	£ 8,052.48	£ 123,884.50	£ 2,070.04
Ward 3A	10.84%	2.72%	£22,822.53	£ 45,535.27	£ 325,161.56	£ 4,200.67
Ward 3C	8.95%	2.56%	£23,734.18	£ 2,397.92	£ 67,907.06	£ 267.92
Ward 4A	12.37%	3.53%	£34,897.69	£ 25,247.67	£ 257,363.21	£ 2,041.04
Ward 4B	11.03%	3.53%	£26,263.60	£ 3,534.29	£ 188,771.66	£ 320.42
Ward 4C	15.41%	3.40%	£28,016.55	£ 2,445.56	£ 52,974.16	£ 158.70
* Sick pay salary costs only			Potential opportunity exc. existing CIP: £ 14,195.46			
**NHSP spend booked as sickness absence cover						

There is a cost improvement scheme lead by the Chief Nursing, AHP and Experience Officer, and Directors of Nursing, focusing on reducing NHSP spend for any reason across PICU, Sunflower House, Ward 4A, Ward 4B and Ward 4C as the highest areas of total spend. Any saving in these areas would be reported through that scheme.

To inform actions, when looking at sick pay, across 12 months (July - June), **50% of sick pay is due to absences for anxiety, stress and depression** (approx. £4.5m), gastro (approx. £1m) and cough, cold and flu (approx. £900k). These are salary only costs.

Looking by band, the highest % of sickness is amongst band 2, 3 and band 5. When looking by sickness salary costs, the highest spend on sick pay is currently with the band 5s, then 6 and 7 (across professional groups).

2.2 Insights

- **Reporting:** Locally, sickness absence information can be reported in each area directly through their manager ESR access. To support ease of reporting, a dashboard is being developed that can filter sickness and other workforce metrics by area (due in the Autumn), with a more detailed dashboard available to the people team. Reporting to Divisional (as was) boards, Execs, People Committee, and Trust Board
- **Hotspot areas:** Targeted support has commenced in the hotspot areas to agree tailored support in each area, with feedback and available data sources (NHSP fill rates, occupancy, etc.) being used to inform action.

3. Policy

3.1 Trust Policy

A regional sickness absence policy has been developed which is under review for implementation at the Trust. The regional policy has a combination of more frequent triggers, and also more triggers before reaching the end of the process, which will require consultation with staff side colleagues. Data is not yet available on its impact at Trust's who have implemented it.

3.2 Probationary Periods & Sickness Absence

There is an opportunity to implement a 6-month probationary period with sickness absence as a portion of the criteria for a successful probation. While this could provide an opportunity to end employment early, the case law is filled with caution around this and the risks of discrimination. At our Trust (Aug 25 – July 26):

- Sickness for colleagues 1-6 months in: 2.05%
- Sickness for colleagues in 6-12 months in: 2.33%
- Sickness for all colleagues: 6.45%

The Deputy CPOs are collecting information on who does/doesn't have probationary periods and their impact from across Cheshire & Mersey. An overview of what a probationary period at the Trust could look like will be worked up.

3.3 Pay Progression & Sickness Absence

An NHS Trust previously had included sickness absence levels within their AfC pay progression process. This was later withdrawn following a tribunal ruling finding that the Trust had acted unlawfully in doing so (Bent and others v Central Manchester University Hospitals NHS Foundation Trust).

4. Audit

MiAA have recently undertaken an audit, with the overall objective to evaluate proactive management of sickness absence and compliance with Trust policy (report being finalised). The audit has returned limited assurance and confirmed:

- Supportive RTW conversations with appropriate phased return arrangements
- Appropriate, evidenced and consistent reporting through to Board
- Inconsistent RTW completion, application of triggers and OH referrals
- Gaps in retention of self-certification and FIT note documentation.

The audit has supported our actions to strengthen sickness management processes.

In addition, there is an existing rule prohibiting colleagues from picking up NHSP shifts 2 weeks after returning from sickness absence. An internal audit was undertaken looking at shifts across a 6-week period. The rule was found to have been applied consistently

on all but one occasion where a shift was worked on day 5 after absence, which has been fed-back. In all other instances, the rule was appropriately applied.

A review of 12 months of occupational health management referrals shows the highest levels of referrals correlating with the higher areas of sickness absence as would be expected, with 1,315 management referrals undertaken across the Trust in the first 12 months of the contract.

5. Approach

In response to the sickness absence position, and to pre-empt future sickness absence, actions are being prioritised across manager support, automation, and targeted, data driven, support, focusing on enhancing both support and challenge and accountability. This approach also aligns with the available research around sickness absence management, and the importance of consistent, quality, early manager intervention, a targeted approach (generally and specifically in relation to mental health support), high-quality return to works, early occupational health, utilisation of reasonable adjustments and work to support prevention.

With much of this already outlined in our policy, supporting robust management practices, in line with Trust policy, is essential. Actions will be overseen by a task and finish group; those actions believed to be most significant are in bold.

Following the implementation of the People Team changes implemented in August 2026, sickness and wellbeing support are now aligned, with the People and Wellbeing team managed by the Clinical Lead for SALS, focusing on how we support health seeking behaviour looking at proactive interventions, with professional accountability and support from People Services (HR as was).

6. Conclusion

Sickness absence continues to be challenging, with our refreshed approach, aligned with changes in the People Services structure outlined. There is focus on improvements to benefit across the Trust, and with targeted work in the areas consistency contributing to the highest proportion to the Trust's sickness absence and bank spend for this reason. The actions outlined will be supported through a task and finish group and sickness absence management updates will continue to be reported to People Committee.

Theme	Action	Target Date
Manager Support	Policy Reset 1. Undertake a full review of colleagues with the most short-term absence episodes across 18 months, ensuring appropriate management is in place, or support compliance moving forwards. Escalation where absences aren't being managed per policy 2. Review and update the sickness management policy Regular Support 3. Bookable manager advice drop-in sessions each week, split across application of triggers, occupational health referrals, general advice, and meeting prep. 4. Regular promotion of long-term condition management sessions lead by occupational health for managers and colleagues, alongside training on completing and getting the best from a quality management referral.	Autum 2026 Spring 2027 August 2026 Autumn 2026
Targeted Support**	5. Specific, targeted, regular support booked in for areas with the highest sickness absence , starting with domestics, PICU, 1C, 3A, 4B, 4A, 3C and 4C.	Initial meeting, Sept 2026
Targeted Support: Mental Health	6. Pilot of additional mental health support for colleagues in the hot spot areas who have had 2+ absences for mental health in 12 months, with a conversation and support plan to be arranged with their manager 7. Pilot: Establishment of a working group on nurse wellbeing on ward 4c, with the Ward Manager, Clinical Lead of SALS, Retention Manager, and People & Wellbeing Manager 8. Support implementation of SALS PALS in areas of high sickness (nurturing nudge) 9. A push for all areas with high levels of sickness absence to appoint and train 1 or more colleagues within the department to undertake Stress Risk Assessments when required.	Autumn 2026 Autumn 2026 Autumn 2026 Spring 2027
Targeted Support	10. Implement actions with the ACE network following their survey of and feedback on reasonable adjustments, building on work lead by the Head of ED&I on improving manager confidence with reasonable adjustments and resources for manager and colleagues.	Commence Autumn 2026
Automation	11. Automate long term sickness email prompts to managers with clear advice and actions 12. Support for completion of meeting invite and outcome letters 13. Expand automatic email prompts to managers for colleagues who have hit sickness absence triggers 14. Introduce additional reason information under 'Anxiety, Stress, Depression' to provide greater understanding	Nov 2026 Dec 2026 February 2027 October 2026
Probationary Period	15. Develop an overview of what a probationary period at the Trust could look like will be worked up.	Autum 2026
Dashboard	16. Complete development of an area level dashboard of workforce KPIs to include sickness absence	Nov 2026

**A previous action focusing on band 2 and 3 colleagues has been reviewed and will be picked up in targeted work with hotspot areas.

***Targeted support for high absence areas involves:**

Initial meeting with the Manager and Matron/Head of Nursing focused on reviewing current attendance management practices and identifying opportunities for improvement. Key objectives will include:

- **Reviewing the team's sickness records** to ensure all employees are being managed at the correct attendance management stage.
- **Verifying compliance with the Attendance Management Policy** to promote a consistent and fair approach to attendance management across the Trust.
- **Reviewing all long-term sickness cases** and developing clear action plans for each employee, including agreed management actions and review dates.
- **Understanding any challenges within the service area** and exploring how the People and Wellbeing Team, alongside senior management, can provide additional support to managers.

Actions Following the Meeting include:

- **Develop individual support plans for employees with high levels of absence related to Stress, Anxiety and Depression.** These plans will include agreed actions, responsibilities and review dates, alongside consideration of Occupational Health referrals, SALS input and other appropriate support measures.
- **Provide leadership development and refresher training for managers** covering attendance management, compassionate leadership, managing difficult conversations, and Occupational Health referral processes.
- **Consider the manager's feedback and any concerns** highlighted during the meeting, identifying any necessary support or resolution measures.
- **Monthly meetings between the manager and HR** to maintain focus and momentum on the management of sickness absence and provide an opportunity for support and advice.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Strategic People Update
Report of:	Melissa Swindell, Chief People Officer
Paper Prepared by:	Sharon Owen, Jo Potier, Katherine Birch, 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 July / August 2026.
Strategic Context	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
#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 Summer 2026.

Thriving Culture

The Thriving Culture programme of work is designed to strengthen the cultural conditions that enable people, teams and services to thrive, by focusing on leadership behaviour, safety, trust, fairness and learning under pressure.

By focusing on leadership behaviour and organisational conditions, this programme will result in more stable and resilient morale, increased psychological safety and trust, improved fairness and consistency, stronger team functioning and inclusion, reduced sickness absence and more stable morale across the organisation.

Central to this programme of work is organisational listening, insight and early intervention, ensuring that staff experience is understood in real time and that feedback leads to timely, visible change.

Collectively, this approach shifts the organisation away from reacting to morale as an outcome, towards actively shaping the conditions that enable trust, fairness, safety and performance.

Organisational listening, insight & early intervention

SALS continues to be utilised as a rapid-response compassionate listening service. Contacts are now at over 21,900 since the establishment of the service in April 2020.

In the last 6 weeks there have been over 570 contacts to SALS, representing 94 new individuals who reached out for support. July saw 76 new referrals which is higher than previous years for this month which is reflective of the impact of ongoing organisational change. The team have proactively offered a 'Coping with Change' session to admin colleagues which shared themes related to tolerating uncertainty, increases in workload and psychological safety due to perceived threats to job losses. Support is being offered to the leadership team who are also affected by parallel processes with change management. Nurses remain the professional group with the highest engagement in SALS which is likely connected to some of the ongoing themes connected to challenges in secondary and vicarious trauma in work. More recent themes connect to the uncertainty of the reconfiguration on ward 4C and the continuation of movement.

Staff also continue to raise concerns via SALS about reasonable adjustments, particularly in clinical environments. SALS continue to work in partnership with People Services to share themes and support EDI activities. The SALS team have also recently reviewed the SALS Pals project and plan to do targeted work with the sickness absence team to support implementation of new SALS Pals in the next quarter. The team have also reviewed the recently released NHS Staff Standards to ensure health and wellbeing activity aligns with the new standards. The team continue to develop their communications and continue to deliver Trust Wide Spotlight sessions, the one in July focused on Self Care for international Self-Care Awareness Day. The team are planning a bulletin in September to signpost staff to all the upcoming offers in the next quarter.

A continued theme is the presentation of leadership strain and burnout. In response to this the team will be doing a spotlight focus on 'Leadership Under Pressure' for Schwartz on the 23rd September. Themes are also being shared with the OD team to ensure that the developing Thriving Leaders development offer is responsive to the needs arising in the organisation and cognisant of the developments from the new NHS College of Leadership and Management.

Organisational Development

Preparations are underway for the launch of the 2026/27 NHS Staff Survey, provisionally scheduled for 16 September. Work has commenced to ensure alignment with our new organisational systems, while final activity relating to the 2025/26 results has focused on creating and sharing thematic analysis of free text comments with divisional leadership teams and supporting local action planning via Thriving Teams Conversations.

The launch of the NHS Staff Standards and associated changes to the NHS Oversight Framework mean that a greater proportion of Staff Survey indicators will contribute directly to the Trust's oversight ratings, highlighting further the importance of staff experience and our Staff Survey results.

As a result of this, alongside maintaining a strong focus on survey participation and engagement, there will be an increased emphasis on supporting local ownership of survey outcomes through Thriving Teams Conversations. To date, approximately 25% of teams have reported completing these discussions in 25/26 and improving this in the coming year is a key priority in improving local staff experience.

Our Staff Survey results continue to provide valuable trust wide and local intelligence, informing priorities for organisational development and team support. A recent example is the Radiology 5 Pillars improvement programme, launched in July following review of local Staff Survey results. The programme is nearing the completion of its listening phase, engaging with 58 colleagues, representing over 65% of the service. Findings and recommendations will be shared with the service leadership team and wider workforce to support action planning and improvement.

The OD team continues to work in partnership with Liverpool Women's Hospital and have co-developed a programme of leadership and culture workshops to support leaders across the Liverpool Neonatal Partnership (LNP). Following the successful delivery of the first workshop in June with the LNP Senior Leadership Team, a further three sessions are scheduled for September and October.

Demand for team-based interventions remain lower than usual while wider organisational transformation activity continues but in contrast, demand for individual coaching support remains high, with 42 active coaching relationships in place and a further 14 colleagues awaiting matching with internal coaches.

The team also continues to support the Trust's How We Will Work in the Future programme. Current priorities include the development of a Senior Leadership Team induction programme, due to launch in October, and the design of a refreshed leadership offer aligned to the recently introduced NHS Leadership and Management Framework. Support continues to be provided to colleagues experiencing significant change, including facilitated sessions for Admin staff, delivered jointly with the Staff Advice and Liaison Service (SALS).

Over the next quarter, the principal focus will be on maximising Staff Survey participation and ensuring leadership development activity robustly supports our Leaders and Managers across the Trust whilst remaining aligned to both organisational transformation priorities and the national NHS Leadership and Management Framework.

Equality, Diversity, and Inclusion

Alder Hey continues to demonstrate a clear and active commitment to progressing equality, diversity and inclusion priorities through a broad programme of work aligned to the Trust's strategic aims, national NHS expectations and local partnership activity. The focus remains on strengthening inclusive leadership, improving staff experience, responding to national anti-racism requirements, and ensuring that children, young people, families and colleagues experience Alder Hey as a welcoming, respectful and inclusive organisation.

Embedding Inclusive Practise and Anti-Racism

Our recent EDI activity has focused on translating national and regional requirements into practical local action. Key areas of activity include: review of the Trust's anti-racism response in light of the Lord Mann Review; continued engagement with regional EDI partners on the Liverpool City Region Anti-Racism Strategy; development of Active Bystander training materials and facilitator arrangements; and continued work to embed inclusive behaviours, psychological safety and equitable staff experience across the organisation.

Area of activity	July position	Next steps
Lord Mann Review response	Initial position reviewed and separate Board paper prepared setting out alignment, gaps and proposed actions.	Confirm Board oversight arrangements and monitor delivery against agreed actions.
Regional anti-racism partnership	Continued engagement with Liverpool City Region partners through public sector EDI networks.	Identify practical opportunities for Trust contribution to regional implementation.
Active Bystander programme	Learning resources and facilitator materials developed to support staff rollout.	Agree rollout schedule, evaluation approach and reporting route.
Inclusive culture and staff experience	Ongoing work continues to promote inclusive behaviours, psychological safety and routes for raising concerns.	Use staff feedback, WRES, staff survey and speaking-up themes to inform future priorities.

Education, Learning & Development

Full details of core education, learning and development activities are provided to Education Governance Committee and considered at People Committee, but some highlights which may be of interest to the Board include:

Mandatory Training

Mandatory training compliance remains an ongoing area of focus as business as usual. This is as although overall Trust compliance remains over 90% (94.25% as at 21.08.26) there remains to be pockets of non-compliance linked to specific staff groups, teams, individuals and topics. Focused reports are distributed across the Trust each month to key leads / managers and with the move to the new systems, work is ongoing to ensure any changes in terms of oversight and local management are reflected in the distribution lists. Subject Matter Experts (SMEs) are also updated with reports to enable them to be aware of the current position and enable corrective action if compliance is not maintained, or there are areas of emerging or continuing concern.

Widening Participation (WP)

Activity in line with our Inspiring Futures programme provides young people from across the Region with opportunities to explore health related careers, undertake supported internships / work experience and receive support and advice continues. Social value is captured and reported upon to SQAC and activity celebrated. A snapshot of activity includes:

- During June
 - a supported internship graduation took place with partners to celebrate the success and development of our 25/26 interns.
 - Alder Hey both sponsored and collaborated on a weeklong programme with our partners Elevate EBP and Year 6 pupils at St Margaret Mary's Primary School. This programme showcased a range of careers available for young people (with a focus on health and care as well as wider sector), enhanced pupil's knowledge of the Liverpool City Region, facilitated learning around promoting health, both physically and mentally, as well as developing a range of skills and abilities.
 - Alder Hey took part in a LCR RoundTable focused on supporting Care Experienced Young People into Further and Higher Education.
- During July
 - Circa 100 year 12 pupils attended our annual Aspiring Medics event, which supports pupils from across LCR who are intending to apply to medical school in the Autumn
 - Work commenced to plan next academic years activity between Alder Hey, Widening Participation, Medical Needs Education

- Planning continued for the Teen Tech event on 6th October 2026.
- Senior leads from the Academy supported a number of Children's University Graduations

PDR Update

Discussions are ongoing with Executive colleagues regarding the culture shift required to ensure PDR compliance is achieved. Key messages have been shared at Connecting Leaders and wider staff sessions, advising that PDRs are not optional and refreshing why they are of benefit and the timelines required. The timeline has been varied within tight boundaries for staff undergoing organisational change currently linked to the HWWWTF programme of work, if felt applicable by the relevant team(s).

The Band 7+ position (data as at 19.8.26) is currently 50.75% / Band 6 and below 65.67%.

As highlighted previously activity with the RPA team is required to develop a dashboard with the intention of providing access to accurate information, no more than 24 hours old for managers, thus reducing email traffic and enhancing the user experience.

Growth & Skills (formerly Apprenticeship) Levy Reforms: Update

The reforms announced in 2025 (with phased implementation across 2026) represent a significant shift in emphasis with a clearer focus on younger talent, pivoting funding away from the more expensive mid-career qualifications toward early-career and priority-skills pathways.

The changes introduced in August 2026 are summarised below:

- Faster expiry of levy funds – Employers will have 12 months, reduced from 24, to use their levy contributions before they expire.
- Higher co-investment once levy funds are used – Employers will need to contribute 25% of training costs once their levy balance is exhausted (up from the current 5%).
- Removal of the 10% top-up – The government's monthly top-up will be withdrawn. Employers will only be able to access the value of their own contributions.

Whilst some of the updates are technical or operational, the faster expiration of levy funds directly impacts our decision-making, particularly around budgeting, recruitment planning and training delivery timelines. The apprenticeship team are therefore working closely with existing learners, managers and wider system leads to ensure robust oversight and forecasting.

In addition, the government has confirmed that the Level 7 Enhanced Clinical Practitioner Apprenticeship will be defunded, which has meant that Alder Hey staff due to commence on the apprenticeship in September 26 now need to be funded directly. This has had a knock-on effect on wider CPD priorities, and the wider picture is being closely monitored

Development Hub

Work has been underway to develop a virtual development hub, in phases. Phase One focused on careers guidance and support, as well as learning and development opportunities and has been live for some time. Whilst Phase Two was ready to launch across the Summer, the publication nationally of the new leadership and management standards for the NHS has required us to delay the launch, as the standards necessitate a refresh of the skills scan component in the Hub. It is expected that the career pathways element will go live the end of September and a date is tbc for the skills scan. Phase Three – talent management - is in development and will become an area of increased focus.

Employee Relations & Wellbeing

Sickness Absence

The Trust's sickness absence position remains a significant workforce, operational and financial risk. Alder Hey was ranked 130 out of 134 acute trusts in the national NHS Oversight Framework for Q3 2025/26, with sickness absence of 7.08% compared with an acute trust median of 5.59%. The scale of the issue is also reflected financially, with increased costs through NHSP to cover sickness absence.

In July 2026 sickness absence was 6.57%, above the Trust target of 4.5%. This comprised of short-term sickness absence of 2.52% which was an increase from previous month (1.75% June 2026), and long-term sickness absence of 4.05% a slight reduction from previous month (4.21% June 2026). The Trust's local position has continued to sit materially above target, with absence driven by both long-term and short-term sickness. Long-term sickness has remained the largest component of absence, whilst recent movement has also shown increased pressure from short-term absence.

Review of sick pay by reason confirms that anxiety, stress and depression, gastro-related absence, and cough, cold and flu account for a substantial proportion of cost, with anxiety, stress and depression the most significant contributor. This reinforces the need for the Trust's response to combine strengthened attendance management with proactive health, wellbeing and prevention activity.

Hotspot analysis shows that ten areas account for approximately one third of the Trust's sickness absence over the 12 months from July to June. These include Domestic Cleaning Services, PICU, Ward 3A, Ward 4B, Outpatients Level 2, Ward 4A, Ward 3C, Accident and Emergency, Ward 4C and Ward 1C.

NHSP spend covering sickness is also concentrated, with PICU, HDU, Domestics, Ward 3A and Ward 4B accounting for 45% of sickness-related NHSP spend. Occupational Health referral activity broadly correlates with these higher absence areas, supporting the case for continued targeted intervention.

The Trust's refreshed approach is focused on manager support, automation, targeted data-driven intervention and clearer accountability. Immediate actions include:

- weekly bookable manager advice sessions;
- review of colleagues with the highest number of short-term absence episodes;
- promotion of long-term condition management sessions;
- targeted support in hotspot areas including absence and trigger review, individual support plans, manager training and monthly HR follow-up;
- additional mental health support for colleagues with repeated mental health-related absence; strengthened stress risk assessment capability;
- implementation of actions arising from ACE Network feedback on reasonable adjustments; development of automated prompts, templates and reporting to improve consistency.

Following the August 2026 People Team changes, sickness and wellbeing support are now more closely aligned through the People and Wellbeing team, with oversight through a task and finish group and continued reporting to People Committee.

Strategic actions to address sickness absence

- **Board-level grip and accountability:** strengthen executive oversight of sickness absence through routine review of system trajectories, hotspot areas, and delivery against agreed improvement actions, ensuring that sickness reduction is treated as a strategic workforce, quality and financial priority
- **Targeted intervention in high-impact areas:** prioritise support to the services with the highest absence and NHSP cost impact, using local diagnostic reviews to identify root causes and agree tailored action plans with clear owners, timescales and follow-up through the People and Wellbeing team.
- **Prevention and early intervention:** increase proactive wellbeing, mental health and stress risk assessment support, with a particular focus on anxiety, stress and depression, ensuring earlier access to support and reducing the risk of long-term absence developing or recurring.
- **Manager capability and consistency:** strengthen line manager confidence in applying attendance management processes, reasonable adjustments, return-to-work planning and compassionate conversations through advice sessions, standardised templates and targeted training.
- **Improved data and automation:** implement automated prompts, dashboards and regular reporting to support timely action, reduce variation in practice and enable clearer tracking of progress against the Trust target of 4.5%.
- **Integration with wider workforce planning:** align sickness absence reduction activity with workforce variance, bank usage and financial recovery work, recognising that sustained improvement will reduce reliance on temporary staffing and support safer, more stable services.

Management of Workforce Variance

Month 4 WTE profile:

Trust WTE Forecast	M12 FCT @ M4
Substantive FCT	4,082
Bank FCT	88
Agency FCT	1
Total WTE FCT	4,171
Substantive Budget	3,963
Bank Budget	35
Agency Budget	0
Total Budget/Establishment	3,998
SIP Plan Target	4,000
Variance to Budget	(172)
Variance to SIP Plan	(171)

Delivery of the 2026/27 workforce plan will continue to be supported through targeted controls on workforce growth, bank usage, recruitment and organisational change.

- **Bank controls:** Bank use increased to 194.68 WTE in July, largely driven by short-term sickness cover and vacancy cover; actions remain focused on reducing avoidable reliance on bank and strengthening grip on reasons for use.
- **Recruitment controls:** Recruitment pauses and vacancy scrutiny will continue where appropriate to manage workforce numbers and cost.
- **Voluntary redundancy:** The scheme opened on 4 March and closed on 30 April 2026. A total of 220 applications were received, with 67 approvals to date equating to 58.41 WTE, supporting planned workforce reduction and alignment to the 2026/27 plan.
- **Organisational change and redesign:** Service redesign, innovation, HWWITF schemes and digital opportunities will support sustainable workforce reduction while maintaining operational requirements.

Collectively, these actions are intended to close the gap between actual and planned workforce numbers and support delivery of the Trust's operational and financial objectives.

An exercise is underway within all systems to review their workforce plans and budgets, with a view to presenting their plans for further workforce efficiencies by mid-September and subsequently for discussion at the Finance, Transformation and Performance Committee.

Voluntary Redundancy Scheme

The Trust Voluntary Redundancy Scheme was open to staff from the 4th March 2026 and closed 30 April 2026. Colleagues who have been eligible to apply for voluntary redundancy in the first round are from the following groups:

- those colleagues who may be subject to organisational change
- in management and leadership roles
- non-patient facing roles

A total of 220 applications were received (several applications have been withdrawn during the process); with 62 (54.34 WTE) approvals granted to date (several VR approvals have been withdrawn). There are a minimal number of applications to be reviewed, and appeals are ongoing which will conclude by the end of June.

Recommendations & Board Actions

The board are asked to note the content of the report and support the actions being taken by the people services teams to support colleagues and mitigate the risks.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	NHS Staff Standards
Report of:	Chief People Officer

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk number	Risk description	Score

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

1. Introduction

The new NHS Staff Standards, a national framework designed to improve staff experience by setting minimum employment requirements and defining the actions employers must take to meet them, has now been launched.

Developed jointly by the Department of Health and Social Care and NHS England, the standards are intended to elevate staff experience to ensure it is prioritised alongside financial and operational performance.

Created in partnership with employers and staff representatives, the standards focus on six core areas identified by staff as the most important contributors to a positive working environment:

1. Line management
2. Health and wellbeing
3. Preventing and reducing violence against staff
4. Championing sexual safety
5. Tackling racism
6. Promoting flexible working

Each of these 6 core areas has been broken down into what staff can expect moving forward, as well as clear expectations and actions for employers to take to fulfil their responsibility for providing the systems, support and organisational environment to ensure the standards are achieved.

Whilst some expectations are relatively straightforward, such as requiring all leaders and managers to complete the new NHS Leadership and Management Framework self-assessment, others will require more complex operational review / change for example 'ensuring that all job plans accurately incorporate and allocate sufficient time for line management responsibilities'.

An overview and a full breakdown of the requirements for employers can be found here [NHS staff standards - GOV.UK](#).

2. Measuring Achievement of the Standards

Whilst it is expected that there will be a requirement to update on progress against embedding the standards, the core method for measuring achievement and outcomes will initially be from the Annual NHS Staff Survey which launches at Alder Hey in mid-September.

Each of the core areas will be measured individually against a range of Staff Survey questions (26 in total) and then the results from each area will be averaged together to create one overall 'NHS Staff Standards of Care' score.

Additional methods of measuring progress against the standards, including performance metrics may be added in the future.

3. Use of the Results in National Oversight Framework

This new 'NHS Staff Standards of Care' score will have a heightened level of importance due to it forming part of the refreshed NHS Oversight Framework (NOF). The NOF, which was launched last year to set out how NHS England will assess and oversee providers against a

range of agreed metrics, was a key part of the evidence that supported us achieving Advanced Foundation Trust status in November 2025.

For 2026/27 the NOF has been refreshed to widen its scope of measurement to improve its ability to accurately assess organisations. As part of this, the new Staff Standards of Care score will sit alongside another new score for the 26/27 NOF focused on the Staff Survey sub-score of 'advocacy' and the already existing Staff Survey scores on 'raising concerns' and 'engagement'.

4. Current Performance

Although the revised NOF will utilise the 2026 Staff Survey results, Model Hospital has produced indicative Staff Standards scores based on the 2025 Staff Survey results which can be seen below and give us an early view of our position against the new measurements.

Metric	Alder Hey Score	Quartile (1-4) (4 is best)	Sector Average
Overall Staff Standards Score	7.82	3	7.80
1. Line Management	6.87	2	6.93
- Line Management	7.16	2	7.18
- Team Management	7.06	3	7.04
- Appraisal	7.09	2	7.25
- Development	6.17	1	6.27
2. Health & Wellbeing	5.79	2	5.90
3. Violence Prevention & Reduction	9.55	2	9.57
4. Championing Sexual Safety	9.79	4	9.66
5. Tackling Racism	8.33	4	8.15
6. Promoting Flexible Working	6.60	2	6.61

5, Next Steps

The People Services function are currently in the process of establishing a working group to complete the process of mapping our current alignment to the new Staff Standards, identifying gaps and developing a robust action plan to support the Trust to achieve full alignment to the standards as soon as possible.

Updates on progress and areas requiring wider organisational support to achieve key expectations of the new standards will be provided as this work progresses.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	The Equality and Human Rights Commission (EHRC) Code of Practice, Supreme Court Judgement and Single-Sex Spaces
Report of:	Chief People Officer

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

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

Risk number	Risk description	Score

Level of assurance (as defined against the risk in InPhase)	☐ Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ Not Assured Evidence indicates poor effectiveness of controls
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The Equality and Human Rights Commission (EHRC) Code of Practice, Supreme Court Judgment and Single-Sex Spaces

Purpose

To brief the Board on the revised EHRC Code of Practice following the Supreme Court judgment, the current NHS England position, and the proposed Alder Hey response. The paper recognises that this is a sensitive, complex and potentially divisive area of law and practice, and that our response must protect legal compliance while showing care, dignity and respect to trans, non-binary, male and female colleagues, patients and families.

Background and context

The Supreme Court judgment in *'For Women Scotland Ltd v Scottish Ministers'* in 2025 confirmed that, for the purposes of the Equality Act 2010, references to sex, man and woman are to biological sex. The judgment also confirmed that people with the protected characteristic of gender reassignment continue to be protected under the Equality Act.

The EHRC has subsequently revised its statutory Code of Practice for services, public functions and associations, and NHS England is reviewing associated NHS guidance.

This is a challenging area for NHS organisations because it requires careful balancing of rights, dignity, privacy, safety, inclusion and operational practicality. The Trust should acknowledge openly that colleagues may hold deeply felt and differing views, and that some staff may feel anxious, exposed, unheard or uncertain about what the changes mean for them personally and professionally.

Principles

- **Respect and compassion:** All colleagues, patients and families should be treated with dignity, kindness and respect. This includes trans and non-binary people, women and men, and those who may feel particularly affected by changes to single-sex spaces.
- **Legal compliance with humanity:** Compliance with the law should be delivered in a way that is calm, proportionate and fair, avoiding language or processes that make any group feel blamed, excluded or unsafe.
- **Privacy, dignity and safety for all:** Decisions about facilities and accommodation should be evidence-based and focused on protecting privacy, dignity and safety, while ensuring that no individual is left without appropriate access to suitable facilities.
- **Constructive engagement:** The Trust should create safe routes for staff, networks and trade unions to raise concerns, recognising the sensitivity of the issue and the potential for polarised debate.

Implications

The main implications are likely to relate to staff toilets, showers and changing rooms, local EDI policies, manager guidance, communications and Board assurance. The Trust will need to review existing arrangements and consider whether any changes are necessary once NHS England guidance is finalised.

Key risks and mitigations

Risk	Why it matters	Mitigation
Legal compliance	Policies may need to be aligned with the statutory Code and revised NHS England guidance.	Structured policy review, EqlAs and executive oversight.
Employee relations	Staff may experience uncertainty, anxiety or disagreement, including trans colleagues and male and female colleagues with concerns about privacy or safety.	Sensitive engagement, safe routes to raise concerns, manager support and respectful communications.
Patient and family experience	Changes may affect confidence in privacy, dignity and inclusion if poorly explained or inconsistently applied.	Clear patient-facing principles, clinical input and consistent operational guidance.
Reputation and culture	The issue is high profile and divisive, and poorly framed messages could undermine trust.	Values-led narrative focused on dignity, compassion, safety and legal compliance.

Suggested action plan

Action	Recommended approach	Output
Establish executive oversight	Create a short-life executive-led group sponsored by People, Nursing and Finance to oversee the review.	Governance route and Board Committee reporting.
Policy review	Review staff facilities, uniform/changing areas	Gap analysis and update plan.
Facilities audit	Map staff and patient toilets, showers, changing facilities, including single-sex, individual and gender-neutral options.	Facilities assessment and prioritised options.
Equality Impact Assessments	Assess potential impacts on sex, gender reassignment, disability, religion or belief, privacy, dignity and safety.	Documented rationale, mitigations and decision record.
Engagement	Engage staff networks, trade unions, clinical leaders, FTSU, safeguarding and patient experience, using carefully facilitated conversations.	Engagement log and themes for action.
Communications and manager guidance	Prepare clear, compassionate communications and manager FAQs that acknowledge the sensitivities and provide escalation routes.	Communication pack and manager briefing.
Monitor national guidance	Track NHS England guidance on staff facilities and update local plans accordingly.	Regular Board assurance update.

Conclusion

Alder Hey will take a careful, legally compliant and values-led approach to the Supreme Court judgment and revised EHRC Code. The Trust recognises that this is a sensitive and potentially divisive issue for staff, patients and families. Our response will be grounded in privacy, dignity, safety, fairness and compassion, ensuring that trans, non-binary, male and female colleagues and service users are treated with respect and that no group is left feeling unsupported or unheard.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Legal Advice following the Publication of the Lord Mann Report
Report of:	Chief Corporate Affairs Officer

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

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

Risk number	Risk description	Score

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

YOUR REF:

OUR REF: TGY/CXO/01414927/3

DATED: 16 July 2026

Dear NHS organisations,

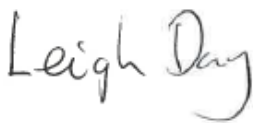
1. We enclose written advice entitled “The legal implications of the adoption of the International Holocaust Remembrance Alliance definition (**“the IHRA definition”**) of antisemitism within the NHS” prepared by specialist barristers Phillippa Kaufmann KC of Matrix Chambers, Zac Sammour of 11 KBW, Rayan Fakhoury and Isabelle Agerbak of Blackstone Chambers (**“the Advice”**).
2. This advice was prepared on the instruction of our client, Health Workers for Palestine (“HW4P”). HW4P advocates for the rights of Palestinian health workers, and its aims include ensuring that healthcare workers and their rights are protected and supported globally during humanitarian crises and armed conflict. The purpose of the Advice is to assist NHS organisations in making an informed decision on whether to adopt the IHRA definition following encouragement to do so by NHS England (‘NHSE’), or, if they have already chosen to adopt the IHRA definition, how to apply it lawfully in practice.¹
3. As is foreshadowed by its title, the Advice explains the legal obligations of NHS organisations in respect of the adoption and application of the IHRA working definition in regulating the speech of health workers and patients. It sets out the legal issues that NHS organisations are likely to face if they choose to adopt and apply the IHRA definition, including the risks of (i) interfering with free speech rights, and/or (ii) discriminating on grounds of race, religion or belief.
4. For the reasons set out in the Advice, there is a very real risk that, absent careful consideration, NHS organisations who choose to adopt and apply the IHRA definition will do so in a manner that is unlawful. The Advice seeks to set

¹ See for example: NHSE, ‘Lord Mann Review’ (4 June 2026), available at: <https://www.england.nhs.uk/long-read/lord-mann-review/>.

out circumstances where this may be the case and seeks to assist NHS managers and decision-makers in exercising their duties lawfully.

5. As is set out in the Advice, NHS organisations may therefore wish to think carefully as to whether it is appropriate (or helpful) for them to adopt the IHRA working definition. For the avoidance of doubt, NHS organisations are under no legal obligation to adopt the IHRA definition. Whilst the Secretary of State has the power to give NHS England (“**NHSE**”) directions as to the exercise of its functions, and NHSE in turn has the power to give directions to NHS trusts as to the exercise of their functions, neither of those powers has been exercised in relation to the IHRA working definition.
6. For NHS organisations that choose to adopt the IHRA definition, the Advice makes clear the need to provide written guidance as to its application and warns that a failure to provide proper guidance will likely give rise to interferences with freedom of expression and belief which may not be “prescribed by law” within the meaning of Articles 9 and/or 10 ECHR and would accordingly be unlawful under s.6 of the Human Rights Act 1998.
7. The Advice also sets out more generally ways in which adoption / application of the IHRA definition may give rise to both direct and indirect discrimination and breaches of duties under both the Equality Act 2010 and Human Rights Act 1998.
8. It is hoped that the enclosed Advice proves helpful in addressing the complex questions that arise for consideration by senior managers of NHS organisations in this context.

Yours faithfully,

A handwritten signature in black ink that reads "Leigh Day". The signature is written in a cursive, slightly informal style.

Leigh Day

The legal implications of the adoption of the IHRA Definition of antisemitism within the NHS

OPINION

A. Introduction and summary

1. The Government, the Secretary of State for Health, and NHS England (“**NHSE**”) have each encouraged NHS organisations¹ to adopt the International Holocaust Remembrance Alliance definition of antisemitism (the “**IHRA working definition**” or “**IHRA definition**”).
2. Health Workers 4 Palestine (“**HW4P**”) are concerned about this. They believe that the adoption by NHS organisations of the IHRA working definition will lead to unlawful censorship of speech by healthcare workers which is supportive of the Palestinian people and critical of Israel. They wish to understand the extent to which the law protects their members, and other workers and patients within the NHS, from censorship of that kind.
3. This advice addresses that question. We explain the legal obligations of NHS organisations in respect of the adoption and application of the IHRA working definition in regulating the speech of health workers and patients. We set out the legal issues that NHS organisations are likely to face if they choose to adopt and then apply the IHRA definition, including the risks of (i) interfering with free speech rights or (ii) discriminating on grounds of race, religion or belief.
4. We understand that HW4P intends to provide this advice to NHS organisations who are either (i) considering whether to adopt the IHRA definition, or (ii) have already adopted the definition, in the first case to assist them in deciding whether to adopt the definition at all and in the latter case to assist them in complying with their legal

¹ In this advice, we use this term broadly, to capture NHS Trusts, Foundation Trusts, Integrated Care Boards and other organisations with a patient service-provision role.

obligations when considering how to apply it. We have drafted this advice with that purpose in mind.

5. For the reasons set out below, there is a very real risk that, absent careful thought, NHS organisations who choose to adopt and apply the IHRA definition will do so in a manner that is unlawful. In summary:

- 5.1. It will not be lawful for an NHS organisation to use the IHRA definition to shield Israel from criticism. Speech which criticises the conduct or ideology of a nation state is essential to the functioning of any democracy and attracts the highest degree of legal protection. Save in very clear and extreme circumstances, it will not be antisemitic for a person to criticise the conduct of Israel or to challenge the moral legitimacy of its creation or continued existence as a state. An attempt by an NHS organisation to apply the IHRA definition to censure such speech is likely therefore to constitute an unlawful restriction of freedom of expression. It will only be antisemitic for a person to criticise Israel, or to challenge its right to exist, if they are motivated in doing so by hatred or prejudice toward Jews as Jews (as opposed to any one of the myriad other reasons why a person might criticise Israel, or challenge its legitimacy).

- 5.2. It will not be lawful for an NHS organisation to apply the IHRA definition in a way that relies on racist stereotypes against Palestinian people, such as the beliefs that (i) they do not exist as a people; (ii) their national aspirations are motivated by antisemitic hatred, as opposed to the natural inclination of any people to be free from alien occupation and domination, or (iii) they are inherently violent or predisposed to violence. In the same way, it is not lawful for an NHS organisation to apply the IHRA definition in a way that relies on racist or Islamophobic stereotypes against Muslims. If an NHS organisation applies the IHRA definition in a way which relies upon such stereotypes (whether expressly or otherwise), it is likely to act in a manner that violates fundamental rights to freedom of expression

and/or belief² and/or in a manner which infringes the Equality Act 2010 (“**EA 2010**”).

- 5.3. It will not be lawful for an NHS organisation to apply the IHRA definition in a way which relies on racist stereotypes against Jewish people, such as the beliefs that (i) Jewish people automatically associate with and/or have an affinity for Israel; or (ii) Jewish people are necessarily offended or upset by symbols of Palestinian national identity or existence. If an NHS organisation applies the IHRA definition in a way which relies upon such stereotypes (whether expressly or otherwise), it is likely to act in a manner that violates Article 10 and/or 9 ECHR and/or in a manner which infringes the EA 2010.
6. If NHS Trusts apply the IHRA definition in a manner which is unlawful, they will face legal and reputational risks. Those risks arise, most obviously, in the form of claims brought by staff or patients who face unlawful discrimination or restrictions on their Article 9 or 10 rights.
7. NHS organisations may therefore wish to think carefully as to whether it is appropriate (or helpful) for them to adopt the IHRA working definition. They are under no legal obligation to do so. Whilst the Secretary of State has the power to give NHSE directions as to the exercise of its functions, and NHSE in turn has the power to give directions to NHS Trusts as to their exercise of their functions, neither of those powers has been exercised in relation to the IHRA working definition.
8. If, despite the risks we identify, NHS organisations are inclined to adopt the IHRA working definition, then we consider that it will be necessary for them to provide written guidance as to its application. Given the opacity of the working definition, and its potential to be understood and applied in a manner that infringes ECHR rights, guidance will be imperative in (i) enabling individuals subject to the relevant NHS organisation’s jurisdiction properly to regulate their conduct and speech, and (ii) limiting arbitrariness in enforcement. A failure to provide guidance will likely give rise to interferences with freedom of expression and belief which may not be

² As protected by Articles 9 and 10 of the European Convention on Human Rights (“**ECHR**”), given domestic effect through s.6 of the Human Rights Act 1998 (“**HRA 1998**”).

“prescribed by law” within the meaning of Articles 9 and/or 10 ECHR and would accordingly be unlawful under s.6 of the HRA 1998.

9. We would therefore encourage any NHS organisation which chooses to adopt the IHRA working definition simultaneously to promulgate guidance as to its application. Such guidance should address, for example: (i) the circumstances in which the IHRA working definition will be applied, (ii) the purposes for which it will be so applied, (iii) the potential consequences of any finding that impugned speech has fallen foul of the definition, (iv) the status and relevance of the accompanying *“examples”* in the context of an assessment of whether impugned speech is properly to be characterised as antisemitic; and (v) the way(s) in which the organisation will apply those examples in a manner consistent with its obligations under the HRA 1998 and EA 2010.
10. We set out our detailed reasons for arriving at those views below. Our advice is structured as follows:
 - 10.1. In Section B, we summarise the basic policy considerations which inform NHSE’s encouragement to NHS organisations to adopt the IHRA working definition.
 - 10.2. In Section C we address the legal framework governing NHS organisations in their application of the IHRA working definition to the speech of NHS employees and patients.
 - 10.3. In Section D, we summarise extra-judicial and judicial consideration of the limits of the IHRA working definition.
 - 10.4. In Section E we set out our analysis as to the legal risks which NHS organisations face in adopting and/or applying the IHRA working definition.
 - 10.5. In Section F, we provide some worked examples of speech which would, and would not, amount to antisemitism on a lawful interpretation of that policy.

B. Why are NHS organisations being encouraged to adopt the IHRA working definition?

11. The Israel-Palestine conflict tends to evoke strong opinion. Many people within the United Kingdom hold and express views about the conflict, its root causes and the conduct of the parties to it. Some people are deeply supportive of one side to the conflict, and critical of the other. For some, beliefs about core issues which underpin the conflict form part of a religious or philosophical belief system which is essential to the believer's sense of self and identity.
12. All of this is true of people who work within, or use, the NHS just as it is for any other group. But, in the healthcare context, there are particular factors at play which do not (at least always) arise elsewhere:
 - 12.1. Many healthcare workers have a profound professional and personal attachment to human rights and the protection of life. Many also have a strong sense of professional and moral solidarity with healthcare workers working in other, sometimes more difficult, contexts.
 - 12.2. Those instincts lead many healthcare workers to hold and express strong views on Israel's treatment of the Palestinian people. In particular, many health workers (and several national medical associations), have publicly expressed their concern about Israel's conduct of its military assault in Gaza and about what they consider to be serious violations of international law and basic morality, including violations of the right to life and the right to be protected from genocide.³
 - 12.3. Doctors occupy a position of trust within society. As such, statements made by doctors (for example) accusing Israel of genocide or violations of international law carry particular weight. Statements by doctors, or

³ See, for example, Roghieh Deghan et al., 'Medical duty and advocacy for Palestine', *The Lancet* (vol. 403, no. 10424, 27 January 2023); British Medical Association ("BMA"), 'BMA urges global co-operation and action against attacks on healthcare in conflict zones' (22 July 2025), available at <https://www.bma.org.uk/bma-media-centre/bma-urges-global-co-operation-and-action-against-attacks-on-healthcare-in-conflict-zones>; BMA, 'An update on the BMA's position on the Israel-Gaza conflict' (4 July 2025), available at <https://www.bma.org.uk/what-we-do/working-internationally/our-international-work/an-update-on-the-bma-s-position-on-the-israel-gaza-conflict>; BMA and others, 'Healthcare in Gaza: a joint statement from national medical associations' (8 October 2025), available at <https://www.bma.org.uk/news-and-opinion/healthcare-in-gaza-a-joint-statement-from-national-medical-associations>.

groups of doctors, on such matters are therefore likely to attract attention (and, in some cases, controversy). This may reflect on the profession as a whole, or on the particular institution for which the doctors work.

13. A further, significant feature of debate in the NHS is that it intersects with a raft of legal duties. NHS Trusts are public authorities and are therefore required to act compatibly with the rights of their staff, patients and other users to freedom of speech (protected by Article 10 of the ECHR) and freedom of conscience (protected by Article 9). They are required to refrain from discriminating on grounds of race, which includes nationality and association with a race or nationality, or on grounds of religious or philosophical belief. They are required to take steps to protect their employees from racial or religious harassment by others, and they may become liable for discriminatory conduct undertaken by their employees.
14. Quite how the NHS, and indeed other public sector authorities, ought to navigate those duties in the context of debate on Israel and Palestine is a vexed question. This is particularly so in relation to debate as to the moral legitimacy of the existence of Israel as a state, and of its founding ideology, Zionism.
15. It is worth briefly unpacking why that debate is so fraught. The answer is that the debate is, or feels to its participants as though it is, existential:
 - 15.1. For its supporters, Zionism is a national liberation movement which calls for (and has succeeded in establishing) a state in which Jewish people could be self-determining and free from the antisemitic persecution which has blighted minority Jewish communities for millennia and which reached its nadir in the systematic campaign of extermination by Nazi Germany. On this view, criticism of Zionism is an existential threat for Jewish people, because it is an attempt to deny them the right to be self-determining, and an effort to return them to a diasporic and vulnerable status as unwelcome minorities in host countries which have historically discriminated against them.
 - 15.2. For its critics, Zionism is a racist ideology which sought to and succeeded in establishing an ethnostate for Jews in a place that was (and is) full of non-Jews. The Zionist project necessitated (and has in fact brought about) the displacement, dispossession and partial extermination of the non-

Jewish population of the territory which Zionism claimed, and the complete denial of the national aspirations of the Palestinian population of that territory. For critics of Zionism, and for the Palestinian people who on this view were its victims, it is the existence of Zionism and of Israel as a Jewish State in historic Palestine that is an existential threat.

16. No employer or public body can seek to resolve that debate. Rather, they must permit it to take place within the boundaries of the law and avoid discriminating against people who hold protected characteristics relevant to one or other side of the argument.
17. Like many other public bodies, NHSE is having to grapple with the question of where the appropriate boundaries in debate on Israel and Zionism lie.
18. In October 2025, NHSE formally adopted the IHRA working definition, and “*strongly encourage[d]*” all NHS organisations to do the same.⁴
19. On 4 June 2026, the report of the review of antisemitism and other forms of racism across the NHS and healthcare regulatory system, led by Lord Mann of Holbeck Moor (the Government’s advisor on antisemitism), was published.⁵ The Mann report expressed concern about the prevalence of racism, including antisemitism, in the NHS, and made a number of recommendations for steps which should be taken to tackle this.
20. In relation to freedom of expression, the report expressed the view that there should be a restriction on NHS staff displaying “*political identifiers*” while at work, and recommended that NHSE should review guidelines for those in the NHS using its name, logo or branding, including in relation to social media accounts.⁶ The Mann report recommended that the Department of Health and Social Care should secure an agreed approach to definitions of racism and religious hatred, and described the

⁴ NHSE, ‘Request for action on racism including antisemitism’ (17 October 2025), available at: <https://www.england.nhs.uk/long-read/request-for-action-on-racism-including-antisemitism/>.

⁵ Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system (4 June 2026), available at: <https://www.gov.uk/government/publications/lord-mann-review-on-antisemitism-and-other-forms-of-racism-in-the-nhs/lord-mann-review-of-antisemitism-and-other-forms-of-racism-in-the-nhs-and-healthcare-regulatory-system>.

⁶ *Ibid.*, under “*Freedom of expression*”.

IHRA definition as “*a helpful guide*” and “*a point of reference which when applied must take account of the overall context of incidents*”.⁷

21. On the same day as the Mann report was published, NHSE wrote to NHS chief executives asking them to confirm whether their organisations had adopted the IHRA definition.⁸
22. At the time of writing, the recommendations of the Mann report remain as such, and have not been implemented or given any legal force.

C. **Legal Framework**

C1. **The IHRA working definition**

23. The IHRA working definition states that antisemitism is:

“a certain perception of Jews, which may be expressed as hatred toward Jews”.

24. This does not explain what antisemitism *is*, but rather what it *might* be. It explains that antisemitism relates to Jews and that it might be expressed in a particular way. But it does not tell us, or even attempt to tell us, what defines antisemitism.
25. Because of the opacity of its definition, the essence of the IHRA working definition lies in its illustrative examples. But even these are conditional. They are characterised as possible instances of antisemitism “*taking into account the overall context*”.
26. Some of these examples are uncontroversial. Speech which “[c]all[s] for, aid[s] or justifi[es] the harming of Jews in the name of a radical ideology or an extremist view of religion” or “mak[es] mendacious, dehumanizing, demonizing or stereotypical allegations about Jews as such” is obviously antisemitic.
27. Others are not; in particular, the examples relating to the circumstances in which criticism of Israel or Zionism might be antisemitic. The IHRA working definition states, in relevant part:

⁷ *Ibid.*, under “Definitions”.

⁸ NHSE, ‘Lord Mann Review’ (4 June 2026), available at: <https://www.england.nhs.uk/long-read/lord-mann-review/>.

Manifestations might include the targeting of the state of Israel, conceived as a Jewish collectivity. However, criticism of Israel similar to that levelled against any other country cannot be regarded as antisemitic...

Accusing Jewish citizens of being more loyal to Israel, or to the alleged priorities of Jews worldwide, than to the interests of their own nations.

Denying the Jewish people their right to self-determination, e.g., by claiming that the existence of a State of Israel is a racist endeavour.

Applying double standards by requiring of it [Israel] a behaviour not expected or demanded of any other democratic nation.

Holding Jews collectively responsible for actions of the state of Israel.

28. As already noted, the IHRA working definition does not claim that this sort of behaviour will always be antisemitic. It states that it *might* be, depending on the context.
29. The key question for anybody trying to apply the IHRA working definition, and in particular for anybody seeking to apply it in a manner that is consistent with English law, is therefore what context is necessary for speech of the sort described above to be antisemitic, as opposed to legitimate criticism of a foreign state.
30. The first point to note in respect of the legal rules governing NHS organisations is that the IHRA working definition is not one of them. The IHRA working definition has no direct legal force whatsoever.
31. Thus, although the IHRA working definition was adopted by the Government in 2016 as a matter of policy and commended to NHS organisations by the Secretary of State for Health from 2025 onward, it has not been incorporated into statute nor adopted by any Court as a definition of antisemitism. Nor has it been the subject of a binding direction by the Secretary of State to NHS England⁹ and NHS Trusts and Special Health Authorities¹⁰, nor any statutory direction by NHS England in relation

⁹ Under s.13ZC NHS Act 2006.

¹⁰ Under s.8 NHS Act 2006.

to NHS Integrated Care Boards¹¹ and NHS Trusts¹². NHS organisations are accordingly not under any obligation to adopt the IHRA working definition and are free not to do so.

32. If NHS organisations choose to adopt the IHRA working definition, then the definition must be applied consistently with their legal obligations. It is not the case that those legal obligations must fit around the working definition.

C2. Human Rights Act 1998

33. NHS organisations are public authorities for the purpose of s. 6 of the HRA 1998. Accordingly, it is unlawful for them to act incompatibly with the rights enshrined in the ECHR, including Articles 9 (which protects freedom of belief) and 10 (which protects freedom of expression). NHS organisations (which are established by statute and which carry out an intrinsically public function) are paradigm ‘core’ public authorities,¹³ which means they must act compatibly with the HRA in everything they do (including, for example, when dealing with employees).

Article 10

34. Article 10 protects the right to free speech, which has been recognised by the Grand Chamber of the European Court of Human Rights (“ECtHR”) as “*one of the essential foundations of any democratic society*” and “*one of the most important conditions of its progress and the personal development of each individual*”: *Animal Defenders v United Kingdom* (2013) 57 EHRR 21 at ¶100. This protection extends “*not only to the substance of the ideas and information expressed but also to the form in which they are conveyed*”: *Animal Defenders* at ¶100.
35. Freedom of political debate attracts particularly strong protection. The ECtHR has consistently held that there is limited scope under Article 10(2) for restrictions on political speech or debate or on debate on matters of public interest: *Brasilier v France* (Application No. 71343/01) (at ¶41). Within this context, the limits of permissible criticism of governments are wider than in relation to a private citizen

¹¹ Under s.14Z61 NHS Act 2006

¹² Under s.27B NHS Act 2006.

¹³ See *YL v Birmingham City Council and others* [2007] UKHL 27, [2008] 1 AC 95 per Baroness Hales at ¶37.

or even a politician: *Surek v Turkey* (No. 1) (Application No. 26682/95) (at ¶61). In the domestic courts, this principle was recognised by Baroness Hale in *R (Lord Carlile) v SSHD* [2015] AC 945 at ¶91:

Freedom of speech, and particularly political speech, is the foundation of any democracy. Without it, how can the electorate know whom to elect and how can the parliamentarians know how to make up their minds on the difficult issues they have to confront? How can they decide whether or not to support the Government in the actions it wishes to take? This is all the more important, the larger the issues at stake.

36. It is a critical feature of Article 10 that, subject to the exceptions in Article 10(2), it is “*applicable not only to ‘information’ or ‘ideas’ that are favourably received or regarded as inoffensive or as a matter of indifference, but also to those that offend, shock or disturb. Such are the demands of that pluralism, tolerance and broadmindedness without which there is no ‘democratic society’*”: *Animal Defenders International* at ¶100. Accordingly,

“[f]ree speech includes not only the inoffensive but the irritating, the contentious, the eccentric, the heretical, the unwelcome and the provocative provided it does not tend to provoke violence. Freedom only to speak inoffensively is not worth having”: per Sedley LJ in *Redmond-Bate v DPP* (1999) 163 JP 789, ¶20.

37. Only where an instance of expression amounts to “*the gravest form of ‘hate speech’*” will Article 17 have the effect of excluding it from the protection of Article 10 (pursuant to Article 17): *Lilliendahl v Iceland* (Application No. 29297/18) at ¶39. Article 17 is to be applied “*only on an exceptional basis and in extreme cases*”, such that the default position is to assess even offensive or disturbing speech within the structured proportionality framework of Article 10(2): *Paksas v Lithuania* (2014) 59 EHRR 30 [GC] (at ¶87). The ECtHR has accordingly distinguished between objectionable beliefs about the characterisation of historical events (which attract the protection of Article 10), and the incitement of hatred or violence against a group (which may not): see *Perinçek v Switzerland* (2016) 63 EHRR 6 (at ¶230).
38. The breadth of protection of Article 10 is illustrated by the case of *Gul v Turkey* (2011) 52 EHRR 38, where the conviction of individuals shouting slogans in support of an armed, illegal organisation was found to breach Article 10 on the basis that

their conduct could not be considered to have an impact on national security “*by way of encouraging the use of violence or inciting others to armed resistance or rebellion, which are essential elements to be taken into account*” (§44). Similarly, in *Stomakhin v Russia* (Application No. 52273/07), the ECtHR found the imprisonment of a journalist for publishing statements purportedly inciting hatred against Russian servicemen (describing them as “*maniacs, bloodthirsty sadists, murderers*”) to constitute a breach of Article 10 (§132). Whilst the Court acknowledged that the statements were “*a clear attempt to justify and advocate violent actions*” (§107), it considered it “*important to note that [...] those accusations may not have been without foundation*” (§106). Analogous considerations may well apply in relation to statements making allegations in respect of Israel’s conduct of its military offensive in Gaza (or its conduct of the military occupation more generally).

39. As explained by the EAT in *Forstater v CGD Europe* [2022] ICR 1 (at ¶70), it is only in “*extreme cases involving the gravest violation of other Convention rights*”, i.e. “*beliefs akin to Nazism or espousing totalitarianism*”, that acts of expression will fall within the scope of Article 17. In all other cases, the limits to speech will be a consequence of the proportionality analysis required by Article 10(2).
40. When determining Article 10 rights in relation to speech in areas of fraught political debate, context is crucial. As the Court of Appeal explained in *R (Miller) v College of Policing* [2022] 1 WLR 4987, which concerned the debate surrounding trans rights (at ¶69):

Further, the context of the debate to which Mr Miller was contributing was complex multi-faceted and important, as was the evidence of Professor Stock and Jodie Ginsberg, which assisted in understanding its contours ([240]-[246]). Contextual evidence was relevant because in the Article 10 context, special protection is afforded to political speech and debate on questions of public interest [252]. The fact that Mr Miller’s tweets were “for the most part, either opaque, profane or unsophisticated” did not rob them of the protection of Article 10(1) [251]. Mr Miller expressed the sort of views that are also held by many academics as part of a multi-faceted debate [265]. When considering the proportionality of the police’s response to Mrs B’s complaint the judge said: “Mrs B profoundly disagrees with [Mr Miller’s] views but such is the nature of free speech in a democracy. Professor Stock’s evidence demonstrates how quickly some

involved in the transgender debate are prepared to accuse others with whom they disagree of showing hatred, or as being transphobic when they are not but simply hold a different view [280]. The judge also said that Mrs B's reaction to the tweets was, at times, at the outer limit of rationality [280].

Article 9

41. Article 9 protects freedom of thought, conscience and belief, which captures not only recognised religious beliefs, but all those which attain “*a certain level of cogency, seriousness, cohesion and importance*”: *Eweida and others v UK* (Application Nos. 48420/10, 59842/10, 51671/10 and 36516/10), at ¶81. Article 9 has been held to cover, for example, pacifism and principled opposition to military service: *Kanatli v Türkiye* (Application No. 18382/15) and *Bayatyan v Armenia* (2012) 54 EHRR 15.

42. Whether a belief is protected or not is subject to the well-known *Grainger* criteria. As Burton J explained in *Grainger Plc v Nicholson* [2010] ICR 360 at ¶24:

(i) The belief must be genuinely held. (ii) It must be a belief and not, as in *McClintock v Department of Constitutional Affairs* [2008] IRLR 29, an opinion or viewpoint based on the present state of information available. (iii) It must be a belief as to a weighty and substantial aspect of human life and behaviour. (iv) It must attain a certain level of cogency, seriousness, cohesion and importance. (v) It must be worthy of respect in a democratic society, be not incompatible with human dignity and not conflict with the fundamental rights of others...

(the “**Grainger Criteria**”)

43. In *Forstater v CHG (Europe)* [2022] ICR 1, Choudhury P summarised the relevant principles to be derived from the jurisprudence of the ECtHR so far as concerns the question whether a belief falls within s.10 EA 2010. He summarised them thus at ¶55 (omitting the citation of authorities):

a. Freedom of expression is one of the essential foundations of democratic society...

b. The paramount guiding principle in assessing any belief is that it is not for the Court to inquire into its validity...

c. The freedom to hold whatever belief one likes goes hand-in-hand with the State remaining neutral as between competing beliefs, refraining from expressing any judgment as to whether a

particular belief is more acceptable than another, and ensuring that groups opposed to one another tolerate each other....

d. A belief that has the protection of Article 9 is one that only needs to satisfy very modest threshold requirements. As stated by Lord Nicholls in *R (Williamson)*, those threshold requirements "*should not be set at a level which would deprive minority beliefs of the protection they are intended to have under the Convention.*" In other words, the bar should not be set too high....

44. The requirements of coherence and intelligibility are not exacting. As Lord Nicholls explained in *R (Williamson) v Secretary of State for Education and Employment* [2005] 2 AC at ¶23:

... The belief must also be coherent in the sense of being intelligible and capable of being understood. But, again, too much should not be demanded in this regard. Typically, religion involves belief in the supernatural. It is not always susceptible to lucid exposition or, still less, rational justification. The language used is often the language of allegory, symbol and metaphor. Depending on the subject matter, individuals cannot always be expected to express themselves with cogency or precision. Nor are an individual's beliefs fixed and static. The beliefs of every individual are prone to change over his lifetime. Overall, these threshold requirements should not be set at a level which would deprive minority beliefs of the protection they are intended to have under the Convention...

45. Likewise, the test set by the fifth Grainger criterion (that the belief be not incompatible with human dignity) is a low one. The relevant jurisprudence was considered in detail by Choudhury P in *Forstater v CHG* [2022] ICR 1, who held at ¶66:

It is clear from these judgments that, in assessing whether a person's rights under Article 9 or Article 10 have been infringed, there is a preliminary question as to whether the person qualifies for protection at all, or, to use the ECtHR's terminology, as to whether the person "fall[s] outside the scope of protection of Article 10 of the Convention by virtue of Article 17": *Lilliendahl* at para 39. Where the expression amounts to the "gravest form of hate speech" then the protection would not apply, as Article 17 would operate to deprive the person of the protection that they seek to invoke. However, if the expression does not fall into that first category, then the question is whether the steps taken by the State to restrict such expression are justified within the meaning of Article 10(2). Thus even

comments which are "serious, severely hurtful and prejudicial", or which promote intolerance and detestation of homosexuals would not fall outside the scope of Article 10 altogether. However, that does not mean that the individual making such comments has free rein to make them in any circumstance at all. The individual's freedom to express their views is limited to the extent provided for by Article 10(2) and it will then be for the Court to assess whether any limitation imposed by the State is justified.

46. That, Choudhury P concluded, is the same approach that is required under s.10 EA 2010. At ¶68, Choudhury P explained:

Of course, the architecture of the EqA does not precisely follow the structure of the ECHR. Section 10, EqA focuses on whether a person has the protected characteristic of belief. In determining whether a person falls within s.10, EqA, the Tribunal is essentially undertaking the 'first stage' analysis described above in relation to ECHR. That is to say, the Tribunal is considering only whether the person falls within the scope of the relevant protection at all. At this stage, therefore, in order to ensure that s.10, EqA is applied compatibly with Article 9, ECHR, the question will be whether the belief meets the "modest threshold requirements" as established by the case law, and as encapsulated in the Grainger Criteria. In relation to Grainger V, that means that only those beliefs whose characteristics are such that they would fall outside the scope of Article 9, ECHR by virtue of Article 17 would fail to satisfy that criterion.

47. The upshot of this is spelled out at ¶79 of the judgment:

In our judgment, it is important that in applying Grainger V, Tribunals bear in mind that it is only those beliefs that would be an affront to Convention principles in a manner akin to that of pursuing totalitarianism, or advocating Nazism, or espousing violence and hatred in the gravest of forms, that should be capable of being not worthy of respect in a democratic society. Beliefs that are offensive, shocking or even disturbing to others, and which fall into the less grave forms of hate speech would not be excluded from the protection. However, the manifestation of such beliefs may, depending on circumstances, justifiably be restricted under Article 9(2) or Article 10(2) as the case may be.

48. In *Miller v University of Bristol* (ET, 10 October 2024), the Employment Tribunal held that anti-Zionist beliefs satisfied the Grainger criteria, and are thus capable of

constituting philosophical beliefs within the meaning of s.10 of the EA 2010 and are protected by Article 9 ECHR.¹⁴ The specific anti-Zionist belief in issue in that case was the claimant's belief that Zionism, the political ideology which asserts that a state for the Jewish people ought to be established and maintained in historic Palestine is racist, imperialistic, colonial and should therefore be opposed. Whilst that judgment is not strictly binding on other tribunals or courts (though it may be persuasive), we consider that it was rightly decided. We understand, further, that judgment is expected from the EAT in July 2026, following an appeal by the University. If the EAT upholds *Miller*, then that will create binding precedent that anti-Zionist beliefs are (subject to the belief being genuinely held) a protected characteristic for the purpose of anti-discrimination law and fall within the scope of Article 9.

49. Protected belief under Article 9 and protected speech under Article 10 are not absolute, but may be subject to justified limitation or interference. The test for justification is the same in respect of both Articles 9 and 10, as set out below.

Justified interference

50. The limitation or interference with freedom of expression or belief will only be justified if it is prescribed by law, pursues a legitimate aim, and is necessary in a democratic society.

(i) 'Prescribed by law'

51. For a measure or step to be 'prescribed by law', it must have some legal basis, and that legal basis must be sufficiently clear, certain and predictable to enable people to plan and regulate their conduct: *Sunday Times v United Kingdom* (1979-80) 2 EHRR 245 (at ¶49). As Judge Zekia put it in his concurring opinion in *Sunday Times* (at ¶7), "you cannot enjoy or exercise the right to freedom of expression if the enjoyment of such right is made conditional and subject to a law or a rule or a principle abounding in uncertainties". The rule may be formulated in such a way as to leave a discretion as to its application in particular factual circumstances, "provided that there is sufficient protection for the individual against arbitrary interferences with

¹⁴ We note that in that case, the respondent accepted that nothing that the claimant had said was antisemitic, though the Employment Tribunal did find fault in his conduct: see paragraphs 233, 272, 285-290, and 305 of the Employment Tribunal's judgment.

their rights”: *R (Gillan) v Commissioner of Police* [2006] UKHL 12, [2006] 2 AC 307 at 326B.

(ii) ‘Necessary in a democratic society’

52. In order for a restriction be ‘necessary’: (i) relevant and sufficient reasons must be provided to justify it; (ii) the restriction must correspond to a “*pressing social need*”; and (iii) it must be proportionate to the legitimate aim pursued: *Morice v France* (2016) 62 EHRR 1 (at ¶124). Where a less intrusive step could satisfy the aim in question, then the interference won’t be proportionate: *Glor v Switzerland* (App. No. 13444/04, 30 April 2009) at ¶94.
53. The approach to ECHR proportionality is that set out in *Bank Mellat v HM Treasury (No. 2)* [2014] AC 700 (at ¶74):¹⁵

it is necessary to determine (1) whether the objective of the measure is sufficiently important to justify the limitation of a protected right, (2) whether the measure is rationally connected to the objective, (3) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective, and (4) whether, balancing the severity of the measure’s effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter”.

C3. Equality Act 2010

54. Like any employer, NHS organisations will need to act compatibly with the EA 2010 in relation to its employees. NHS organisations will also need to act compatibly with the EA 2010 in relation to those who use its services, such as patients.
55. In particular, NHS organisations must not:
- 55.1. directly discriminate against a service user or employee because of a protected characteristic (s.13, s.29 and s.39);
 - 55.2. indirectly discriminate against a service user or employee by applying a provision, criterion or practice which puts those with a protected

¹⁵ See further *Shvidler v Secretary of State for Foreign, Commonwealth and Development Affairs* [2025] 3 WLR 346 (at §§120 *et seq*).

characteristic at a particular disadvantage, and cannot be justified as a proportionate means of achieving a legitimate aim (s.19, s.29 and s.39); or

- 55.3. harass any person in relation to a protected characteristic in the course of their employment or use of the service (s.26, s.29(3) and s.40). ‘Harassment’ is defined as unwanted conduct in relation to a protected characteristic which has the purpose or effect of violating the person’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for them.¹⁶ Steps taken in the course of disciplinary proceedings or during service provision can (where this definition is satisfied) constitute harassment.
56. A ‘protected characteristic’ for these purposes will include someone’s ethnicity, nationality or national origin, and therefore would include, for example, being Palestinian, or being of Arab descent.
57. It would also include the characteristic of having a ‘philosophical belief’. As described above, the scope of that concept under s.10 EA 2010 is coterminous with Article 9 ECHR. A person will have a philosophical belief if their belief is one which would be protected under Article 9 ECHR.
58. The provisions of the EA 2010 set out above are engaged not only in relation to a protected characteristic, but also in relation to being associated with persons with a protected characteristic. ‘Association’ does not require the existence of a particular *type* of relationship; what matters is whether the less favourable treatment (or harassment) of someone is ‘on the grounds of’ the protected characteristic of one or more other people’: *Lee v Ashers Baking Co Ltd* [2020] AC 413 (at ¶27-34), and *Thompson v London Central Bus Co Ltd* [2016] IRLR 9 (EAT) (at ¶24-26). This means that NHS organisations will, in some circumstances, have obligations not only to employees who are, say, Palestinian, or who have a philosophical commitment to anti-Zionism, but also those who are associated with Palestinians or anti-Zionists.

¹⁶ Under s.26 Equality Act 2010.

C4. Specific considerations which apply to the NHS

59. The NHS has a unique mandate and purpose, which is to provide health services to the public. This role is reflected in the provisions of the NHS Constitution (to which NHS organisations must have regard when exercising their functions¹⁷):

[The NHS] is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status [...] It has a duty to each and every individual it serves and must protect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides [...]. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. [...]

[Patients] have the right to access NHS services. You will not be refused access on unreasonable grounds. You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

60. The NHS's unique mandate gives rise to particular considerations which may be relevant to the question of whether any restriction on the speech of health workers is justified. Given the potentially contentious nature of debate about the conflict between Israel and Palestine and recent events in Gaza, it is possible that in extreme cases patients (with good reason or not) may feel less able or willing to access health services on account of views expressed by health workers responsible for delivering their care. NHS organisations obviously have a strong interest in ensuring that patients are able to access NHS services. NHS organisations are more likely¹⁸ to be justified in limiting the expression of views about such matters in clinical or other patient-facing contexts in order to address genuine patient concerns which (if left unresolved) may impact patients' access to NHS services, and the achievement of the NHS's purpose. This point is applicable generally, both as between the sides of

¹⁷ See s.2(1) of the Health Act 2009. Those subject to this duty are listed in s.2(2), including NHS Trusts, NHS Foundation Trusts, integrated care boards, local authorities and Special Health Authorities. Integrated Care Boards are under the same duty under s.25 Health and Care Act 2022.

¹⁸ Of course, this will not always be the case. If, for example, a homophobic patient refuses to enter the waiting room of a GP practice unless the receptionist removes her rainbow lanyard, the practice may well be justified in refusing the patient's request and allowing the receptionist to continue to wear the lanyard. The precise balance between patient comfort and freedom of expression will turn on the particular circumstances of the case.

the debate on Israel-Palestine and any other contentious debate. It would, for example, apply to symbols of support for Ukrainian resistance to Russia's invasion and occupation of that country.¹⁹

61. On the other hand, NHS organisations will also need to take into account the competing public interest in the views of health workers on certain issues being freely shared and heard, given their unique position and expertise. Medical personnel operating in situations of armed conflict are afforded particular status and protection under international law, and health workers (wherever they are operating) are subject to professional and ethical duties by reference to which they may feel obliged to speak out or act in certain ways. The views of health workers on the provision of medical aid, the protection of medical personnel, hospitals and other medical sites, and on public health issues, are of special weight and significance in the public debate on these topics. Some health workers may have direct experience or expertise which is of particular value. The public has a legitimate and weighty interest in hearing health workers' views on issues on which they are well positioned to speak, and in health workers being able to identify themselves as such when doing so. This interest must be taken into account and weighed in the balance when determining whether any proposed restriction on their speech (or other expression) is justified.
62. Those legitimate interests will be relevant to the application of qualified rights held by healthcare workers or patients of NHS organisations, such as Article 9/10 rights and the right not to be subject to indirect discrimination. However, they cannot justify directly discriminatory conduct on grounds of race or (save in what has been termed "manifestation cases",²⁰ in which proportionality principles apply) belief.

¹⁹ Whether any particular restriction is justified or not will depend upon the facts of the specific case, and the application of the proportionality analysis (as discussed in greater detail below).

²⁰ These are cases in which a person (A) subjects another (B) to unfavourable treatment because of a manifestation by B of his or her belief. In such cases, if A can show that its treatment of B was proportionate to a legitimate aim, then the treatment is not discriminatory. If A cannot show this, then its conduct will be direct discrimination on grounds of belief: see *Higgs v Farmors School* [2025] EWCA Civ 109.

"Manifestation cases" differ from traditional discrimination claims, where A treats B unfavourably simply because B holds the belief (regardless of whether it is manifest). In the latter case, A is not able to justify its treatment of B on grounds of proportionality.

D. The limits of the IHRA working definition

D1. Extra-judicial consideration of the IHRA working definition

63. The IHRA working definition has faced serious and sustained criticism from legal professionals, journalists, academics, and human rights and civil society groups. This includes more than 100 Israeli, Jewish and international civil society groups, who criticise the definition for being vague and uncertain in scope, suppressing freedom of speech and legitimate criticism of Israel, and ultimately undermining the fight against antisemitism.²¹
64. For example, in an article in the London Review of Books published in May 2017, former Court of Appeal judge Sir Stephen Sedley made the following observations:
- 64.1. The IHRA definition's description of antisemitism as "*a certain perception of Jews, which may be expressed as hatred towards Jews*", "*fails the first test of any definition: it is indefinite [and] invites a string of questions. Is anti-Semitism solely a matter of perception? What about discriminatory practices and policies? What about perceptions of Jews that are expressed otherwise than as hatred?*"
- 64.2. The IHRA definition "*endorses the conflation*" between "*discriminatory acts or inflammatory speech*" which are generally unlawful and "*criticism (and equally defence) of Israel or of Zionism*" which are not only lawful but also "*affirmatively protected by law*".
- 64.3. The "*examples*" accompanying the IHRA definition give rise to particular concerns. Thus, in relation to the examples concerning "*targeting of the state of Israel*", "*applying double standards*" towards Israel and "*claiming that the existence of a state of Israel is a racist endeavour*":

The first and second of these examples assume that Israel, apart from being a Jewish state, is a country like any other and so open only to criticism resembling such criticism as can be made of other states, placing the historical, political, military and humanitarian uniqueness of Israel's occupation and colonisation of Palestine beyond permissible criticism. The third example bristles with contentious assumptions about the racial identity of

²¹Available at: <https://www.hrw.org/news/2023/04/04/human-rights-and-other-civil-society-groups-urge-united-nations-respect-human>.

Jews, assumptions contested by many diaspora Jews but on which both Zionism and anti-Semitism fasten, and about Israel as the embodiment of a collective right of Jews to self-determination.

- 64.4. The adoption of the IHRA definition by public authorities, “*while not a source of law, gives respectability and encouragement to forms of intolerance which are themselves contrary to law* [because they fail to respect legal obligations in relation to freedom of expression]”.
65. Similarly, in an opinion for Free Speech on Israel, Independent Jewish Voices, Jews for Justice for Palestinians and the Palestine Solidarity Campaign,²² Hugh Tomlinson KC warned that:

any public authority which sought to apply the IHRA Definition to decisions concerning the prohibition or sanctioning of activity which was critical of the State or Government of Israel would be acting unlawfully if it did not require such activity also to manifest or incite hatred or intolerance towards Jews. If an authority applied the IHRA Definition without such a requirement it would be in breach of Article 10 of the Convention and would, therefore, be acting unlawfully under domestic law in the United Kingdom.

66. To similar effect, Geoffrey Robertson KC concluded in an opinion for the Palestinian Return Centre²³ that the UK Government was wrong to adopt the IHRA definition without the “caveats” recommended by the House of Commons Home Affairs Select Committee,²⁴ and stated that:

The IHRA definition of anti-Semitism is not fit for any purpose that seeks to use it as an adjudicative standard. It is imprecise, confusing and open to misinterpretation and even manipulation. It does not cover some insidious forms of anti-Semitism. It [...] should not be used (or be used with great caution) as a measure for discipline or in ways which have consequences for political speech.

²² Available at: <https://freespeechonisrael.org.uk/ihra-opinion/>

²³ Available at: <https://prc.org.uk/en/post/3992>

²⁴ Available at: <https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/136/13610.htm>

67. The application of the IHRA working definition by public authorities in their disciplinary procedures has given rise to allegations of unlawful censorship. For example, in their report ‘The Adverse Impact of the IHRA working definition of Antisemitism’,²⁵ the European Legal Support Centre and the British Society for Middle Eastern Studies analysed 40 cases between 2017 and 2022 in which a university staff member or student was accused of antisemitism on the basis of the IHRA working definition. The report pointed to the ease with which the IHRA working definition could be misused to hinder criticism of Israel in an academic context. Due to the vagueness of the wording of the IHRA working definition and its ‘*contemporary examples*’, complainants were able to rely on it to trigger the relevant institutions’ disciplinary procedures, leading to lengthy investigations, cancelled academic events and damaging impacts on the reputations, careers and wellbeing of staff and students against whom complaints were made.
68. The report concluded that “*[i]n all cases recorded by the ELSC, except for two ongoing cases, the accusations of antisemitism with reference to the IHRA definition have been rejected. The final two have yet to be substantiated.*”
69. On 4 April 2023, a number of human rights and other civil society groups wrote a joint letter to the UN Secretary-General and Under Secretary General to urge the UN not to adopt the IHRA Definition,²⁶ stating:
- the IHRA definition has often been used to wrongly label criticism of Israel as antisemitic, and thus chill and sometimes suppress, non-violent protest, activism and speech critical of Israel and/or Zionism, including in the US and Europe. [...] The targets of accusations of antisemitism based on the IHRA definition have included university students and professors, grassroots organizers, human rights and civil rights organizations, humanitarian groups and members of the US Congress, who either document or criticize Israeli policies and who speak in favor of Palestinian human rights.
70. Concern has also been raised by a wide range of Jewish civil society groups. By way of illustration:

²⁵ Available at: <https://www.brismes.ac.uk/files/documents/brismes-elsc-joint-report-ihra.pdf>

²⁶ Available at: <https://www.hrw.org/news/2023/04/04/human-rights-and-other-civil-society-groups-urge-united-nations-respect-human>

70.1. Diaspora Alliance,²⁷ a Jewish-led group which *“fights antisemitism and its political misuse”* warned against Israel’s campaign for the adoption of the IHRA definition by all governments.²⁸ Diaspora Alliance pointed to Israel’s use of the definition as the basis for labelling as antisemitic²⁹ the Boycott, Divestment, and Sanctions (‘BDS’) movement, a movement launched by 170 Palestinian civil society bodies which calls for boycotts, divestments and sanctions as a form of non-violent pressure on Israel. Its position is that proponents of the IHRA definition *“have used it to reframe legitimate criticism of well-documented Israeli state violence against Palestinians as anti-Jewish bigotry, and in so doing, to silence critics of the State of Israel and of Zionism”*.³⁰ Diaspora Alliance states in its ‘Arguments Against the IHRA definition’:³¹

The IHRA definition is prone to being adopted by institutions and governments as a ‘quick fix’ to antisemitism, precluding the more complex and long-term project of identifying the root causes of anti-Jewish bigotry and working to dismantle them [...]

The IHRA campaign harms Jews by undermining the struggle against antisemitism and isolating it from other forms of oppression, while also hurting Palestinians and allies in the Palestinian freedom movement. A singular strategy cannot effectively combat antisemitism, and the push to implement the IHRA definition does not constitute an expansive and collaborative effort to fight anti-Jewish prejudice.

²⁷ See <https://diasporaalliance.co/>

²⁸ See Israeli Ministry of Foreign Affairs, ‘PM Netanyahu’s message to the conference on the fight against anti-Semitism and anti-Zionism’ (21 November 2018), available at: <https://www.gov.il/en/pages/pm-netanyahus-message-to-the-conference-on-the-fight-against-antisemitism-and-antizionism>.

²⁹ Israeli Ministry of Strategic Affairs and Public Diplomacy, ‘Behind the Mask, The Antisemitic Nature of BDS Exposed’ (September 2019), available at: <https://web.archive.org/web/20191102000444/https://4il.org.il/wp-content/uploads/2019/09/MSA-report-Behind-the-Mask.pdf>

³⁰ Available at: <https://diasporaalliance.co/wp-content/uploads/2023/11/IHRA-Explainer-and-Messaging.pdf>

³¹ *Ibid.*

- 70.2. In 2018, over 40 Jewish groups worldwide signed a letter urging governments around the world to reject the IHRA definition, stating that it “*undermines both the Palestinian struggle for freedom, justice and equality and the global struggle against antisemitism. It also serves to shield Israel from being held accountable to universal standards of human rights and international law.*”³²
- 70.3. In October 2025, academics with Jewish Voice for Peace dubbed the IHRA definition “*restrictive and inaccurate*” and a violation of the “*fundamental commitments to free inquiry and social justice*”.³³
71. The shortcomings of the IHRA definition have led to the introduction of alternative definitions, such as the Jerusalem Declaration on Antisemitism (the “Jerusalem Declaration”).³⁴ The Jerusalem Declaration defines antisemitism as “*[d]iscrimination, prejudice, hostility or violence against Jews as Jews (or Jewish institutions as Jewish)*”.
72. The Jerusalem Declaration seeks to clarify the distinction between antisemitism and legitimate criticism of Israel or Zionism. It provides the following examples of legitimate (i.e. not antisemitic) opinion or speech:

Supporting the Palestinian demand for justice and the full grant of their political, national, civil and human rights, as encapsulated in international law.

Criticizing or opposing Zionism as a form of nationalism, or arguing for a variety of constitutional arrangements for Jews and Palestinians in the area between the Jordan River and the Mediterranean. It is not antisemitic to support arrangements that accord full equality to all inhabitants “between the river and the sea,” whether in two states, a binational state, unitary democratic state, federal state, or in whatever form.

Evidence-based criticism of Israel as a state. This includes its institutions and founding principles. It also includes its policies and practices, domestic and abroad, such as the conduct of Israel in the West Bank and Gaza, the role Israel plays in the region, or any other way in which, as a state, it influences events in the

³² Available at: <https://www.jewishvoiceforpeace.org/2018/07/17/first-ever-40-jewish-groups-worldwide-oppose-equating-antisemitism-with-criticism-of-israel/>

³³ Available at: <https://www.jewishvoiceforpeace.org/2025/10/22/no-choice-but-to-disobey-ihra/>

³⁴ Available at: <https://jerusalemdeclaration.org/>

world. It is not antisemitic to point out systematic racial discrimination. In general, the same norms of debate that apply to other states and to other conflicts over national self-determination apply in the case of Israel and Palestine. Thus, even if contentious, it is not antisemitic, in and of itself, to compare Israel with other historical cases, including settler-colonialism or apartheid.

D2. Judicial consideration of the IHRA Definition, and the line between criticism of Israel/Zionism and antisemitism

73. The fundamental limits of the IHRA working definition have also been recognised in the Courts. In his judgment in *PSA v GPhC & Ali* [2021] EWHC 1692 (Admin), echoing the Jerusalem Declaration definition, Chamberlain J defined antisemitism as follows: “[a]ntisemitism is hatred or hostility towards Jews as a racial and/or religious group” (at ¶57).

74. Chamberlain J went on to explain at ¶62:

accusations of antisemitism can be used to malign and discredit those engaging in legitimate criticism of the policy and conduct of the state of Israel and thereby to suppress such criticism. Foreign policy decisions by the United Kingdom and other governments may affect that policy. In a liberal democracy such as ours, there is a strong public interest in allowing such decisions to be informed by criticisms of Israel and the responses to those criticisms. To that end, legal frameworks, whether in the criminal or in the regulatory sphere, must be interpreted and applied so as to avoid the ‘chilling’ of legitimate political speech, which attracts the highest level of protection under Article 10 ECHR, as given effect in this jurisdiction by the [Human Rights Act 1998]...

75. In his subsequent judgment in *Husain v SRA* [2025] EWHC 1170 (Admin), Chamberlain J considered the limits of the IHRA working definition. He emphasised that a number of the “contemporary examples” in the IHRA working definition are not automatically, or even presumptively, antisemitic, and are specific to the time and context in which the definition was written. As Chamberlain J explained at ¶¶107-108:

It must also be borne in mind that the IHRA’s examples were billed as “contemporary examples” in 2016. They were not intended to set the parameters of legitimate political debate for

all time. Whether a particular criticism of Israel's conduct falls within the bounds of legitimate political debate depends on the facts—and the facts change. A court or tribunal using the IHRA working definition and examples must be alert to this and must avoid using them in a way which forecloses political debate on new events as they unfold.

For all these reasons, where speech is said to fall within the seventh and eighth of the IHRA's examples, it is unlikely that the substantive content of the message alone will justify the label "antisemitic". However, depending on the language used, and in context, the speech may be antisemitic. The focus of the court or tribunal should therefore be on the language and context.

76. Chamberlain J held that:

- 76.1. "[p]articular care" is required in the application of the seventh and eighth examples "*because they relate to speech which is critical of the historic or contemporary conduct of the State of Israel*", which "*attracts the highest level of protection under Article 10 ECHR*" (¶102).
- 76.2. Courts and tribunals should "*be cautious in accepting that a statement is antisemitic on the basis that it employs an alleged double standard*" of the kind contemplated by the eighth example (¶103);
- 76.3. Advocating for "*the abolition of the State of Israel and its replacement with a unitary state comprising both Jewish and Palestinian citizens*" should not be regarded as "*automatically or even presumptively antisemitic*" (¶104);
- 76.4. "*Nor... can it be regarded as axiomatically antisemitic to claim that the existence of Israel is a racist endeavour*". Such a view is not "*off-limits in a democratic society which values the right to freedom of expression*" (¶105);
- 76.5. "*The claim that Israel is an 'apartheid State'... also lies in principle within the area protected by Article 10 [...]. [The ICJ's Advisory Opinion in Legal Consequences Arising from the Policies and Practices of Israel in the Occupied Palestinian Territories] does seem to me to illustrate the difficulty of an approach which places outside the bounds of legitimate*

political debate claims that the policies and practices of the State of Israel are systematically discriminatory or amount to apartheid” (¶106).

E. The issue: the legal risks associated with adopting and applying the IHRA working definition

77. It is apparent from the foregoing that caution is required by any NHS organisation considering whether to adopt the IHRA working definition, and any NHS organisations that do choose to adopt it will have to be extremely careful when applying the definition to determine whether or not speech crosses the line from legitimate criticism of Israel and Zionism, into antisemitism.
78. We make six observations at the outset of our analysis.
79. First, as noted above, NHS organisations are not required to adopt the IHRA working definition. They ought only do so where they consider that it will assist them in properly identifying and addressing instances of antisemitism within their areas of responsibility.
80. Secondly, the IHRA working definition does not actually define antisemitism. As we noted at the outset of this advice, it goes no further than identifying what antisemitism *might* be, depending on the context.
81. What follows from this unpromising start is that no NHS organisation can apply the IHRA working definition by automatically treating as antisemitic any speech which falls within any of the illustrative examples. A decision to censor speech on the sole basis that it fell within one of the illustrative examples within the IHRA working definition would constitute an unlawful interference with Article 10 rights, because (i) the interference would not be prescribed by law (it would not even be prescribed by the IHRA working definition), and (ii) the interference could not be justified, because much speech which falls within at least some of the illustrative examples is perfectly legitimate and not antisemitic at all.
82. Thirdly, given the failure of the IHRA working definition to actually provide a definition, any NHS organisation must necessarily look elsewhere to determine whether a particular utterance is in fact antisemitic.

83. Fourthly, the definition of antisemitism which NHS organisations ought to adopt is that given by the Court, namely the definition provided by Chamberlain J in PSA: hatred or hostility toward Jews *as a racial or religious group*. In other words, it is hatred of or hostility toward Jews *because they are Jews*.
84. Fifthly, the clarity and precision of the PSA definition brings into focus the critical feature of the context that falls to be considered in determining whether the speech or other expressive act which falls within one or other of the illustrative examples in the IHRA working definition is antisemitic. If the speech captured by any of those illustrative examples is motivated by hatred of or hostility towards Jews as Jews, it will be antisemitic. If it is motivated by something else, for example by a sense of sympathy for Palestinians, then it will not be.
85. Sixthly, as Chamberlain J explained in Hussain, a number of the illustrative examples in the IHRA working definition are not necessarily or even presumptively antisemitic. In particular, speech which is critical of Israel’s contemporary conduct, its historical origin, its constitutional order, the legitimacy of its founding or the ideology of Zionism attracts the highest degree of protection under Article 10 ECHR. Indeed, in our view, such speech ought to be presumed not to be antisemitic.
86. There are numerous grounds on which Israel, its policies toward the Palestinian people and its neighbouring countries, its foundation, ideology or its right to exist as a Jewish State might be criticised or called into question which have nothing to do with hatred of or hostility towards Jews or the Jewish people. Most obviously, criticism of Israel’s contemporary policies and its foundations, or its existence as a Jewish State (including calls for its dissolution as such) can be motivated by an honest and good-faith assessment that (for example) Israel is currently committing serious violations of international law in its treatment of the Palestinian people (including the crime of genocide in respect of Palestinians in Gaza),³⁵ or that its

³⁵ We note in this context that the International Court of Justice has concluded: (i) that Israeli settlements in Palestine, and the regime associated with them, were established and maintained in violation of international law (See ICJ, Advisory Opinion on the Legal Consequences arising from the Policies and Practices of Israel in the Occupied Palestinian Territory, including East Jerusalem (19 July 2024), paragraphs 155-156 and 223.) (ii) that Israel’s policies and practices towards Palestinians constitute an ongoing breach of the prohibition on racial segregation and apartheid in international law (*Ibid.* paragraphs 223-229.) (iii) that the “*sustained abuse*” by Israel of its position as an occupying power violates fundamental principles of international law and renders Israel’s presence in occupied Palestine unlawful (*ibid* 261) (iv) in relation to acts committed by Israel in Gaza following 7 October 2023, that there was a real and imminent risk of prejudice to the rights of the Palestinian people in Gaza not to be subjected to

creation (and continued existence as a Jewish State) was premised on their expulsion, or that it is founded on racist principles which prioritise the claims and aspirations of Jewish people within historic Palestine over those of Palestinians.

87. There can be, and is, vigorous debate about the circumstances of Israel's foundation, its right to exist as a Jewish state (to the exclusion of its Palestinian inhabitants and the Palestinian refugees displaced by its creation), its policies, and its treatment of Palestinians in Gaza and elsewhere.³⁶ But absent some very clear basis in the surrounding context, statements of that nature should not be regarded as motivated by hatred of or hostility towards Jews as Jews.
88. Accordingly, in our view an NHS organisation applying the IHRA working definition should assume that criticism of Israel which falls within one or other of the working definition's illustrative examples is not antisemitic absent clear evidence that the speech is motivated by hatred of or hostility towards Jews as Jews. This reflects the common-sense assumption that people generally mean what they say. It also reflects the basic common law principle that cogent evidence is required before a finding of serious, culpable wrongdoing can be made (as is the longstanding position, for example, in relation to allegations of fraud).
89. Thus, when a person criticises Israel on the basis that (for example) it is racist, or treats Palestinian people badly, that criticism ought to be taken at face value as reflecting the critic's genuine views. It is wrong, as a matter of principle, to infer any nefarious or racist motive absent compelling evidence to justify that inference.
90. Applying those principles, the following statement:

acts of genocide: See ICJ, *Application of the Convention on the Prevention and Punishment of the Crime of Genocide in the Gaza Strip (South Africa v Israel)*, Provisional Order of 26 January 2024 at paragraphs 54, 59 and 74, Provisional Order of 28 March 2024 at paragraph 40, and Provisional Order of 24 May 2024 at paragraph 47. On 13 March 2025, the UN Human Rights Council's Report of the International Commission of Inquiry on the Occupied Palestinian Territory, including East Jerusalem and Israel, concluded that Israeli forces had "*caused serious bodily and mental harm to members of [the Palestinian people in Gaza], and deliberately inflicted conditions of life that were calculated to bring about the physical destruction of Palestinians in Gaza as a group, in whole or in part, which are categories of genocidal acts in the Rome Statute and the Genocide Convention*" UN Doc A/HRC/58/CRP.6, paragraph 178. There is thus ample basis on which a doctor or other healthcare worker might form good-faith views to these effect.

³⁶ See, for example, Human Rights Watch's 2021 report, "a Threshold Crossed: Israeli Authorities and the Crimes of Apartheid and Persecution" for consideration of Israeli policies of racial discrimination against Palestinians, available at: <https://www.hrw.org/report/2021/04/27/threshold-crossed/israeli-authorities-and-crimes-apartheid-and-persecution>.

“Israel should not exist. It should never have been created. It should be dissolved...”

will not be antisemitic unless it is accompanied by some other statement or contextual factor which makes clear that the speaker’s opposition to Israel and its existence is motivated by a hatred of or hostility towards Jews as such. For example, that statement would be antisemitic if followed by the following:

“...you just can’t trust the Jews. They can’t be allowed to have a State of their own ...”

91. On that example, the criticism of Israel and opposition to its existence is based on the author’s hostility toward Jews as Jews. It is therefore antisemitic.
92. However, absent that sort of comment (or other contextual factor), criticism of Israel, its creation or its continued existence as a state will not be antisemitic. Thus, the following statement would not be antisemitic:

“Israel should not exist. It should never have been created. It should be dissolved. It is obviously racist to have created a “Jewish State” in a land that was majority non-Jewish when Israel was created, and which is only “Jewish” now because the non-Jews have been kicked out, killed or politically dispossessed. What other country defines itself as a land for only one race of people?”

93. That criticism of Israel is not antisemitic, because it is motivated by concern for the impact of Israel’s conduct on the Palestinian people, and by the author’s good faith assessment of the implications of Zionist thought. Plainly, it is not antisemitic to be concerned about Palestinian people. Nor is it antisemitic to subject Zionism to logical or empirical scrutiny.
94. The statement above is not rendered antisemitic by the fact that the author does not immediately list other States whose conduct he or she deprecates. As Chamberlain J explained in *Hussain*, caution is required before criticism of Israel can be regarded as antisemitic on the basis that it has “singled out” Israel. Such “singling out” will only be antisemitic if motivated by hatred of Jews as Jews. It will only ever be in the clearest, and we suspect extremely rare, case that the mere fact that a person criticises

Israel without also criticising other States justifies a finding of antisemitism. This is because there are a number of obvious, non-antisemitic reasons why a person might have a particular interest in Israel its creation, and its contemporary conduct. For example:

- 94.1. The critic of Israel might be Palestinian. Palestinians have obvious reasons to be concerned about Israel, which has nothing to do with their view of Jews or the Jewish people.
 - 94.2. The critic of Israel might have a personal, religious or cultural affiliation with Palestinians or the cause of Palestinian self-determination. Many non-Palestinian Arabs and Muslims have a natural affinity and solidarity with Palestinians because of their common cultural and religious traditions, because of the importance of Palestine and Jerusalem to Islam as a religion, because of personal or social links with Palestinians, or because of other ideological and philosophical commitments such as anti-racism or anti-imperialism.
 - 94.3. The critic of Israel might have a greater awareness of, and thus sympathy for, the plight of the Palestinian people than other people. This may be because, for example, the Palestinians have been successful in drawing attention to their plight within the West in ways that other people have not, or (in the UK context, in particular) there is a particular historical and contemporary connection between the conduct of the UK and that of Israel (e.g. because the UK contributed to the establishment of Israel through the Balfour Declaration and its administration of Palestine as a League of Nations Mandate between 1917 and 1948 or because the UK supports Israel diplomatically, militarily and economically).
 - 94.4. The critic of Israel may consider Israel's conduct towards the Palestinian people to be particularly abhorrent, and worse than the conduct of other States.
95. It follows that, in the absence of very clear evidence of animus toward Jews as Jews, it will not be antisemitic for a person to focus their criticism of foreign states exclusively on Israel.

Risk of violation of the HRA

96. With those general observations in mind, we turn now to consider a number of the specific risks that arise in the application of the IHRA working definition.

(i) Whether interference is prescribed by law

97. The IHRA working definition is not law and does not authorise NHS organisations to interfere with speech which falls foul of its terms. The ‘prescribed by law’ requirement does not mean that every interference must be expressly authorised by statute; a public authority may rely on general or implied legal powers, and ‘law’ for the purposes of the requirement may encompass published policies or guidance. However, the norm or rule must still satisfy the conditions of precision and protection against arbitrariness set out above. A provision whose application depends heavily on subjective evaluative factors risks inconsistent or capricious enforcement, which runs contrary to the rule of law considerations underpinning the ‘prescribed by law’ requirement.

98. The IHRA working definition is, for the reasons canvassed above at ¶¶23-32 and 73-76, “*abounding in uncertainties*” (see ¶51 above). There is therefore a real risk that any interferences with the rights of freedom of expression or belief imposed by reference to the IHRA working definition will be in breach of the ‘prescribed by law’ requirement under Articles 9 and/or 10 ECHR, unless an NHS organisation’s adoption and/or application of the definition is accompanied by detailed guidance which enables individuals properly to regulate their conduct and speech and limits arbitrariness in enforcement.

99. This would include, for example, guidance as to (i) the actual definition of antisemitism that the NHS organisation will use, given the absence of a definition in the IHRA working definition, (ii) the circumstances in which the IHRA working definition will be applied, (iii) the purposes for which it will be so applied, (iv) the potential consequences of any finding that impugned speech has fallen foul of the definition, (v) the status and relevance of the accompanying “*examples*” in the context of an assessment of whether impugned speech is properly to be characterised as antisemitic; and (vi) the way(s) in which the organisation will apply those examples in a manner consistent with its obligations under the HRA 1998 and EA 2010.

(ii) Whether interference is proportionate

100. Assuming that an interference by an NHS organisation with a person's expression or belief satisfies the prescribed by law requirement, the interference will only be lawful if it is objectively justified and proportionate. Whether that is the case will turn on a fact-sensitive assessment of the particular circumstances of each case. Justification will depend, among other matters, upon whether or not the speech is properly to be regarded as antisemitic, having regard to the principles we identify above.

Risk of unlawfulness under the Equality Act

101. Where the person whose speech may be censured has a protected characteristic (such as being Palestinian, or being anti-Zionist, or being Muslim, or being Jewish), or where a person is associated with Palestinians or anti-Zionists, for example because of their express support for the Palestinian cause, the provisions of the EA 2010 set out at ¶55 above may be engaged.

(i) Indirect discrimination

102. NHS organisations are prohibited from applying a provision, criterion or practice (such as a disciplinary or service-use policy which incorporates the IHRA working definition) to any person with a protected characteristic which puts them at a disadvantage when compared to people without that characteristic, unless that provision, criterion or practice can be shown to be a proportionate means of achieving a legitimate aim.

103. A policy which incorporates the IHRA working definition and which does not adopt guidance to ensure that it is applied consistently with Article 10 is likely to put Palestinians and anti-Zionists (or those associated with them) at a particular disadvantage, because persons with those characteristics are more likely to be censured in relation to speech of importance to them than people who do not share those characteristics. Whereas a person who feels strongly that Israel should exist and should be permitted to occupy and/or wage war on the Palestinians (or others) in order to secure its existence as a Jewish State would be able to express those views without interference, Palestinians or anti-Zionists who wish to criticise that view could not. If the relevant speech act is not in fact discriminatory, the application of

the policy to capture and censure such an act is unlikely to be a proportionate step in pursuit of a legitimate aim. The application of such a policy to speech which does not in fact manifest hatred of or hostility towards Jews as Jews is therefore likely to constitute unlawful indirect discrimination.

(ii) Direct discrimination

104. The uncritical application of the IHRA working definition and/or its accompanying examples will likely give rise to direct discrimination. This will be true in relation to speech which manifests a protected belief, most obviously anti-Zionism. For example, if the IHRA working definition is applied in such a manner as to prohibit speech which characterises the creation of Israel as a racist endeavour in all contexts, without regard to the question of whether such speech in fact expresses or is motivated by hatred or hostility towards Jews as such, then this is likely unlawfully to interfere with the rights of anti-Zionists to manifest their philosophical views.
105. There is also a risk of direct race discrimination against Palestinians, people who associate with Palestinians, and Jews. For example, if a decision-maker decides that a Palestinian or Arab employee's criticism of Israel is antisemitic, without any evidence that such criticism was motivated by prejudice towards Jewish people as such, that decision may be directly discriminatory if and to the extent that it is motivated by racist assumptions to the effect that Palestinians or Arabs are generally antisemitic.
106. The uncritical application of the IHRA Definition may also be antisemitic. For example, it may be antisemitic for an NHS organisation to make disciplinary decisions on the basis that Jewish people are likely to be offended or upset by certain forms of speech exclusively on the basis that the impugned speech is critical of Israel. To do so would conflate the Jewish people with the State of Israel, in circumstances where (i) there is no necessary connection between the two (however Israel self-defines, it has no claim to represent or speak for non-Israeli Jews), and (ii) there are a range of views within the Jewish community towards Israel and/or Zionism as an ideological project, including some Jews and Jewish groups which are anti-Zionist.
107. When determining whether there has been direct discrimination, it is accordingly important to examine the role that discriminatory assumptions can sometimes play

when the conduct or speech of people with particular characteristics or beliefs is categorised as hateful. Where an employer or service provider censures someone's speech on the basis of an assumption that the person, on the basis of their protected characteristic, is likely to hate people with another protected characteristic, this may constitute direct discrimination. As Underhill LJ explained in *Higgs v Farmor's School* [2025] EWCA Civ 109, [2025] ICR 1172 at ¶172:

It is right to record that we had helpful written submissions from the EHRC on the law concerning direct discrimination by stereotyping in the context of religion or belief. So that their work is available in a case where it may be directly useful, I quote the following passage:

50. [...] One particular species of [direct discrimination] in which an employees holding or manifesting their belief might have a significant influence on their treatment is through the putative discriminator's adoption of a stereotype. In such a case, although the reason for the treatment given by the employer is not the protected characteristic, it is nonetheless positively relied on by the claimant. The claimant argues that the decision-maker has, consciously or unconsciously, adopted a stereotype and was significantly influenced by it in deciding on the treatment complained of i.e. on the basis that the claimant would share the perceived attributes of the group, rather than relying on evidence about the particular individual. If that is so then the treatment will be because of the protected characteristic. It does not matter if the stereotype is very likely to be true: see e.g. *R (European Roma Rights Centre) v Immigration Officer at Prague Airport* [2005] 2 AC 1 per Baroness Hale of Richmond at para 82; *Commerzbank AG v Rajput* [2019] ICR 1613, at para 77 per Soole J [...]

52. In relation to religion or belief, a decision-maker will accordingly discriminate where the reason given for the treatment is significantly influenced, consciously or unconsciously, by a stereotype that persons who hold or manifest the relevant belief will share attributes of a group which they might not in fact possess. Examples of stereotypes in relation to religion or belief explicitly recognised in the case law are that: persons who hold/manifest certain gender-critical beliefs have animus towards trans persons (see e.g. *R (Miller) v College of Policing* [2020] 4 All ER 31, paras 250, 281); or that persons holding/manifesting the belief that same-sex sexual activity is sinful have animus towards gay persons (see e.g. *R (Ngole) v University of Sheffield* [2019] ELR 443, para 115). It may be that some persons who hold/manifest such beliefs have such animus, but it is stereotyping to assume that all do. Given the above cases, the EHRC considers that a tribunal is likely to be able to proceed

on the basis that the stereotypes which they identify exist (Commerzbank, paras 79—80), although it may need to give prior notice to the parties of a proposed use of the principle: Commerzbank, para 84.

53. The stereotype must significantly influence the decision-maker's decision. That is irrespective of whether, as in a case such as the present, the employer is acting following a third-party objection/complaint about the claimant.

I am prepared to say, albeit entirely obiter, that my provisional view is that that is a correct summary of the law.

108. We consider this guidance to be apt. There are a number of racially discriminatory stereotypes which may operate on the mind of a decision-maker applying the IHRA working definition. Key racist stereotypes include the following:

108.1. The racially discriminatory stereotype that Palestinians are inherently (or likely to be) antisemitic.

108.2. The racially discriminatory stereotype that Jews are inherently (or likely to be) anti-Palestinian.

108.3. The racially discriminatory stereotype that Palestinians are inherently (or likely to be) violent.

109. These stereotypes can play out in a number of ways. Perhaps the most obvious is the well-known Palestinian chant “from the River to the Sea, Palestine will be free”. Because of the racially discriminatory stereotypes referred to above, that phrase is sometimes understood as a call by Palestinians for genocide or ethnic cleansing against Jewish Israelis. On this analysis, the Palestinian conception of “freedom” is aimed at (or at least involves) violence or systematic persecution towards Jews (or Jewish Israelis).

110. If the racist stereotypes above are relinquished, then a call for all of historic Palestine to be “free” would more readily be understood (as, we expect, it is intended in almost all cases of its use) as a call for the end of a system of racial domination in Palestine, in which (in the view of those employing the chant) Palestinians are oppressed and Jews systemically advantaged. It would be no different to the way that the phrase (less catchy, perhaps) “from the Atlantic to the Pacific, Black Americans will be free” might have been understood during the Jim Crow era.

Harassment

111. NHS organisations seeking to apply the IHRA Definition will need to ensure that they do not (even inadvertently) harass persons with a protected characteristic because of that characteristic in the course of their employment or the use of the service. Where a person is subjected to some detriment on the basis of speech which is not in fact antisemitic, this could, in certain circumstances, constitute harassment (for example, where it is based on a racist assumption). Subjecting someone to disciplinary proceedings can, in certain circumstances, create a hostile work environment or otherwise amount to harassment within the meaning of the EA 2010.

F. Illustrative examples

Example 1:

A Palestinian nurse posts criticism of Israel on social media. His profile states that he is a nurse, but makes clear he is posting in a personal capacity. His posts criticise attacks on civilians in Gaza, and express the view that those attacks are rooted in racism. His posts include the statement “Zionism is a racist ideology”. His line manager sees the posts and initiates disciplinary proceedings, relying on the IHRA working definition.

112. By initiating disciplinary proceedings against the nurse in question, the NHS is likely to be acting unlawfully. This conduct is likely to constitute:

- 112.1. Breach of Article 10 ECHR: The nurse’s posts, as instances of political speech, will attract strong protection under Article 10. Subjecting him to disciplinary proceedings is likely to constitute interference with that speech. Given the ambiguity in the IHRA working definition (in particular in respect of its application to the expression ‘*Zionism is a racist ideology*’), the interference may not be ‘prescribed by law’. Further and in any event, absent independent evidence of hatred or prejudice towards Jews as such, the nurse’s posts are not antisemitic. The relevant statements were made in a non-work context, and the nurse’s profile makes clear that he is posting in a private capacity. While his profile identifies him as a nurse, the public has an interest in health workers being able to freely and publicly express themselves on issues and in being able to identify

themselves as health workers when doing so. Balancing these considerations, initiating disciplinary proceedings is unlikely to be a proportionate means of achieving a legitimate aim and is likely therefore to be unlawful.

112.2. Breach of Article 9 ECHR: The staff member may be a committed anti-Zionist, and his speech in this regard may be a manifestation of that deeply-held belief. Subjecting him to disciplinary proceedings in connection with these posts is likely to constitute interference with that manifestation of his belief, and, for the reasons set out above, is unlikely to be a proportionate means of achieving a legitimate aim.

112.3. Direct discrimination contrary to s.39 EA 2010: The staff member's line manager may be assuming that the staff member's posts were antisemitic on the basis of his Palestinian identity. By categorising his conduct as antisemitism (without any independent evidence of prejudice towards Jews), and taking disciplinary steps accordingly, this may constitute direct discrimination on the grounds of religion or race.

Example 2:

A group of NHS staff members organise a panel discussion about threats to health services in Gaza and invite academics from a number of disciplines to speak, as well as a doctor who has spent time working in Gaza. As with other educational events which had been organised by staff in the past, the panel discussion was to be held outside of working hours in a lecture theatre owned by the NHS Trust, and was to be open to all staff but not to the public. The Trust cancels the event because of a complaint that the organisers were singling out Israel and were thus antisemitic.

113. Cancelling the panel discussion is likely to be inconsistent with Article 10 ECHR (and possibly also Article 11, which protects freedom of assembly). By doing so, the trust interfered with the free expression of the event's organisers, the proposed panellists, and staff members who may have wished to attend and to engage with the discussion. The organisers of the event, by specifying that it would be concerned with Gaza, were not thereby expressing hatred of or prejudice towards Jews as Jews, and therefore, absent evidence of the same, were not being antisemitic. A private

event for staff is unlikely to interfere with the trust's ability to effectively deliver health services to the public. There is a public interest in medical professionals, including those with particular expertise, being able to share their views on relevant matters with each other. In the circumstances, cancelling the event is unlikely to be a proportionate step in pursuit of a legitimate aim.

Example 3:

An anaesthetist is speaking to a colleague about the news in a waiting area in which several patients are sitting. She says: "*It's despicable what the Israelis are doing in Gaza. Anyone who defends Israel is despicable too.*" After overhearing the conversation, a manager asks the anaesthetist not to speak in this way in the presence of patients. The manager directs the anaesthetist's attention to a provision in the trust's staff code of conduct which states that staff should not speak to or in front of patients about political or religious issues or current affairs, in so far as doing so would not be a relevant and helpful part of the patient's care. The manager has asked other colleagues to desist from political speech on other issues unrelated to Israel-Palestine in the recent past (for example, speech concerning Russia's invasion of Ukraine or the Reform party in the UK).

114. This speech could not lawfully be characterised as antisemitic. There is no evidence that the anaesthetist is motivated in criticising Israel by hatred of Jews as Jews, nor that she is applying a double-standard to Israel which she would not apply to other democratic nations. The anaesthetist is not required to condemn all breaches of international law whilst condemning Israel's conduct in Gaza.
115. However, the manager's direction is likely to be lawful. A patient overhearing the conversation may conceivably have felt offended by what the anaesthetist said, and may have felt less safe in the anaesthetist's care as a result. While the steps taken by the manager are likely to have constituted an interference with the anaesthetist's rights under Article 10 ECHR (and possibly Article 9 ECHR), that interference is likely to be justified in the circumstances, as it represents a proportionate step in pursuit of a legitimate aim (ensuring the safe and efficient delivery of healthcare services).

116. The restriction is likely to be prescribed by law, on the grounds that it is based on a reasonably clear provision in the trust's staff policy. Whilst what counts as 'political' will be open to debate, the provision described in the example is likely to be sufficiently precise to enable a staff member to plan their conduct and to protect them against arbitrary interference with their rights.
117. Because the policy is applied equally to Ukraine and Israel-Palestine, its application to the anaesthetist is unlikely to constitute direct discrimination on grounds of race or belief. To the extent that it has a particular impact on those who share the anaesthetists' views, it is likely to be proportionate and so not constitute indirect discrimination.

Example 4:

Alongside photos of his family and other personal effects, an occupational therapist has hung a keffiyeh (a traditional scarf which has become a symbol of support for Palestinians) on a shelf in his office. The office is shared with a number of other staff members but is not accessible to patients or the public. He also wears a badge with a Palestine flag on it when seeing and treating patients.

A manager tells him he must remove the keffiyeh from his office and that he cannot wear the badge while at work.

118. Both the keffiyeh which the occupational therapist has hung in his office and the badge which he wears at work are likely to represent forms of speech which are protected by Article 10 ECHR. The display of the keffiyeh may also engage the occupational therapist's rights under Article 8 (the right to private life).
119. Whether the NHS organisation he works for can lawfully prevent him from displaying either will depend on whether it is a proportionate step in pursuit of a legitimate aim to do so.
120. In patient-facing contexts, it is likely to be proportionate for the NHS organisation to require the occupational therapist to remove symbols such as badges, flags and scarves associated with a non-work-related message or cause, on the basis that such symbols may have a detrimental effect on the service he is able to provide to patients because they might (rightly or wrongly) take offence at the symbol, or it might

otherwise adversely affect the patient-staff member relationship. The NHS organisation is therefore likely to be justified in requiring the occupational therapist to remove the badge when interacting with patients.

121. By contrast, it is unlikely to be proportionate to require the therapist to remove the keffiyeh from the shelf in his office, given (i) the fact that only other staff members will see it, and (ii) the personal nature of the items stored on his shelf, which means that by hanging the keffiyeh there, the occupational therapist appears to express a personal message of support and association (rather than one which purports to speak for the person's team or organisation, which may be more likely to give rise to objection or offence) and (iii) the inherently unobjectionable nature of the item. Requiring him to remove the keffiyeh is therefore unlikely to be consistent with Article 10 ECHR.
122. If and to the extent that the NHS organisation regulates national or political symbols selectively (whether as a matter of policy or practice), for example by requiring the occupational therapist to remove his badge whilst permitting a Nigerian member of staff to wear a lanyard in the colours of the Nigerian flag, or by requiring the occupational therapist to remove the keffiyeh from his office whilst permitting a LGBT+ staff member to display a rainbow flag, the organisation is likely thereby to be discriminating unlawfully against Palestinians (or persons associated with Palestinians) in violation of the EA 2010. A blanket ban on symbols associated with the culture or nationality identity of Palestine or Palestinians will be directly discriminatory.

F1. Conclusion

123. We have summarised our views at ¶5-9 above. As we explained there, NHS organisations are under no legal obligation to adopt the IHRA working definition. If they choose to do so, they should carefully consider the legal, operational and equality implications of adoption and should ensure that detailed guidance is available governing its application. Particular care should be taken to ensure compliance with obligations arising under the Human Rights Act 1998 and Equality Act 2010.

**PHILLIPPA KAUFMANN KC
ZAC SAMMOUR
RAYAN FAKHOURY
ISABELLE AGERBAK**

15 July 2026

People & Culture Committee
Minutes of the last meeting held on 29th June 2026
Teams

Present:

Jo Revill	Non-Executive Director (Chair)	(JR)
Nathan Askew	Chief Nursing Officer	(NA)
Adam Bateman	Deputy Chief Executive & Chief Operating Officer	(AB)
Fiona Beveridge	Non-Executive Director	(FB)
Erica Saunders	Chief Corporate Affairs	(ES)
Melissa Swindell	Chief People Officer	(MS)
Sharon Owen	Deputy Chief People Officer	(SO)

In attendance:

Katherine Birch	Director of Academy	(KB)
Angela Ditchfield	EDI Lead	(AD)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Gill Foden	Head of L&D and Widening Partnership	(GF)
Kathryn Guy	HR Advisor	(KG)
Sarah Leo	Associate Chief Operating Officer	(SL)
Rebecca Murphy	Head of Marketing & Communications	(RM)
Nicola Norris	E-Roster Manager	(NN)
Rachel Rowson	Service Manger – Surgery	(RR)
Kerry Turner	FTSU Guardian	(KT)
Neil Thomas	Acting Health & Safety Manager	(NT)
Julie Worthington	Staff Side Chair	(JW)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Kathryn Allsopp	Associate Director of People	(KA)
Alfie Bass	Chief Medical Officer	(AB)
Pauline Brown	Deputy Director of Nursing	(PB)
Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
Audrey Chindiya	Finance Manager	(AC)
Garth Dallas	Non-Executive Director	(GD)
Urmi Das	Director, Division of Medicine	(UD)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Chloe Lee	Associate Chief Operating Officer – Surgery	(CL)
Jo Potier	Associate Director of Organisational Development	(JP)
Jill Preece	Governance Manager	(JP)

26/27/013 **Declarations of Interest**
No declarations were declared.

26/27/014 **Minutes of the previous meeting held on 13th May 2026.**
The minutes of the last meeting were approved as an accurate record.

26/27/015 **Matters Arising and Action Log**
Action log was updated accordingly.

26/27/016 **Terms of Reference**
- **Workplan**

The Committee reviewed the updated Terms of Reference and annual workplan. Discussion focused on ensuring that the Committee's membership, reporting arrangements and assurance responsibilities remain aligned with the Trust's changing operating model and future workforce governance requirements.

Members agreed that the Terms of Reference should move away from outdated divisional references and should strengthen wording relating to oversight of education, learning and training.

Next Steps:

Update the Terms of Reference to reflect the future organisational structure, including revised membership, reporting and education, learning and training oversight.

Resolved: The Committee received the Terms of Reference recommendation.

26/27/017 **Internal Communications Update**

The Committee received the Internal Communications update and noted continued progress in delivering the Trust's Internal Communications Strategy, which provides the framework for communication activity across the seven strategic pillars.

The Committee noted continued progress against the Internal Communications Strategy, with significant activity focused on supporting staff through the How We Work in the Future programme and wider leadership, campaign and engagement priorities.

The Staff Awards were highlighted as a major positive development, with record engagement and more than 500 nominations received overall, including over 200 nominations for the Children, Young People and Families Choice Award.

Members discussed feedback from Connecting Alder Hey sessions. Attendance remains strong, although completion of formal feedback forms remains lower than desired. The Committee recognised the need to continue reassuring staff that feedback mechanisms are anonymous.

Next Steps:

- Continue to reinforce the anonymity of Connecting Alder Hey feedback and that individual responses cannot be traced.
- Consider additional ways to encourage feedback completion and improve evaluation participation.

Resolved: The Committee noted the contents of the Internal Communications

26/27/018 **People Plan Update – Key People Issues**

The Committee received and noted the latest People Plan update, including the regular strategic workforce report also submitted to June Trust Board.

The Committee noted progress across People Plan priorities, including leadership development, education, widening participation and equality, diversity and inclusion activity.

The leadership development spotlight was welcomed. Early analysis suggests positive emerging trends around retention and progression for colleagues who have participated in leadership development programmes, although further monitoring is required before firm conclusions can be drawn.

Learning at Work Week and the Long Service Recognition Awards were positively received and were recognised as important opportunities to celebrate staff contribution, promote learning and reinforce organisational culture.

The Committee noted ongoing work to strengthen the Performance Development Review process, including development of a PDR dashboard and work with Digital colleagues to resolve technical issues.

Next Steps:

- Continue longitudinal monitoring of leadership development outcomes and incorporate findings into future workforce metrics where appropriate.
- Continue work with Digital colleagues to progress the PDR dashboard and provide further updates to the Committee.
- Use internal communications to showcase long service stories and learning opportunities.

Resolved: The Committee noted the contents of the People Plan Update.

26/27/019

Trust-wide Workforce Metrics

The Committee reviewed the trust-wide workforce metrics, with discussion focused on sickness absence, PDR compliance, workforce reporting, overpayments and assurance through transition to the future operating model.

- Sickness absence had increased slightly, largely driven by short-term absence, while long-term absence continued to reduce. Members emphasised the importance of core management practice, including clear reporting routes, direct contact with staff, timely return-to-work conversations and early support.
- The Committee noted that sickness absence should not be reported by text or WhatsApp and that staff should speak directly with an appropriate person when reporting absence. Members also discussed the value of a simple local guide for wards and service areas.
- PDR compliance remained a continued area of focus. Work to develop the PDR dashboard continues with Digital support.
- Overpayments were discussed as an issue requiring linkage between Audit Committee and People Committee, recognising both workforce and financial governance implications.

Members also discussed the need to protect continuity of workforce metrics and trend reporting as current divisional structures change.

Next Steps:

- Clarify and communicate sickness absence reporting expectations, including that absence should not be reported by WhatsApp or text.
- Provide continued updates on development of the PDR dashboard.
- Work with relevant colleagues to close the loop on overpayments across Audit Committee and People Committee.
- Develop a paper setting out how workforce metrics and reporting will be managed through transition to the future operating model, drawing on the approach used for SQAC.

Resolved: The Committee noted the content of the metrics report.

26/27/020 **Surgery Divisional Metrics**

The Committee received The Surgery Division metrics report (June 2025) data.

Surgery reported strong PDR performance for Band 7 and above, mandatory training compliance above 90%, and agency usage maintained at zero. The Committee recognised the considerable effort required to maintain zero agency use during a period of operational and organisational change.

The Committee discussed staff morale and workforce experience during the How We Work in the Future programme. Some teams, particularly administrative teams, continue to experience uncertainty regarding future roles and structures. Members were reassured that divisional leaders are maintaining visible leadership, regular staff conversations and open communication channels.

Next Steps:

- Continue monitoring PDR completion, mandatory training, sickness absence and return-to-work practice during organisational transition.
- Maintain visible leadership and regular communication with teams affected by change.

Resolved: The Committee noted the content of the metrics report.

26/27/021 **Clinical Research Divisional Metrics**

The Committee received The Clinical Research Division metrics report (June 2025) data.

- The Committee noted that long-term sickness absence had increased, but all cases were being actively managed and supported. Return-to-work completion had improved to 100% following focused intervention.
- PDR completion for Band 7 and above was expected by the end of July. A Thriving Teams session had been arranged, with feedback to inform future reporting.

Members discussed the need to ensure that future workforce structures and representation are reflected within Committee governance arrangements.

Actions:

- Bring feedback from the forthcoming Thriving Teams session to a future report.
- Maintain focus on completion of outstanding PDRs by the end of July.

Resolved: The Committee noted the content of the metrics report.

26/27/022 **Community & Mental Health and Medicine Divisional Metrics**

Reports were received and noted in the absence of divisional representation. The Chair confirmed that any matters requiring escalation or clarification could be followed up outside the meeting and brought back through future reporting if required.

26/27/023 **Raising Concerns: Freedom to Speak Up Update**

The Committee noted significant developments in the Trust's Freedom to Speak Up arrangements, including the appointment of a Deputy FTSU Guardian, the development of a new InPhase reporting function and plans to relaunch the Champion Network.

Members welcomed the additional reporting route, including anonymous reporting, and the opportunity to improve data capture, trend analysis and assurance reporting.

Discussion focused on improving visibility, accessibility and staff confidence in speaking up arrangements, particularly for staff from protected characteristic groups and underrepresented communities. The importance of a diverse and representative Champion Network was emphasised.

Members also discussed the need to clarify anonymity arrangements, protection from detriment, access to champions outside immediate departments, and completion of the national Speak Up, Listen Up, Follow Up training programme.

The Committee supported triangulation of FTSU information with wider workforce intelligence, including staff survey findings and workforce metrics.

Next Steps:

- Relaunch the FTSU Champion Network with clearer structure, training and visibility.
- Strengthen engagement with staff networks and workforce events and develop demographic monitoring to understand access and representation.
- Clarify promotional messaging so staff know they can approach champions outside their own department where appropriate.

- Develop an approach to target and monitor Speak Up, Listen Up, Follow Up training completion.
- Communicate confidentiality, anonymity and protection from detriment clearly as the InPhase reporting route is implemented.
- Explore triangulation of FTSU data with workforce metrics, staff survey findings and other intelligence.

Resolved: The Committee noted the FTSU update.

26/27/024 **Workforce Numbers**

The Committee received the Freedom to Speak Up (FTSU) update. KT highlighted a number of significant developments aimed at strengthening the Trust's speaking up arrangements, improving accessibility for staff and increasing the organisation.

The Committee reviewed workforce numbers and noted continued progress against the trajectory to reduce workforce establishment to approximately 4,000 WTE by year-end.

Members discussed the relationship between workforce reductions, vacancies and temporary staffing expenditure. Bank usage had increased in some areas, but this was understood in the context of held vacancies, maternity leave cover and safe staffing requirements during organisational transition.

The Voluntary Redundancy programme was also reviewed. The scheme had received 220 applications, with 62 approved at the time of reporting

Resolved: The Committee noted the content of the Workforce Numbers update.

26/27/025 **How We Work in the Future / VR Update**

The Committee received an update on the How We Work in the Future (HWWITF) programme, recognising it as a recurring theme throughout the meeting and the Trust's most significant organisational change initiative.

The Committee noted that How We Work in the Future remains a major organisational change programme and a recurring theme across workforce, communications, metrics and governance discussions.

Members discussed the impact of organisational change on staff morale and uncertainty, particularly for colleagues affected by changes to roles and structures. Assurance was provided that visible leadership, regular staff conversations and clear communications continue to support staff engagement.

The Committee also considered the implications of the programme for governance, Committee Terms of Reference, reporting arrangements, workforce metrics and temporary staffing.

Next Steps:

- Review People Committee Terms of Reference, membership and reporting arrangements to align with the future operating model.
- Provide assurance on how workforce metrics, benchmarking and trend reporting will be maintained through organisational transition.
- Continue communication and engagement activity to support staff through change.

Resolved: The Committee noted the contents of the report.

26/27/026

Development Hub

The Committee received the regular workforce numbers update. SO advised that the workforce establishment and the whole-time equivalent (WTE) reductions continue to represent a key priority for the organisation as part of its financial and workforce planning objectives.

The Committee welcomed the Development Hub as a significant workforce development resource designed to improve career visibility, access to learning and staff progression.

Members received an overview of the Skills Scan tool and enhanced Career Pathways Framework. The Hub is intended to support self-assessment, career conversations, PDRs and wider workforce flexibility.

The Committee discussed the importance of reflecting modern, non-linear career pathways and ensuring the Hub remains inclusive of multiple professional groups and occupational families.

Members received assurance that mandatory, statutory and professional requirements remain integral to workforce development arrangements.

Next Steps:

- Continue developing pathway content with clinical and professional leaders, including flexible and non-linear career routes.
- Ensure mandatory, statutory and professional training requirements remain visible within relevant pathways.
- Promote the Hub across all staff groups so it supports career conversations and access to development opportunities.

Resolved: The Committee noted the contents Workforce Numbers Update.

26/27/027 **Health & Safety Annual Report**

The Committee received the annual Health and Safety Report. NT provided assurance regarding the overall effectiveness of health and safety, security and campus services functions across the Trust during 2025/26.

The Committee received the annual Health and Safety Report and noted assurance on statutory training compliance, improved incident investigation processes, no serious incidents and six HSE-reportable seven-day injuries (RIDDOR)

Members welcomed the reinstatement of Trust-wide audit activity, including site inspections and compliance reviews expected to complete by October 2026, followed by further sharps audits and equipment inspections.

The Committee challenged the level of assurance provided where formal on-site verification visits had not taken place for several years due to capacity constraints. Members agreed that future reporting should distinguish between documented compliance and independently verified compliance.

Improved collaboration between Health and Safety, Estates and Facilities was noted as a positive development supporting a more mature safety culture and proactive risk management.

Next Steps:

- Complete the Trust-wide site inspection and compliance review programme by October 2026, including community sites.
- Progress subsequent sharps audits and equipment inspections later in the year.
- Ensure assurance reporting clearly distinguishes between documented compliance and independently verified compliance.
- Maintain monitoring of legislative developments and emerging safety risks through Health and Safety governance arrangements.

Resolved: The Committee noted the contents of the report.

26/27/028 **Equality, Diversity and Inclusion Update**

The Committee received an update on Equality, Diversity and Inclusion (EDI) activity from AD, who reported continued progress across several key strategic priorities and highlighted a number of significant achievements during the reporting period.

The Committee noted continued progress across EDI priorities, including achievement of North West Race Equity Assembly Bronze Status and development of an action plan towards Silver.

Members recognised the ongoing impact of staff networks, including the ACE Network's contribution to Stoma Friendly Trust status and the introduction of eleven stoma-friendly facilities.

The Trust's role in the Liverpool City Region anti-racism strategy was noted as an important opportunity to contribute to regional work and learn from system partners.

The Committee discussed the Lord Mann Review and its links to leadership accountability, support for staff, education, speaking-up confidence and inclusive culture. The Trust's existing activity was considered to align closely with many of the emerging recommendations.

Resolved: The committee received and noted the contents of the report.

26/27/029 **Lord Mann Review**

The Committee received a detailed briefing from AD on the implications of the recently published Lord Mann Review, which examined experiences of antisemitism, racism and other forms of discrimination across the NHS.

The Committee considered the implications of the Lord Mann Review, which highlighted the need for stronger leadership accountability, enhanced organisational responses to discrimination, improved education and training, and cultures where staff feel safe to raise concerns.

Members recognised the strong links between the review, Freedom to Speak Up, staff networks, anti-racism work, leadership development and wider cultural transformation.

The Committee agreed that the Trust's response should be coordinated across workforce programmes rather than treated as a standalone EDI initiative, with Board-level scrutiny and ongoing governance oversight.

Next Steps:

- Present the Lord Mann Review and proposed Trust response to Trust Board.
- Maintain oversight of actions through governance structures with regular reporting on progress.
- Coordinate delivery across EDI, FTSU, leadership development, staff networks and culture workstreams.

Resolved: The Committee noted the contents of the Lord Mann Review.

26/27/030 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received the regular BAF update and noted that many key workforce risks had been discussed through earlier agenda items, including workforce reduction, organisational redesign, sickness absence, workforce planning, FTSU, leadership development, staff experience and EDI.

No significant new issues were escalated beyond those already discussed. Members noted Trust Board's request for deeper scrutiny of the principal workforce risks and agreed that fuller analysis should remain within the Committee work programme.

Resolved: The Committee noted the contents of the BAF report.

26/27/031 **Policies for ratification:**

- **Freedom To Speak Up Policy**

The Committee received the Freedom to Speak Up Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Freedom to Speak Up Policy.

- **E-Roster Policy**

The Committee received the E-Roster Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the E-Roster Policy

- **Alcohol and Substance Misuse Policy**

The Committee received the Alcohol and Substance Misuse Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Alcohol and Substance Misuse Policy

26/27/032 **EDI Steering Group (EDISG)**

The Committee received the approved minutes of the EDISG meeting held on March 2026)

26/27/033 **Education Governance Committee**

The Committee received the approved minutes of the ECG meeting held on March 2026)

26/27/034 **Any Other Business**

There were no items of AOB

26/27/035 **Review of Meeting – Chair's Report to Board**

• **Terms of Reference/Workplan:**

Further amendments will be made to the documentation and resubmitted to July's meeting for rarefication.

- **Internal Communications:**
Activity focused mainly on supporting staff through the How We Work in the Future programme, alongside ongoing leadership, campaign and engagement work. The Staff Awards saw record engagement, with over 500 nominations received.
- **People Plan:**
Success of Learning at Work Week, strong engagement with long service recognition, and ongoing development of workforce metrics. The Committee also noted continued work to strengthen the PDR process, including progress towards a new dashboard, while recognising that technical issues remain under review with Digital support.
- **Divisional Metrics:**
The metrics was highlighted on sickness absence leaves and agency usage across areas.
- **FTSU:**
Successful appointment of Deputy FTSU Guardian, development of a new InPhase reporting function to improve accessibility and support anonymous reporting and plans to relaunch the FTSU Champion Network with clearer structure, visibility and training.
- **Workforce Numbers:**
Aim of approximately 4,000 WTE by year-end, with May reporting slightly below plan by 33 WTE. 220 applications received and 62 approved, and a fuller position expected at the next meeting.
- **How We Will Work in the Future**
Remains a major organisational change programme, with communications, workforce planning and leadership activity focused on supporting staff through transition. Recognised ongoing uncertainty for some teams, particularly around future roles and structures but assurance given that visible leadership, regular staff conversations and clear communications were helping to maintain engagement.
- **VR Update:**
The scheme continues to progress at pace, with 220 applications received and 62 approved at the time of reporting.
- **Development Hub:**
The Development Hub will improve career visibility, learning access and staff progression through the Skills Scan Tool and enhanced Career Pathways Framework.
- **Health & Safety Annual Report**
The Committee noted strong statutory training compliance, no serious incidents, and six HSE-reportable seven-day injuries. Progress was highlighted in incident investigation, root cause analysis and organisational learning. Members welcomed the reinstatement of Trust-wide audits, including site, sharps and equipment inspections, and noted that additional capacity would help address previous assurance gaps and strengthen compliance monitoring.
- **EDI:**
The Committee noted the Trust's North West Race Equity Assembly Bronze Status and action plan towards Silver. Staff networks continued to show impact, including

the ACE Network's support for Stoma Friendly Trust status and 11 stoma-friendly facilities. The update also covered Alder Hey's role in the Liverpool City Region anti-racism strategy and the Trust's response to the Lord Mann Review, focused on leadership accountability, staff support, training, speaking-up confidence and inclusive culture.

- **Polices:**

- Freedom to Speak Up Policy – **APPROVED**
- E-Roster Policy - **APPROVED**
- Alcohol and Substance Misuse Policy – **APPROVED**

Date and Time of the Next Meeting:

Wednesday 29 July 2026, 2.00pm – 4.30pm, via Teams

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Freedom To Speak Up (FTSU) Q1 Report
Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian/Deputy FTSU Guardian
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:	N/A



1. Executive Summary

This paper presents the Board with the Freedom to Speak Up (FTSU) activity report for Q1 2026, 1 April to 30 June.

The service has continued to provide trusted and accessible support to colleagues during an ongoing period of change and challenge for the organisation.

We have responded to a total of 41 cases during this reporting period, hearing from colleagues covering the whole breadth of the organisation.

There have been major changes to the way FTSU is organised at a national level, with ownership being removed from the now defunct National Guardian's Office (NGO) and handed over to NHS England (NHSE) on 30 June 2026.

The service developed a bespoke InPhase FTSU reporting module, coupled with using InPhase as the sole service database, soft launched in April with an official launch on 2 July 2026.

The FTSU Champion group was reviewed and a new model developed over the reporting period. A call for interest was published 27 July 2026, and a dedicated programme of engagement with our staff networks put into place.

We also responded to the new organisational structure, introducing the service and FTSUG/Deputy FTSUG to all new system leads. Regular meetings with each of the three clinical system leads were requested and will be in place by beginning September 2026.

The Board is asked to note progress made to date, to continue giving support to the aims of the service as well as the specific initiatives proposed.

2. FTSU Activity Report 1 April – 30 June 2026

Freedom to Speak Up enables staff to raise concerns about patient safety, quality, behaviours, culture or ideas for improvement without fear of reprisal.

A positive speaking up culture supports early identification of risk, learning and staff wellbeing and is central to the NHS People Promise commitment that "we each have a voice that counts".

We know that an open and responsive raising concerns culture, where all of our staff feel confident to speak up when things go wrong, is a huge part of what makes Alder Hey the caring hospital it is, every day.

However, we also know that colleagues can and do require support to make sure they are able and willing to speak up when they want to do so.

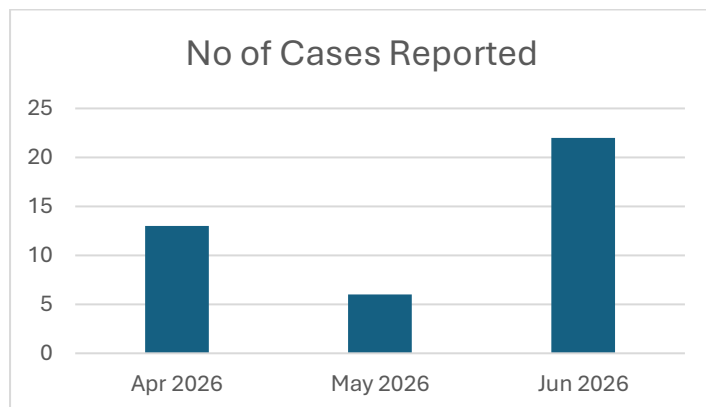
The organisation employs 1 full-time FTSU Guardian Kerry Turner, and 1 part-time Deputy FTSU Guardian Joe Fitzpatrick, who provides support to Kerry alongside his substantive role as Internal Communications Manager.

These roles are supported by a network of FTSU Champions, volunteer positions who advocate for and raise awareness of the service, and signpost colleagues to the FTSUG/Deputy FTSUG as required (see more on FTSU Champions below).

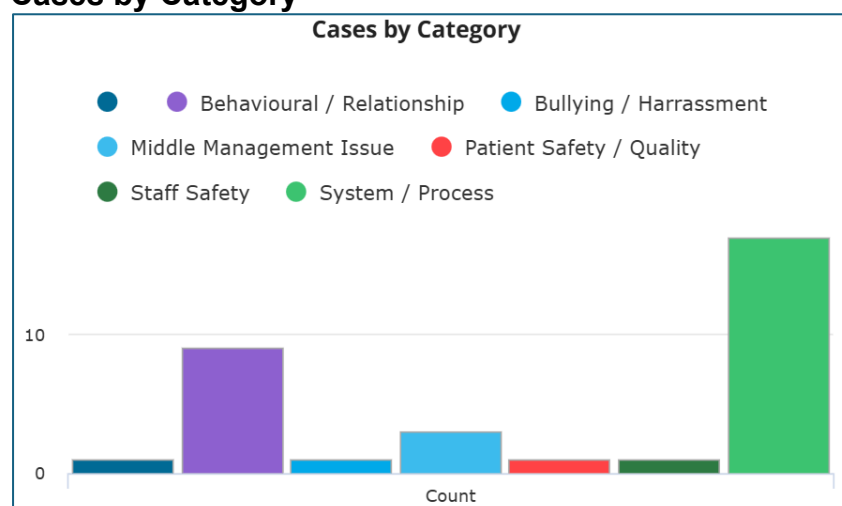
We have responded to a total of 41 cases during this reporting period, hearing from colleagues covering the whole breadth of the organisation.

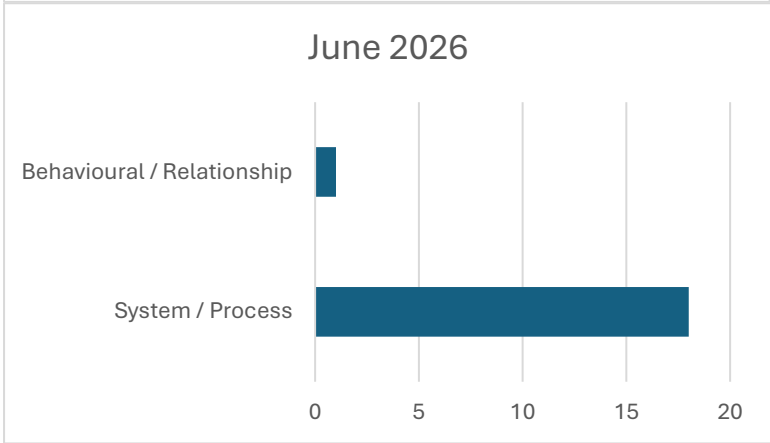
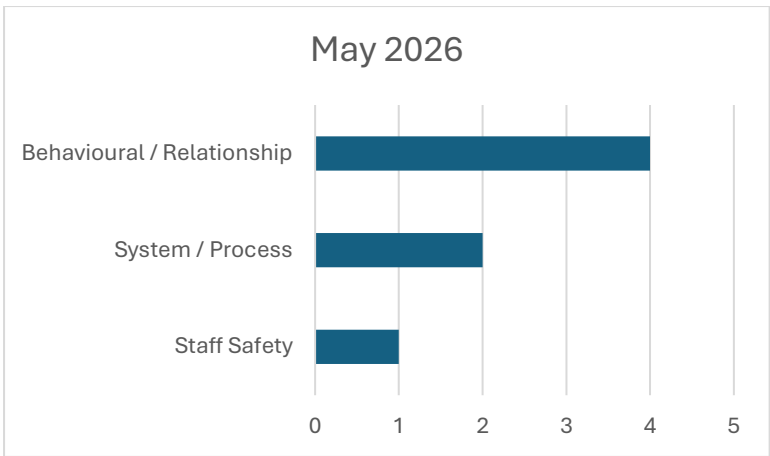
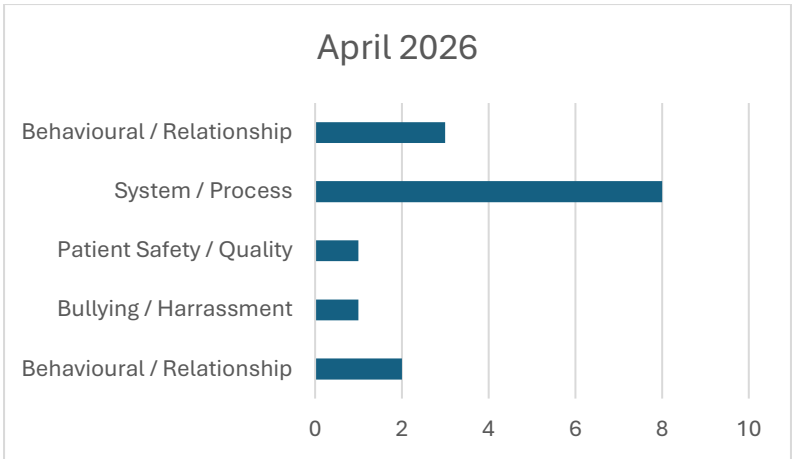
These are captured as single contacts on the FTSU database, as indicated by the NGO, however, each contact will, on average, have between 4-5 additional interactions associated with the case, while some cases have considerable more and last for an extended period of time.

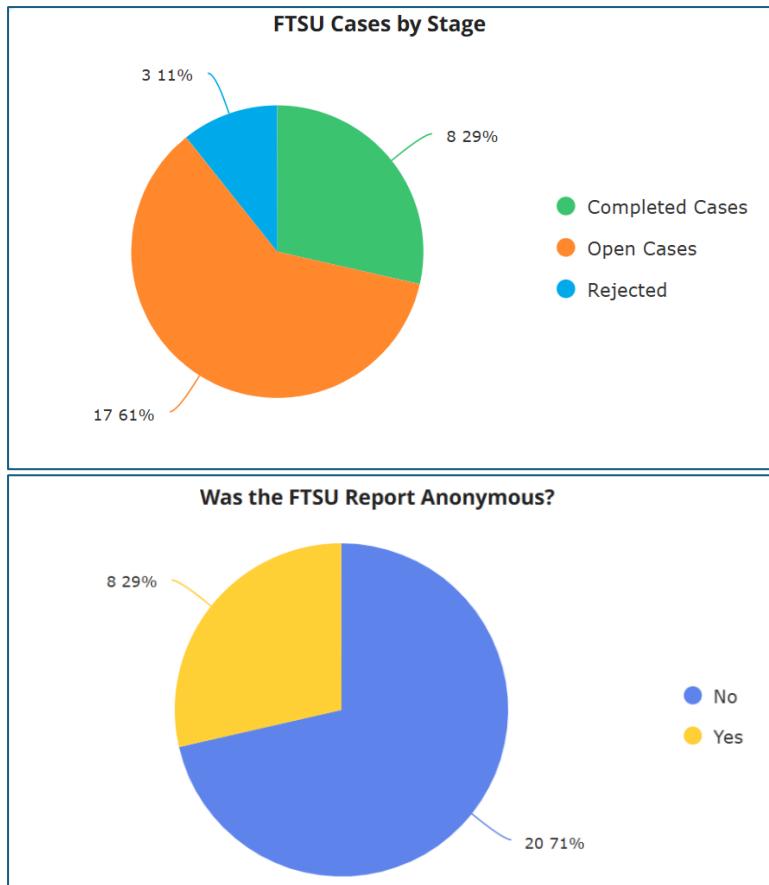
Taken as an entirety there have been c. 164 to 205 contacts are made between the individual, manager/lead and the FTSUG and Deputy.



Cases by Category







3. Closure of NGO, transfer to NHSE

In line with NHS England's revised Freedom to Speak Up (FTSU) arrangements, implemented following the recommendations of the Dash Review and the closure of the National Guardian's Office, the organisation has reviewed its local FTSU processes and governance arrangements to ensure compliance with national expectations.

The organisation maintains clear and accessible information regarding Freedom to Speak Up routes and Guardian contact details, supports Guardians to complete mandatory foundation training and continuing professional development, and participates in national data collection and reporting requirements. In addition, arrangements are in place to provide independent wellbeing and psychological support to Guardians and to promote organisational learning from concerns raised.

The organisation recognises its responsibility for embedding a positive speaking up culture and ensuring that concerns are handled in a fair, transparent and supportive manner. Learning from FTSU cases is routinely used to inform improvements to policies, processes and leadership practices. This includes undertaking thematic reviews where appropriate to identify lessons learned, strengthen support for workers raising concerns, and improve the interface between Freedom to Speak Up, HR, patient safety and workforce processes.

Through these arrangements, the organisation is aligned with NHS England's expectations for local accountability, effective Freedom to Speak Up governance,

organisational learning, and the promotion of psychologically safe environments in which staff feel confident to raise concerns

4. Case review

A case review is currently underway to undertake a learning-focused evaluation of two cases that were initially raised through the FTSU process and subsequently progressed into formal HR disciplinary investigations. Initial meeting took place on 18th May 2026.

While the concerns raised were considered serious and warranted formal investigation, both cases highlighted significant unintended consequences for the individuals who spoke up. The disciplinary processes were experienced as lengthy, unclear, and insufficiently supportive, resulting in increased stress and trauma for those who had raised the concerns in good faith.

The review seeks to:

- Examine the end-to-end journey of both cases from initial FTSU disclosure through to the conclusion of the disciplinary process.
- Identify factors that contributed to negative experiences for those raising concerns, including the impact of prolonged timescales, communication practices, role clarity, and availability of support.
- Assess whether transitions between the FTSU process and formal HR procedures were effectively managed and understood by all parties.
- Explore whether expectations were appropriately set regarding the likely process, timescales, confidentiality, and potential outcomes.
- Identify gaps in organisational support mechanisms available to speaking up workers once cases enter formal investigation processes.
- Capture lessons learned from both cases to strengthen organisational practice and minimise the risk of similar experiences occurring in future.
- Develop recommendations to improve communication, case management, support arrangements, and collaboration between FTSU, HR, managers, and investigators.
- Ensure that future processes remain fair, robust, and transparent while maintaining the wellbeing and psychological safety of those who raise concerns.

Intended Outcome

The review is not intended to revisit disciplinary findings or apportion blame. Instead, its purpose is to promote organisational learning, improve the experience of staff who speak up, and strengthen confidence in the organisation's ability to respond to concerns in a timely, compassionate, and transparent manner. Ultimately, the review aims to ensure that individuals who raise concerns in good faith feel supported throughout the process and are not adversely affected by the mechanisms designed to address their concerns.

5. InPhase

NGO guidance requires organisations to provide a robust anonymous reporting system for colleagues. We have used a number of different options in the past, including a bespoke Alder Hey Innovation provided application, as well as Microsoft Forms links. These options have been unsuitable, and so have – along with expert guidance from the Risk and Governance Team – developed a bespoke InPhase FTSU reporting module.

Benefits to using InPhase include :

- already familiar and well used platform for a large proportion of staff who use it to report under different circumstances
- can be modified to provide much more detailed and robust data collection and reporting capabilities than previous platforms (see tables and data above for proof)
- confidentiality assured and data only accessible to FTSUG and Deputy FTSUG.

The new module was soft launched in April 2026, with a full launch to colleagues 2 June 2026. The FTSU team have worked hard since April to transfer across all historical active data into the new system which is now complete. We are continuing to work with the development team to improve the system's data capture and reporting.

We remain grateful to Katherine Martin, Risk Systems Development Lead, for her help in scoping, developing and delivering this new advance which will make it easier and safer for colleagues to report issues through to FTSU.

6. Freedom to Speak Up Champions

After a number of years of service, it was agreed that the existing cohort of FTSU Champions had come to the end of useful operation, and a complete review and refresh tasked to the Deputy FTSUG. After taking on feedback from senior and/or longstanding FTSU Champions, as well as fact funding with local Trust FTSUGs and through the FTSUG NW Network, a reformed approach has been developed. Potential champions are required to submit formal expressions of interest, including a signed affidavit from their line manager. They will then need to complete an in-house training package, together with the Deputy FTSUG and, where possible, other Champion applicants. To instil a sense of shared commitment and community, regular Champion Network meetings will take place bi-monthly, led by the Deputy FTSUG focussing on intelligence sharing between Champions, lessons learnt and further support as required. To reporting date (27 August) we have received eight applications, and are directly engaging with each of the staff networks to ask for applications from those groups.

7. FTSU Service Feedback

Each closed case is offered the chance to provide anonymous feedback via an online Form, as well as providing any comments through direct contact with the FTSUG/Deputy FTSUG at the conclusion of their case.

During the reporting period there has only been one response to the online form, and the free text submission from this colleague is worth including in full as below:

“It was easy to access FTSU - Kerry was easy to email and quick to respond. She has always followed up, scheduled catch ups at my convenience both face to face and on Teams, and been extremely supportive and understanding. She has guided and coached me in how to respond and offered to intervene where necessary. Where situations have resolved she has still followed up to check in with me. She has been absolutely excellent. Joe was also extremely supportive when I reached out in Kerry's absence. FTSU is a brilliant and essential service and helped me deal with things and work through them without overreacting. It's an extremely safe and welcoming space and absolutely essential at Alder Hey. Thank you for all you do and all of your support.”

8. Next steps

- Continue to deliver Champion recruitment and training programme, with aim to gain representation from every corner of the organisation
- Begin system leader SLT schedule meetings
- Complete InPhase build out, resolving remaining data and reporting gaps with particular focus on demographic question and answers.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Chair's Report from ARC meeting, 16 th July 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 18 th June 2026
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

The main focus of the meeting was Risk Management Processes

Risk

- Presentation on risk management processes within the Neighbourhood, Public & Mental Health System
- Update on the Roll Out of Risk Appetite and Tolerances
- Board Assurance Framework
- ARC Review of FTPC BAF Risks
- Risk Management Forum (RMF) Update including Chair's Report and Minutes from most recent meeting
- Corporate Risk Register
- Trust Risk Management Report
- Risk Horizon Scanning Discussion

Internal Audit

- Internal Audit Progress Report (see Appendix 1 for summary of all audit outcomes to date), including the information in relation to the of audit of Theatre Management Systems which received Limited Assurance.
- Presentation on Theatre Management Systems Action Plan.
- Follow Up of Previously Agreed Internal Audit Recommendations

Governance

- ARC Terms of Reference and Work Plan (Approved)
- Engagement of External Auditors in Non-Audit Work Policy (Approved)
- Progress against actions arising from the ARC Self-Assessment, and Effectiveness Reviews of Internal Audit, External Audit and the Counter Fraud Service.

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

The Committee noted that the ongoing operational redesign and move from Divisions to Services has introduced uncertainties in where some teams may "sit" and the design of future governance systems. As a result there is need for Managers and Committees (and other reporting forum) to maintain oversight and scrutiny over the management of risks to ensure that new risks are identified and recorded and review of existing risks and actions remains timely. In addition, there will be a short period of reduced reporting from InPhase whilst teams and services are allocated into their Systems.

4. Positive highlights of note / areas of significant discussion

Being the “risk focussed” meeting, the BAF, Corporate Risk Register and Trust Risk Register received significant focus with ARC undertaking a deep dive review of FTPC BAF risks.

5. Issues for other Committees

ARC has referred a request to SQAC and CEOB (to be lead by the Assistant Director of Quality) to design and implement a process to enable the effectiveness of Clinical Audit processes to be measured.

6. Recommendations

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

Appendix 1 – Outcome of audits reported in 26/7

2025/26 Internal Audit Plan

Audit	Assurance	May be of interest to...
Governance of Workforce Reduction Programme	(Ongoing)	People Committee
Theatre Management	Limited	SQAC
Governance of Financial Improvement Programme	(Ongoing)	FTPC

2026/7 Internal Audit Plan

Audit	Assurance	May be of interest to...
Assurance Framework Opinion		Board
Governance of the Paediatric Open Innovation Zone		GOC
Key Financial Controls		FTPC
PFI Contract Management		FTPC
Data Security & Protection Toolkit		FTPC
AI Governance		FTPC
Third Party Supplier Management		FTPC
Medicines Management		SQAC
Specialist Mental Health Waiting List Management		FTPC & SQAC
Sickness Absence Management		PC
Placeholder (to be determined)		Tbc

Audit and Risk Committee

Confirmed Minutes of the meeting held on Thursday 18th June 2026

Lecture Theatre 1, Institute in the Park

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Meehan	Non-Executive Director	(GM)
In Attendance:	Ms. E. Kirkpatrick	Deputy Director of Finance	(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. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Item 26/27/45	Ms. M. Perrigo	Clinical Legal Services Manager	(MP)
Observing:	Mr. Geoff Bagnall	Staff Governor	(GB)
Apologies:	Mr. A Bateman	Chief Operating Officer & Deputy Chief Executive	(AB)
	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)

26/27/33 Introductions and Apologies

The Chair welcomed everyone and noted the apologies.

26/27/34 Declarations of Interest

Non-Executive Director (NED), Gerald Meehan, declared that he is the Independent Chair of Liverpool's Children's Services Improvement Board. It was noted that GM's work with Liverpool City Council is due to end and therefore a declaration won't be required going forward.

26/27/35 Minutes from the Meeting held on 16th April 2026

Resolved:

The minutes from the meeting held on the 16.4.26 were agreed as an accurate record of the meeting.

26/27/36 Matters Arising and Action Log

Matters Arising

There was nothing to discuss.

Action Log

Action 23/24/59.1: *Non-Clinical Claims Report, 2022/23 (Convert previous data into graphs and include this detail in the 2023/24 Non-Clinical Claims Annual Report)* – This information

was included in the report submitted to the Committee during July's meeting.

ACTION CLOSED

Action 24/25/72.1: *Annual Assurance Report and Forward Plan – Clinical Claims (Include trend analysis of the values of claims for the last five years and re-circulate the report to the Committee)* – This information was included in the report submitted to the Committee during July's meeting. **ACTION CLOSED**

Action 25/26/130.1: *Internal Audit Follow up Report (Rec 1 in Safety Standards for Invasive Procedures Audit relating to the provision of training to remain open. Whilst the delivery of the STAT Programme outlined in the original management response has been ceased, this has been replaced by the implementation of the NATSIPS 2 Programme which is not yet established. The original risk therefore still remains, and the Chair asked that this recommendation remain open and MIAA continue to follow up until the underlying risk is addressed)* – This action remains open and is subject to follow up. **ACTION TO BE CLOSED**

Action 25/26/138.1: *Effectiveness Review (IA benchmarking to be repeated at the end of the year)* – This item was deferred to September 2026. **ACTION TO REMAIN OPEN**

Action 26/26/26.1: *Annual Governance Statement* – It was confirmed that the requested amendments to the AGS have been completed. **ACTION CLOSED**

26/2737

E&Y External Audit Year End Report on the Trust's Accounts - (ISA260)

The Committee received the External Audit Results Report for year ended the 31st of March 2026. HR presented the report, highlighting the findings and scope changes since April. Attention was drawn to the following key points:

- Following receipt of the Trust's draft financial statements, materiality levels were updated.
- At the time the report was written, outstanding audit procedures related to journals, patient care income, agreement of balances and review of the Annual Report and Accounts. The Committee was advised that the procedures relating to journals and patient care income have since been completed, with only documentation relating to agreement of balances remaining to be finalised.
- In respect of audit differences, no uncorrected misstatements were identified above the reporting threshold, and no matters arose from the key areas of audit focus.
- It was reported that minor amendments have been made to related party disclosures.
- *Controls Observations (section 6)* - Completion of the journals' procedure identified an additional control recommendation. This related to the necessity to formalise the de minimis level for journals, following instances where some amounts exceeded the threshold and may have required accrual. The amounts were relatively small, which informed the nature of the recommendation.
- *Control Recommendations (section 6)* – Due to a number of inconsistencies being identified, a recommendation was made about strengthening reconciliation between the Fixed Assets Register and the General Ledger. It was confirmed that this recommendation has been accepted by management.
- *Value for Money (Page 7 of the Executive Summary)* – It was confirmed that there were no significant weaknesses identified in arrangements against the criteria that E&Y were required to report on. Additional procedures undertaken in relation to the

PFI contract were considered in the context of Value for Money (VFM) reporting responsibilities. It was noted that, while the matters identified don't represent a significant weakness in arrangements, the contract issues being managed by the Trust will require continued Board oversight to ensure that the mitigations being implemented are appropriate. It was confirmed that no further action was required.

- *Patient Care Income* – Additional audit procedures were required in relation to patient care income, as the information initially provided was not sufficient to support the relevant transactions. It was reported that there wasn't a complete reconciliation of patient care income from contracts and financial statements at the outset therefore it was recommended that reconciliations are undertaken regularly and are subject to appropriate review. This recommendation has been accepted by management.
- *Assessment of Control Environment (Officer's Remuneration Report)* – Work in this area has been completed and only minor banding changes have been made to the position previously reported.

The Chair queried as to whether the agreement of balances was the only remaining outstanding item. It was confirmed that this was the case.

A question was raised about how some related party disclosures had initially been missed. Management explained that this had been a cut-and-paste error in the schedule provided to the auditors, rather than a failure to identify or record the related party relationship internally. HR confirmed that the matter related to disclosure in the notes to the financial statements, rather than an omission from the underlying accounting records.

The Chair referred to the fixed asset reconciliation and patient care income recommendations, noting disappointment given the previous training provided to raise staff awareness and understanding of reconciliations. It was explained that the fixed asset reconciliation had been undertaken at net value, with the difference relating to gross value and depreciation. It was confirmed that future reconciliations will be completed at this level whenever the register is updated.

A question was asked about whether the Trust is doing everything it should be to mitigate the risks associated with the PFI contract, recognising its complexity and the challenges it presents. It was reported that the audit work undertaken considered the issue from a VFM perspective and had assessed whether the arrangements represented a significant weakness. It was confirmed that action is being taken and that External Audit are satisfied that mitigations are being progressed. It was explained that the audit did not involve a detailed review of every contractual issue or mitigation, but previous work by a PFI specialist had provided assurance that the contractual issues did not have an accounting implication for the PFI model.

The Chair referred to the level and value of adjusted misstatements, noting that it was unusual for the Trust to receive a clean report with no unadjusted items. It was explained that the related party changes were disclosure matters and that the gross-to-net fixed asset adjustment was significant in value but did not affect the net book value or the overall accounting position.

The Chair drew attention to the Trust's target to close the ledger on day one and whether that remained realistic. Management acknowledged that the target was ambitious and explained that the process was more nuanced, as the in-month position was normally targeted for closure by working day one, while the forecast position was targeted by working day three. It was also noted that formal ledger closure may depend on the ICB approving the

position. Management advised that further analysis would be undertaken to understand which journals were being posted after the target point and whether the process could be refined.

The Chair noted that a clean audit opinion was expected, subject to completion of the remaining outstanding items. It was noted that there were no unadjusted items, no issues arising from the Annual Report or Remuneration Report, no VFM or public interest matters to report, and that all prior year recommendations had been cleared. External Audit also confirmed its independence and objectivity.

It was felt that the audit process had improved significantly, although it would have been preferable for all outstanding elements to have been completed within the timeline. External Audit advised that this year's process was tightly managed but opportunities to accelerate timescales will be reviewed during the year-end wash up. It was confirmed that the remaining elements of the audit are expected to be completed by the 23.6.26.

Resolved:

ARC approved the External Audit Year End Report on the Trust's Accounts.

26/27/38

Letter of Representations (LoR)

The Committee considered the LoR that is to be submitted to the External Auditors and reviewed the assurances being provided on behalf of the Trust. The Chair highlighted a number of areas requiring clarification prior to sign-off, including the inclusion of wording relating to employee fraud matters and references to segmental reporting, noting that the Trust did not undertake segmental reporting. A request was also made to remove the reference to unadjusted misstatements in section A, reflecting the external audit conclusion that there were no unadjusted differences requiring representation.

Post meeting note: The LoR was updated as required before signature by the ARC Chair and CFO.

Whilst recognising that artificial intelligence (AI) was not used in the preparation of the 2025/26 accounts, the Committee considered the wider implications of AI use, including the potential for AI tools to indirectly influence figures or information included in the accounts. The Committee felt that it is important for the Trust to understand how AI tools might affect financial reporting in the future and ensure appropriate oversight. It was noted that an AI Policy is being developed and that further consideration should be given to governance arrangements. The Committee agreed that this matter should be flagged to the Board, via the Chair's Report as an area where early assurance and clear procedures will be important.

ES agreed to share the Trust's draft AI Policy with the Chair.

Post meeting note: The AI Policy was provided to the Chair.

Resolved:

ARC noted the LoR.

26/27/39

Trust's Annual Report and Accounts - 2025/26

The Committee received the Trust's Annual Report for 2025/26 which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. An overview of the report was provided to the Committee.

An overview of the Financial Accounts was also shared with the Committee. It was noted that the accounts showed a £7.37m deficit; however, after adjustment for technical and exceptional items, this equated to a £7.1m surplus against the Trust's control total. It was confirmed that the Trust achieved its control total, consistent with the financial performance reported throughout the year to the Finance, Transformation and Performance Committee (FTPC). The Trust also reported capital expenditure of £26.1m and a year-end cash balance of £35.9m.

The Committee was advised that the reported deficit reflected a number of technical and exceptional accounting adjustments, including impairments associated with revaluations of assets, the accounting treatment of donated income and depreciation, and a technical PFI accounting adjustment. A reconciliation of the reported deficit to the control total was included within the accounts, and additional narrative has been prepared to support understanding of these adjustments.

A number of questions were raised and responded to relating to the increase in education and training income, internal audit costs, an increase in bad debt cases, and salary overpayments and recovery processes.

A discussion took place about whether sufficient assurance exists in respect to the Trust's recovery processes for salary overpayments and whether responsibilities were clearly defined. It was felt that it would be beneficial to strengthen feedback loops so that Divisions and managers understand the impact of unrecovered overpayments and are able to identify recurring issues. Management agreed to discuss the matter further with Human Resources to discuss the Trust's existing process and consider whether additional procedures could be implemented to strengthen oversight and ensure appropriate follow up.

26/27/39.1 Action: RL

The Chair offered thanks to all those involved in compiling the 2025/26 Annual Report, particularly the Governance Manager, and to External Audit and the Finance Team for working together to produce a timely and efficient audit process of the Accounts.

Resolved:

ARC received and endorsed the Annual Report and Accounts for 2025/26 for approval by Trust Board (subject to completion of outstanding audit items)

26/27/40 Understanding how the Audit and Risk Committee gains assurance from Management

The Committee received a copy of the response letter that was sent to E&Y in this regard. It was reported that information is compiled as part of the audit process to provide E&Y with an overview of the risk assessment of fraud/error on the accounts and how the Trust manages risk generally.

Resolved:

ARC noted the Chair's letter to E&Y that provided an understanding of how the Committee gains assurance from management.

26/26/41 Final Head of Internal Audit Annual Opinion, 2025/26

The Committee received the final Head of Internal Audit Opinion for 2025/26. The overall opinion for the period from the 1.4.25 to the 31.3.26 provides Substantial Assurance that "there is a good system of internal control designed to meet the organisation's objectives,

and that controls are generally being applied consistently". It was reported that there was one amendment to the draft version considered earlier in the year that relates to third-party assurances.

It was noted that the Internal Audit Plan had not been fully completed at the time the opinion was presented, with two audits remaining outstanding. It was confirmed that the outstanding reviews will be incorporated in the 2026/27 Internal Audit Plan and considered within the following year's opinion. It was acknowledged that the incomplete position reflected wider organisational pressures and challenges affecting service capacity and the ability of some areas to respond to audit activity during the year.

An accelerated approach has been agreed with work for Q1/Q2 being progressed at the outset, with the aim of completing key activity by mid-December and using the final quarter to address any remaining matters.

Resolved:

ARC received and noted the content of the Head of Internal Audit Opinion for 2025/26.

26/27/42 Clinical Audit Annual Report for 2025/26

The Committee received the Clinical Audit Annual Report for 2025/26 which has been approved by the Safety and Quality Assurance Committee (SQAC). It was confirmed that the Trust met its clinical audit activity requirements in line with accepted practice, with the exception of one national audit which is being actively managed via governance and risk management arrangements.

Resolved:

ARC received and approved the Clinical Audit Annual Report for 2025/26.

26/27/43 Clinical Audit Annual Plan for 2026/27

The Committee received the Clinical Audit Annual Plan for 2026/27. The Chair confirmed that she had reviewed the Plan and was satisfied that it reflected the Trust's clinical audit priorities for the coming year. It was noted that the plan has been considered by the Clinical Effectiveness and Outcomes Board (CEOB) and approved by SQAC, with no concerns raised regarding its scope or content.

Resolved:

ARC approved the Clinical Audit Annual Plan for 2026/27

26/27/44 Third Party Assurance – ELFS Payroll Audit Report for 2025/26

The Committee received the third party report on ELFS payroll provision for 2025/26 which provided a positive, unqualified opinion confirming that the control environment within ELFS is robust. Controls are appropriately designed and have operated effectively across the reporting period. This includes key financial processes such as payroll, accounts payable, income, treasury and IT controls. The opinion is, however, dependent on the effectiveness of complementary controls operated by both user entities and subservice organisations.

Whilst overall assurance is strong, the report identifies a small number of control exceptions. These relate primarily to timeliness, documentation and adherence to procedures rather than

fundamental control design weaknesses. Management has provided responses to all issues and actions are in place to strengthen control operation going forward.

The Chair pointed out that while the report covered areas beyond those directly relevant to the Trust, its main relevance was in relation to payroll and expenses. It was also confirmed that the Trust has reached out to ELF's to confirm what assurance they gain around the complementary controls in subservice organisations and an updated will be provided.

26/27/44.1 Action: EK

Resolved:

ARC received and noted ELF's Payroll Audit Report for 2025/26.

26/27/45 Clinical and Non-Clinical Claims Annual Report for 2025/26

The Committee received the Clinical and Non Clinical Claims Assurance Report for 2025/26.

MP advised that the production of the report had been affected by ongoing data and accessibility challenges associated with NHS Resolution's migration to a new case management system. However, improved support from NHS Resolution has enabled the Trust to access data in a timelier way. It was noted that further refinement of the data in the report remains necessary, particularly in relation to the categorisation of claims and divisional reporting, but that significant progress has been made in establishing a baseline for future analysis.

It was pointed out that the report has been developed in collaboration with the Trust's analytics team and reflected a move towards a dashboard-based reporting approach. The Committee welcomed the improved visibility of trends and analysis of claims for the last five years, whilst recognising that further work is required to improve data consistency and analytical capability. It was further noted that implementation of claims management functionality within the Trust's InPhase system will strengthen future reporting.

The Chair thanked MP for the report and confirmed that, due to late submission of the paper it would not be discussed in the meeting and that it would be reviewed following the meeting and any feedback on the revised format will be provided such that it can be re-presented and discussed at a future meeting.

26/27/46.1 Action: KB

Resolved:

ARC received the verbal update on Clinical and Non-Clinical Claims Annual Report for 2025/26.

26/27/46 Audit and Risk Committee Annual Report for 2025/26

Resolved:

The Committee received and approved the Audit and Risk Committee Annual Report for 2025/26.

26/27/47 Committee Annual Reports for 2025/26

The Audit and Risk Committee received and approved the 2025/26 Annual Reports for the:

- Finance, Transformation and Performance Committee.
- Safety and Quality Assurance Committee.

- People Committee.
- Growth and Opportunities Committee

The Chair thanked the Governance Manager for drafting each of the reports and arranging their review and approval by the Assurance Committees. The Chair recognised significantly improved clarity of specific assurances provided, particularly in the FTPC report, and requested that this approach be continued for future years.

Resolved;

ARC received and approved the Assurance Committee Annual Reports for 2025/26.

26/27/48 Gifts and Hospitality Register

The Committee received the 2025/26 Gifts and Hospitality Register.

It was reported that the number of declarations recorded during the year have decreased compared with the previous reporting period. The Chair felt that it would be beneficial for future reports to be accompanied by a short cover sheet summarising an Executive review of the Register highlighting the key messages to help members understand the overall position and focus on any areas of concern.

26/27/48.1 Action: JP

Resolved:

ARC received the Gifts and Hospitality Register for 2025/26.

26/27/49 Any Other Business

There was none to discuss.

26/27/50 Meeting Review

The Chair reflected positively on the assurances received and the significant progress made during the year, particularly in relation to the year-end accounts and the External Audit process, noting the importance of completing the remaining audit procedures in advance of Trust Board on the 23.6.26. The Chair also highlighted artificial intelligence as an emerging area, emphasising the need for robust controls, oversight and assurance arrangements as the Trust's use of AI develops.

The Chair took the opportunity to acknowledge the forthcoming rotation of the External Audit Lead. It was noted that June's ARC was HR's final meeting with the Committee and thanks were offered to HR for his contributions over the years. RL also thanked HR for his leadership of the External Audit team and for the support provided to the Trust.

Date and Time of the Next Meeting: Thursday, 16th July, 2:00pm-5:00pm, via Teams

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Tuesday 30th June 2026 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)
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Mr. A. Bateman	Deputy Chief Executive/ Chief Operating Officer	(AB)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mr. N. Askew	Chief Nursing Officer	(NA)
In Attendance:			
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mr. G. Wadson	Associate Director of Finance	(GW)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Mrs J Holloran	Deputy Development & Estates Director	(JH)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs N Palin	Director of Transformation	(NP)
	Mrs E Matthews	Head of Service Development and Performance	(EM)
	Mr A McColl	Deputy Director of Finance	(AMc)
	Mrs. J Tsao	Executive Assistant (Minutes)	(JT)
Observer:			
	Mr T Crowley	Executive Associate at Advancing Quality Alliance (AQuA)	(TC)
Agenda item:			
	Ms K Tooltill		
Apologies:			
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)

26/27/34	Welcome and Apologies The Chair welcomed everyone to the meeting and noted apologies received. The Chair introduced Mr Tim Crowley, Executive Associate at AQuA. As part of a Trust Well-Led Development review the meeting was being observed to assess Trust Board sub committees.
26/27/35	Minutes of the Last Meeting The minutes of the last meeting held on 3 rd June 2026 were approved.
26/27/36	Matter Arising and Action Log FTPC went through and discussed outstanding actions: National Cost Collection (NCC) and Service Line Reporting (SLR) submissions An update paper relating to the current year's NCC submission had been circulated and was scheduled for consideration under Any Other Business.

	Pharmacy Outsourcing No appeals had been lodged following the procurement decision and transition planning was now underway with the successful provider. There was currently no set implementation date, EK agreed to keep FTPC updated on this. Action: EK
26/27/37	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.
26/27/38	Overview of Key Priority Areas RL gave a presentation inviting comments on the new format. Trust Financial Performance - Red Rating is now red due financial plan not being met. Income and activity performance would continue to be closely monitored over the coming months. Operational Performance – Amber Whilst some deterioration had been observed, management remained confident that overall operational performance remained strong. CIP and Transformation – Red Remains red rated priority area due to ongoing delivery risks within the Financial Improvement Programme and Cost Improvement Programme. Capital and Campus Development – Amber Remains amber. Whilst progress had been made regarding the PFI settlement and associated NICU programme, FTPC acknowledged that delivery risks remained until key milestones, including connection works and completion activity, were demonstrably achieved. Growth and Investment – Green It was recognised that whilst there had been positive progress in establishing systemwide discussions and engagement, further work was required to determine what growth opportunities would ultimately emerge and how they could be translated into deliverable plans.
26/27/39	Month 2 Financial Report EK Deficit of £1.4m in line with plan. Forecast 0.7m surplus dependant on meeting CIP programme plans. CIP £0.6m behind plan, is moving forward. JK asked if there would be a Divisional improvement in M3. EK noted cancellation of Industrial Action supported this however there was still impact due to the short notice. AB advised that IA was minimal impact and surgery sustainability is being reviewed in how support can be given to more complex areas. It was agreed an update would be provided at the Divisional update next month on Surgical activity. Action: CL FTPC explored whether organisational restructuring and leadership changes may be contributing to reduced performance. Management indicated there was no evidence linking leadership changes to reduced theatre utilisation, with workforce vacancies in specialist services remaining the primary issue. Resolved: FTPC noted the current position in relation to the M2 Finance report.

26/27/40	AFT Financial Freedoms RL noted the update to the policy on Financial Freedoms had been circulated with Trust Board and noted a number of highlights: The three new financial freedoms; Capital flexibility (reinvesting surpluses) Capital autonomy (approving investments up to £100 million without NHS England approval). Revenue flexibility (using aggregate surplus for revenue investment, subject to break-even conditions). Alder Hey aggregate surplus of over £9 million has already been largely allocated to capital projects, with last year's surplus used for capital and this year's plan assuming use of the remaining surplus for capital investment. Revenue vs Capital Investment decisions debated the merits of shifting some surplus to revenue to address anticipated shortfalls in CIP with a consensus to model the impact and prioritise revenue flexibility if feasible, given the one-off opportunity this year. KW suggested exploring external freedoms and collaboration with the city region and ICB to leverage innovation and diversify income, while EK and others emphasised the need to risk-rate and phase capital projects based on funding uncertainties. FTPC asked for conduct detailed cash and risk modelling, explore capital flexibility options with NHS England and ICB, and bring recommendations to the Trust Board in September after further analysis and engagement. Action: RL Resolved: FTPC noted the current position in relation to AFT Financial Freedoms.
26/27/41	IPR report M2 AB highlighted challenging area including: Audiology waiting list is over the 6 week standards. AB said a review was taking place in relation to capacity and demand and suggested bringing an update to the next FTPC. Action: AB ED targets are behind the standard. ED are looking at changes to improve the target to 95% national standard. DJW asked how we support families who return frequently to ED. AB referred to neighbourhood care, respiratory pathways and community services that provide support. Questions were raised regarding progress in supporting patients into more appropriate long-term settings and the wider impact on capacity. As majority of patients represented complex cases requiring long-term care it was agreed a detailed review would be beneficial. Action: AB Resolved: FTPC received the monthly IPR M2 update.
26/27/42	Procurement Monitoring KT highlighted 17 projects were delivered from a plan of 20.

	FTPC was assured that the procurement team continued to support several major Trust programmes, including workstreams contributing to the wider Financial Improvement Programme and Cost Improvement Programme. FTPC questioned as to whether procurement had sufficient influence and scope to maximise opportunities across inventory management and stock control processes and whether further organisational changes might be required to achieve the full benefits available. It was acknowledged that further work would be required to strengthen procurement's oversight of stock management arrangements and that future developments may require broader discussions regarding operational ownership and workforce implications. It was confirmed that Alder Hey had secured approximately £270,000 of national funding from NHS Supply Chain to support the implementation of an Inventory Management System. A project team was being established and that market assessments of available systems had commenced. The system was expected to improve stock visibility, traceability and control whilst supporting the delivery of wider efficiency and savings programmes. It was noted that the programme was now funded and progressing into implementation planning. FTPC received an update on work being undertaken with KPMG to explore a managed service approach for clinical consumables and stock management. KT agreed to report on emerging opportunities and benefits from the KPMG-managed service review. Action: KT An update regarding work to develop collaborative procurement arrangements across Cheshire and Merseyside. FTPC explored the potential role of artificial intelligence in transforming procurement processes. Resolved: FTPC receive the quarterly update on Procurement Monitoring.
26/27/43	Digital Futures Strategy KW reported on the recent hosting of the newly appointed Chief Digital, Data and Technology Officer for the Department of Health and Social Care. FTPC was advised that the visit had been highly successful and had generated a number of opportunities for further collaboration and innovation. FTPC heard that ongoing discussions were underway regarding future areas of partnership and that updates would be provided to future meetings as these opportunities developed. Another hosting event due to take place in July was SickKids Toronto, linked to the Trust's paediatric innovation agenda, Hero AI and the Paediatric Open Innovation Zone. FTPC welcomed continued progress in establishing Alder Hey as a national and international leader in digital innovation. Assurance was received on Alder Hey continuing to strengthen its national profile and strategic relationships through the Digital Futures Strategy and associated innovation programmes. The Alder Care 2.2 programme had its first programme board meeting. Nathan Askew had assumed responsibility as Senior Responsible Officer, reflecting the significant nursing benefits expected from the programme.

	FTPC reviewed progress against the annual Data Security and Protection Toolkit submission. FTPC was advised that an independent review undertaken by MIAA had identified two areas requiring improvement, relating to emergency preparedness and business continuity arrangements and system backup processes. Since completion of the audit, significant remedial work had been undertaken and management reported that sufficient progress had been made to support submission against a "Standards Met" position. Resolved: FTPC noted progress to date in relation to the Digital Futures Strategy.
26/27/44	Network Managed Service – Tender award Contract with current provider is due for renewal and a formal tender process had been undertaken with support from procurement colleagues at HPL. Following evaluation, the recommendation was to award the contract to a new provider. FTPC was informed that the proposed contract would generate an overall saving over its lifetime, although a cost pressure would arise during the first year. Management confirmed that mitigating actions had been agreed with the Finance Team and that a small Cost Improvement Programme benefit would be released over the contract term. FTPC emphasised the importance of ensuring that future network infrastructure supports progression towards a zero-trust cyber security architecture. MJ highlighted the increasing importance of cyber resilience and stressed that implementation of a zero-trust framework should be prioritised. Whilst supportive of the proposed contract award, he cautioned that network infrastructure decisions should be aligned with the organisation's future cyber security ambitions. Management confirmed that the recommended supplier possessed strong credentials and experience and provided assurance that future network developments would support evolving cyber-security requirements. FTPC queried that opportunities to improve mobile phone signal coverage across the Trust estate be considered as part of future network refresh plans. Management agreed this would be incorporated into future specifications. FTPC supported the proposed tender award and noted that the contract would provide continuity of network services while enabling the Trust to progress its longer-term digital infrastructure strategy. Resolved: APPROVED the recommendation to award the Network Managed Service contract.
26/27/45	Financial Improvement Update Significant progress has been made in the savings programme since the previous reporting period. AMc advised that savings posted had increased from under £7m at the previous update to over £13m. In addition, approximately £14.5m of schemes were now assessed as either delivered or fully developed and expected to be delivered. Examples of fully developed schemes included approved voluntary redundancy arrangements awaiting completion and organisational change programmes where consultation processes were nearing conclusion.

	FTPC was advised that the programme had achieved the target position of approximately 75% forecast delivery with 25% risk, representing a significant milestone in programme delivery. The substantial progress made during Quarter 1 was congratulated noting the scale of transformation activity that had been undertaken across the organisation. Approximately £10 million of schemes remained rated Amber or Red and that the current risk-adjusted forecast identified a shortfall of approximately £6.1 million. Many of the remaining schemes were inherently more complex and carried longer implementation timescales than those already delivered. The implementation of timescales for several of these programmes extended into the latter part of the financial year, creating a risk that benefits may not be realised quickly enough to support the current year's financial plan. The Chair observed that for every month of delay, the likelihood of securing full-year benefits diminished and stressed the need for greater clarity regarding what remained achievable. FTPC noted that long-term sickness absence had reduced, but that short-term sickness absence—particularly relating to stress and anxiety—had increased. The Committee heard that hotspot areas had been identified and that divisional leaders were actively managing these trends through People Committee and Executive Team oversight arrangements. Resolved: FTPC noted progress made as well as continued risks.
26/27/46	Transformation Programme It was noted that significant progress was being made across a number of strategic workstreams, including digital transformation, urgent care redesign, organisational development and wider system transformation initiatives. The programme encompassed a much broader remit than financial savings alone and was intended to support the delivery of long-term service transformation and improved patient outcomes. FTPC acknowledged the significant volume of transformational activity currently underway and recognised the positive feedback previously received from the Board regarding programme delivery. The Digital Transformation Programme continued to make strong progress. Members noted that several digital initiatives were already supporting service redesign and enabling the development of new clinical delivery models. Particular reference was made to digital programmes that would support future transformational change and improve operational efficiency across the organisation. FTPC noted that digital innovation was increasingly becoming an enabler of wider transformation objectives. FTPC noted that this would be Natalie Palin's final meeting before commencing a secondment opportunity. FTPC thanked NP for her contribution to the transformation programme wishing her well in her new role. Resolved: FTPC noted progress to date.
26/27/47	Campus Update JH highlighted three main areas below:

	- PFI Two weeks into the 18-month standstill period following agreement with the PFI provider. Enhanced governance arrangements had been established to oversee delivery of the agreed programme, including revised escalation arrangements and more frequent monitoring meetings. - NICU and Emergency Care Floor Connection Works Programme mobilisation activity had commenced, including a formal project initiation meeting and detailed work with contractors to establish delivery dates and responsibilities. Particular focus was being given to ensuring that all required connection works were completed within the initial three-month milestone period. - Building Defects Programme Procurement activity was underway to appoint specialist support for the defects survey programme. A dedicated dashboard had been established to monitor and prioritise defects. Particular attention was being given to issues relating to water systems, pipework and other critical infrastructure risks. - ED Car Park Is being developed and is due to be completed around November 2026. - Governance and Oversight FTPC agreed that the existing Non-Executive Director oversight subgroup should continue throughout the next phase of the programme to maintain detailed scrutiny between formal Committee and Board meetings. It was also noted the importance of maintaining visibility of the programme's critical milestones, particularly as the initial three-month review period progresses. Action: RL Resolved: FTPC received and noted progress to date.
26/27/48	Board Assurance Framework ES advised that the majority of changes reflected ongoing management of existing strategic risks rather than the emergence of new principal risks. The Committee was asked to note the updates and consider whether further amendments may be required as major organisational programmes continued to develop. FTPC noted the Board Assurance Framework update and supported further review of strategic risks over the summer period. Members agreed that recent developments, including implementation of the new organisational structure, progression of the Campus Programme, increasing cyber-security requirements and the introduction of AFT financial freedoms, warranted a broader review of the Trust's strategic risk profile before reporting to the Board in September. Resolved: FTPC received and noted risks to be updated within the BAF.
26/27/49	Any Other Business Terms of Reference FTPC reviewed the proposed Terms of Reference and noted that the document had been updated following review and support from the governance team. FTPC were invited to identify any amendments required before approval.

	KW proposed adding a line on cyber assurance and the NED subcommittee to the FTPC terms of reference, which was agreed by the committee. Resolved: FTPC APPROVED the revised Terms of Reference. National Cost Collection RL referred to the paper circulated for Approval to be submitted on Friday 3rd July. considered the National Cost Collection pre-submission report and noted that the report outlined the methodology, assurance processes and preparatory work that had been undertaken to support the Trust's 2025/26 submission. Members were advised that the paper had been prepared by Chris McNally and set out the steps taken to ensure the accuracy and completeness of the submission. MJ queried the methodology used for identifying and reporting critical care costs. FTPC noted the report appeared to indicate that critical care costs were not separately tracked as a standalone reporting stream but instead derived through ward-based allocations and activity information. The finance team responded noting further clarification would be sought from the costing team. It was recognised that understanding how critical care costs are identified and reported would provide additional assurance regarding future National Cost Collection submissions. Action: CMc
26/27/50	Review of the Meeting The Chair noted substantial progress had been achieved across a number of major programmes, including the Financial Improvement Programme, organisational redesign, procurement transformation, digital initiatives and the Campus Programme. The Committee recognised that the organisation was in a stronger position than in previous reporting periods and that significant effort had been invested by teams across the Trust to deliver this progress.
	Date and Time of Next Meeting: Monday 3rd August 2026, at 1:30pm, Lecture Theatre 1, Institute, Alder Hey Children's Foundation Trust.

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Monday 3rd August 2026 at 1:30pm**
Lecture Theatre 1, Institute, Alder Hey Children's NHS Foundation Trust

Present:	Mr J. Kelly	Non-Executive Director (Chair)	(JK)
	Dame. J. Williams	Non-Executive Director	(JW)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Mr. A. Bateman	Deputy Chief Executive/ Chief Operating Officer	(AB)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. N. Askew	Chief Nursing Officer	(NA)
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 J Holloran	Deputy Development & Estates Director	(JH)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs E Matthews	Head of Service Development and Performance	(EM)
	Ms K Allsopp	Associate Director People Officer	(KA)
	Mr I Gilbertson	Chief Digital and Information Officer	(IG)
	Mrs. J Tsao	Executive Assistant (Minutes)	(JT)
Agenda item:			
	Mr R Vinner	Project Manager, Urgent Care	(RV)
	Mrs S Calderwood	Director of Operations & Performance – Acute & Specialist System	(SC)
	Mrs A Bibi	Director of Operations & Performance – Personalised Care, Therapeutics & Diagnostic System	(ABibi)
	Ms B Pettorini	Medical Director - Acute & Specialist System	(BP)
	Ms L Simon	Finance BP Personalised Care	(LS)
Apologies:			
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mr A McColl	Deputy Director of Finance	(AMc)

26/27/51	Welcome and Apologies The Chair welcomed everyone to the meeting and noted apologies received.
26/27/52	Minutes of the Last Meeting The minutes of the last meeting held on 3 rd June 2026 were approved.
26/27/53	Matter Arising and Action Log FTPC went through and discussed outstanding actions: Pharmacy Outsourcing The new provider was due to start in April 2027. Concerns were raised in relation to the delay. RL agreed to discuss with Personalised Care in the quarterly update on the agenda today. Long Stay Patients/Complex Care

	AB provided an update on the completed review following concerns of increased numbers of patients requiring long-term care highlighting - Increased numbers reflect complexity rather than delayed discharge. - Numbers of medically fit patients awaiting discharge have reduced. - Complex Care Support Team has managed 311 referrals, 77% relating to long-stay patients. - Work continues through the Beyond programme to develop appropriate placements. Procurement Monitoring Options are being developed for a VAT managed service arrangement with KPMG. A further update will be provided at the September FTPC. Action: RL/KT PFI Oversight group Meetings in place this week to provide an update at the Non Executive sub group on Monday 10th August 2026.
26/27/54	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.
26/27/55	Overview of Key Priority Areas RL noted that ratings hadn't changed from last month and red rated areas were on the agenda. Trust Financial Performance - Red Operational Performance – Amber CIP and Transformation – Red Capital and Campus Development – Amber Growth and Investment – Green Detailed update to be presented in September. Action: DJ JG suggested including additional information next to ratings. Action: EK - completed
26/27/56	Month 3 Financial Report EK reported £2.8mD as in line with plan. Month 3 represented the first full financial forecast undertaken under the new system structure. The initial forecast identified a £5.2m variance between budget and forecast, driven primarily by lower than planned delivery of Cost Improvement Programme (CIP) schemes and Elective Recovery Fund (ERF) income performance. FTPC acknowledged that system leadership teams were newly established and required time to fully understand their positions. Cash is in line with plan assuming CIP is delivered. Income non-elective is currently overperforming. High value NHS age debts over 90 days is being escalated for resolutions. Discussion took place regarding the potential use of Foundation Trust freedoms and whether surplus resources might be more beneficially directed towards revenue rather than capital expenditure.

	Resolved: FTPC noted the current position in relation to the M3 Finance report.
26/27/57	26/27 Financial Strategy An update was received under Month 3 Finance report and FIP Action Tracker. Resolved: FTPC noted the current position in relation to the 26/27 Financial Strategy.
26/27/58	FIP Action Tracker FTPC received an update on the Financial Improvement Programme (FIP) Action Tracker, which has been established as a weekly Executive Team monitoring mechanism to oversee the actions required to support delivery of the Trust's financial recovery plan. It was noted that the tracker was intended to supplement the CIP programme by providing oversight of key operational, workforce and financial actions necessary to achieve the planned financial position. Concerns were raised in relation to some clinical workforce actions appearing less mature than other areas of the tracker and highlighted the need to prevent slippage. FTPC considered workforce actions to be fundamental to both current-year delivery and longer-term recurrent savings. Actions were discussed in association with clinical workforce reform, including the medical leadership programme and associated workforce initiatives. It was acknowledged that delivery remained challenging and would require ongoing executive support. The appointment of additional clinical leadership support was noted as a positive development. FTPC were advised that system-level recovery plans on ERF had been developed and were now being monitored through the FIP process. It was agreed a further update would be provided at the August meeting to review progress. Resolved: FTPC noted the current position in relation to FIP Action Tracker.
26/27/59	Transformation Programme EM provided an update noting focus on digital transformation, urgent care, elective improvement opportunities and alignment between internal transformation priorities and wider system objectives. FTPC noted the overall direction of the programme had evolved from monitoring milestones towards prioritising delivery of measurable benefits and organisational impact. An update was provided on the digital innovation work that had followed the recent Toronto visit. FTPC heard that clinical teams had worked directly with innovation partners and digital specialists to identify practical solutions to operational challenges, particularly within urgent and emergency care. The approach was viewed positively as it brought transformation activity closer to frontline clinical teams and encouraged co-design of solutions. Development on urgent care transformation initiatives, and the Single Point of Access programme was noted. Initial programme governance arrangements had been established and discussions were underway regarding how external and internal priorities should be integrated into a coherent transformation portfolio. FTPC agreed that focusing innovation resources on the most significant organisational challenges would maximise impact and ensure transformation activity contributed directly to delivery of strategic and financial objectives.

	FTPC stressed that whilst innovation initiatives such as AI-enabled solutions were encouraging, successful implementation would require robust benefit tracking and prioritisation. Resolved: FTPC noted progress to date on the Transformation Programme.
26/27/60	Acute and Specialist Care SC and BP noted ASC was £2.5mD to date. Main challenges included: Cardiac is £0.5mD. Contact has been made with Trust's who have a long waiting lists for Cardiac, currently awaiting a response. FTPC queried whether reliance on external referrals alone would be sufficient and requested a broader, system-wide approach to utilisation of available theatre and elective capacity. Progress was acknowledged on CIP noting that delivery risk remained against approximately £4.4m of planned savings. FTPC encouraged continued development of additional schemes and requested stronger scrutiny of delivery trajectories. SC highlighted a structured programme of financial recovery, ERF improvement and CIP delivery was underway. Resolved: FTPC noted progress and challenges for the Acute and Specialist Care quarterly update.
26/27/61	Personalised Care, Therapeutics and Diagnostics ABibi reported an adverse year-to-date position of approximately £195k, of which around £95k related to unachieved CIP and the remainder primarily related to non-pay pressures. Activity performance remained broadly stable, with early indications suggesting positive performance during Month 4. Workforce levels were reported as stable with no significant headcount concerns identified at that stage. AB noted the system would prioritise delivery of fully developed schemes, strengthen delivery dates for amber schemes and develop further opportunities through specialty reviews, workforce initiatives and transformation programmes. As workforce pressures continued within Radiology further work was underway to assess workforce requirements and future demand. A formal business case would be required to address service pressures and future capacity needs. FTPC recognised both pharmacy and pathology as areas with significant potential for future savings and transformation and encouraged a more ambitious and radical approach to service redesign where opportunities existed. Workforce numbers within the system had remained largely static despite organisational change and voluntary redundancy activity elsewhere. Resolved: FTPC noted progress and challenges for the Personalised Care, Therapeutics and Diagnostics.
26/27/62	IPR report M3 AB update from Neighbourhood system, over contract. Reviewing patients 18 years and over for them to transition. Change referral process, due to go back to

	Execs and would need to be approved at SQAC. Patients waiting over 52 weeks in Dentistry and Plastic Surgery. Improvement plans was underway to reduce these waits and eliminate the longest waiting patients during the current financial year. Referral to Treatment (RTT) is 70% and is being met. Nationally the target will be changed to 75%. Resolved: FTPC received the monthly IPR M3 update.
26/27/63	Audiology Recovery RV presented a report highlighting Audiology continued to experience significant waiting list pressures, affecting both first outpatient appointments and follow-up patients. FTPC were advised that this created a potential risk of patient harm due to delays in assessment and treatment. A further concern was that patient priority coding had not historically been applied consistently, making it difficult to fully assess the clinical risk within the waiting list. National concerns regarding aspects of the Audiology service had resulted in a requirement for an external clinical audit of children with childhood hearing impairment. The first phase of the audit would review 25 cases. Should concerns be identified, a broader review would be undertaken. RV noted funding had been approve for the actions going forward to support the recovery plan: - Clinical review would be undertaken for every patient waiting. - High, medium and low clinical priority ratings would be assigned. - Patients no longer requiring follow-up would be removed from the waiting list. A discussion was held in relation to AI and how this could support the service going forward. JG asked when the 13 high priority patients will be seen. VR advised that this will be completed within 6 weeks. A discussion was held on long waiting lists for other services. AB agreed to undertake a wider review of diagnostic waiting lists to identify whether similar risks exist in other services. Action AB Resolved: FTPC received progress to date on actions implemented to reduce waiting times in Audiology services.
26/27/64	Campus JH noted the standstill agreement is at 7 weeks. Revised construction completion plan is now December 2026. Updated cost plan is due to be presented at FTPC in September and Trust Board in October 2026. Liaison Committee is to be re-established and and will meet monthly. An extraordinary meeting had been arranged to review the water rectification programme. Work was underway to establish a comprehensive plan setting out remediation works, sequencing, operational implications and clinical sign-off

	arrangements. Clinical and operational teams were fully engaged in planning and governance arrangements. Resolved: FTPC noted progress to date in relation to the Campus.
26/27/65	Board Assurance Framework FTPC reviewed the Board Assurance Framework and key priority risks, agreed that current RAG ratings remained appropriate, and requested enhanced visibility of risk trajectory, emerging risks and mitigation progress in future reports. Review the corporate risk rating associated with Audiology in light of waiting list and patient safety concerns. Action: AB/CL – completed. Resolved: FTPC received and noted risks to be updated within the BAF.
26/27/66	Cheshire and Merseyside Procurement Target Operating Model and Business Case RL provided an update outlining the development of a Cheshire and Merseyside-wide Procurement Target Operating Model (TOM) and the associated business case. FTPC was advised that the work was being led through the Cheshire and Merseyside Provider Collaborative and was seeking to establish future options for procurement services across the region. Trust Boards across Cheshire and Merseyside were being asked to support progression of the business case development phase before a preferred option is formally recommended. FTPC requested that future iterations place greater emphasis on innovation, automation, artificial intelligence and delivery of transformational procurement benefits rather than focusing solely on structural consolidation. As Trust Boards were being asked to support continued development of the proposals at this stage rather than approve a final model, an update would be presented at the September Trust Board. Action: RL Resolved: FTPC noted the report and supported continuation of the Cheshire and Merseyside Procurement Target Operating Model business case development.
26/27/67	Any Other Business Outpatients Transformation Programme DJW asked if an update on Outpatients could be scheduled for a future meeting. Actions: EM MJ reflected on the discussions throughout the meeting and observed that the written reports had initially given the impression of a more severe deterioration than the discussion itself had suggested.
26/27/68	Review of the Meeting FTPC agreed that the primary focus should now be on delivery, evidence of improvement and maintaining momentum against the recovery programme over the coming months.
	Date and Time of Next Meeting: Thursday 20th August 2026, at 3:00pm, via Teams.

Strategic Priority	Purpose	Trend	Confidence	Executive Commentary
Trust Financial Performance	Deliver the plan, strengthen grip and control, and improve forecasting and recovery.	↑	Medium	M4 achieved plan with one off benefits however also seen a reduction in forecast gap in M4 by c£1m. Control targets set by system and clear recovery and mitigation plans required.
Operational Performance	Provide oversight of access, productivity delivery of standards, aligned to the NHS Oversight Framework.	→	High	Awaiting Q1 report from NHSE. Internal assessment underway based on new set metrics with some deterioration anticipated but overall confidence to remain in top 2 segments.
CIP & Transformation	Deliver recurrent CIP and a prioritised transformation portfolio with clear benefits realisation	→	Low	Minimal movement on recurrent CIP at £16m green. Low confidence on recurrent plans. Focus from September to improve position for April 27.
Capital & Campus Programme	Maintain robust capital governance, safety-led prioritisation and delivery	↑	High	Remains on plan with progress on NICU/SDEC build. Decision required on Elective hub following BSR approval.
Growth & Investment	Monitor progress and developments on opportunities.	↑	High	Work continues on case for change with update to October FPTC. Left Shift working group held with ICB discussions progressing well.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Board Assurance Framework Report (July 2026) Report
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 July 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
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Board Assurance Framework 2026/27

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 and Culture 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 and Culture Committee
2.3	Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust	People and Culture 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

Ref, Owner	Risk Title	Monitoring Committee	Deep dive at monitoring committee	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	June 2026	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	Sept 2025 (SQAC)	5x3	3x3
1.3 RL	Building and infrastructure defects that could affect quality and provision of services	FTPC	Scheduled Nov 2026	4x4	2x3
1.4 LC	Increased waiting times for Specialist Mental Health community services.	FTPC / SQAC	Jan 2026 (SQAC)	3x5	3x3
STRATEGIC OBJECTIVE: Support our people					
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	P&C	July 2026	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	P&C	July 2026	3x4	2x3
2.3 MS	Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust	P&C	July 2026	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	Scheduled Feb 2027	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	Scheduled Dec 2026	4x4	4x2
3.4 RL	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	FTPC	Scheduled Sept 2026	4x5	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	Strategy Board discussions once per quarter	4x3	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs					
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	GO	Refresh of risk scheduled during Sept 2026	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	Scheduled Mar 2027	4x4	2x4

4. Application of risk appetite to BAF Risks

The agreed risk appetite and tolerances for BAF Risks are set out below and now need to be applied as follows:

Risk Title	Risk category	Risk Rating: I x L			
		Current Score	Current Target	Risk appetite & tolerance	Suggested new target
STRATEGIC OBJECTIVE: Outstanding care and experience					
Inability to deliver safe and high-quality services	Quality - Safety	3x3	2x1 (minor x rare)	LOW (1-3)	No change
Children and young people not having have timely and safe access to elective, urgent and follow up care	Compliance - Regulatory	5x3	3x3 (moderate x possible)	LOW-MEDIUM (4-6)	3x2 (moderate x unlikely)
Building and infrastructure defects that could affect quality and provision of services	Environment	4x4	2x3 (minor x possible)	MEDIUM-HIGH (10-12)	4x3 (major x possible)
Increased waiting times for Specialist Mental Health community services.	Workforce – Sustainability	3x5	3x3 (moderate x possible)	MEDIUM (8-9)	No change
STRATEGIC OBJECTIVE: Support our people					
Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	Workforce – Sustainability	4x4	3x2 (moderate x unlikely)	MEDIUM (8-9)	3x3 (moderate x possible)
Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	Workforce – Culture	3x4	2x3 (minor x possible)	MEDIUM (8-9)	3x3 (moderate x possible)
Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust	Workforce - EDI	4x3	4x1 (major x rare)	MEDIUM (8-9)	3x3 (moderate x possible)
STRATEGIC OBJECTIVE: Collaborate for children and young people					
Failure to fully realise the Trust’s Vision for the Alder Hey Campus	Environment	3x2	2x2 (minor x unlikely)	MEDIUM-HIGH (10-12)	4x3 (major x possible)
Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	Systems and Partnerships	4x4	4x2 (major x unlikely)	MEDIUM (8-9)	No change
Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	Financial – Compliance	4x5	4x3 (major x possible)	LOW-MEDIUM (4-6)	4x2 (major x unlikely)

System working to deliver 2030 Strategy	Systems and Partnerships	4x3	3x3 (moderate x possible)	MEDIUM (8-9)	No change
STRATEGIC OBJECTIVE: Pioneering breakthroughs					
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.	Futures	3x3	3x2 (moderate x unlikely)	MEDIUM-HIGH (10-12)	4x3 (major x possible)
STRATEGIC OBJECTIVE: Revolutionise care					
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	Technology – Transformati onal Change	4x4	2x4 (minor x likely)	MEDIUM (8-9)	No change

5. Summary of updates to end of July 2026:

- Inability to deliver safe and high-quality services (NA).**
 Risk 1.1 has been reviewed, and all current controls remain in place. The risk will be reviewed against the recently released NHS Quality Strategy which the Trust are assessing over the summer with a plan to present an agreed approach for implementation to the board in Q3.
- Children and young people not having timely and safe access to elective, urgent and follow up care (AB).**
 July performance against 2026/27 targets:
 - Acute (95% by September'26) - ED performance achieved 89%, against the new national paediatric target of 95%. This is a significant improvement since June.
 - RTT (75.5% by March 2027) - 67.3% in month, a slight decline in performance in June.
 - Pts >52 weeks (0 by March 2026) - 192 in July with the majority under dentistry admitted, an improvement in comparison to June.
 - DM01 (88%) - Performance decreased in July due to Gastrosocopy compliance. Recovery action plans in place.
- Building and infrastructure defects that could affect quality and provision of services (RL).**
 The overall risk position remains broadly unchanged from the previous reporting period. However, significant progress has been made following execution of the Letter of Intent and agreement in principle of a commercial settlement and standstill arrangement.

Under the proposed arrangement, which is six weeks in, Project Co will have an initial three-month period in which to deliver a defined set of contractual, commercial and operational objectives. Subject to satisfactory completion of those objectives, the arrangement will continue for a further 15 months, providing both parties with the opportunity to resolve a number of longstanding contractual, commercial and operational matters.

The risk position will remain elevated until the standstill agreement has been formally executed by all parties.

Key Actions

- * Monitor Project Co's delivery of the initial three-month objectives.
- * Continue enhanced monitoring of water safety and other critical engineering systems.
- * Progress the defects programme and associated legal actions.
- * Maintain oversight of the potential step-in position as a contingency measure. The standstill agreement remains the preferred route to resolving the current issues and enabling delivery of the required works.

- ***Increased waiting times for Specialist Mental Health community services. (LC).***

Feedback from Chair Audit & Risk committee regarding action relating to choice and partnership trajectory. This action has now been closed and new action created relating to national metrics of 104+ weeks (zero by 31 March 2027) and 4 weeks full clock stop (50% by 31 March 2027).

Above will be monitored via Mental Health waiting times group and divisional board.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***

This risk continues to be monitored closely by both People Committee and FTPC as well as discussions at Trust Board, whilst action plans are on track, the current WTE remains higher than plan.

Impact and plans to mitigate associated risk are reviewed regularly with oversight at People Committee.

- ***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. Duplicate control removed (relating to culture insights during organisational change). All actions reviewed and updated to reflect current position with updates relating to progress in the HWWWITF work and planned move to phase 2 of the programme. Action relating to communications marked as complete as work now BAU.

- ***Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust (MS).***

Actions remain on track, mitigations to be put in place to ensure actions do not slip as Head of EDI has now left the Trust. Strategic EDI lead not due to commence until September, however 1.1 meetings are in place to manage the transition.

- ***Failure to fully realise the Trust's Vision for the Alder Hey Campus (RL).***

Head of the Blue Light route was completed and is now fully operational. The final demolition works have concluded, and the end works have commenced on the new ED car park and the final section of Springfield Park to enable handover to LCC later this year. RE NICU - a revised programme has been received from MSC with a revised handover date of the new facility to the trust 11th Dec 2026. This is subject to completion of all connection works via MITIE.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).***

The Transformation Programme is now established as the Trust's primary mechanism for delivering Vision 2030 and the Financial Improvement Programme (FIP). Delivery across the portfolio continues to mature, with all five strategic transformation programmes progressing.

There is a risk that the programme does not deliver the scale, pace and sustainability of workforce, productivity, operational and financial benefits required to achieve the Trust's strategic ambitions and financial recovery. Whilst implementation across the portfolio is progressing, there remains a recognised risk that programme delivery does not translate into validated recurrent benefits at the pace required, particularly across the Trust's largest transformation opportunities, including HWWWITF, Revolutionising Care and Digital, Data & AI.

The risk is compounded by the scale and complexity of the transformation portfolio, dependencies between programmes, competing operational pressures, organisational capacity and the need to deliver significant change whilst maintaining safe, high-quality services.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***

Risk reviewed and score remain static. Additional risk included on the deconstruction of the block exercise that is currently underway to be submitted to commissioners for 27/28 planning. This work will report into FTPC with clear implications and any risks or opportunities. The I&E position remains on plan at the end of M4 but with emerging risks in the system positions with recovery and mitigation plans to be presented through executive team and FTPC monthly. A framework was presented to FTPC in July which set out the actions required to deliver the CIP requirement and mitigate emerging risks.

- ***System working to deliver 2030 Strategy (DJ).***

Risk reviewed, actions and controls updated - no change to risk score. Broader BAF review scheduled September 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. Risk needs to be re-articulated in line with new Bring me the Future systems plans (once risk owner has been confirmed) including approach to financial sustainability, comms and education/culture. Meeting re-scheduled for 8th Sept to review/reframe risk.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***

Risk Reviewed and remains at 16. Meeting scheduled to review disaggregation of strategy delivery and Cyber Risk.

Ageing infrastructure is progressing, final data centre migration progressing well and will be complete in August. Network and Telephony refresh Business Cases in development due for submission in September.

Organisational Change is now complete and some key roles have now been recruited to internally. External recruitment to key roles has also commenced. CIP is 90% complete awaiting final staffing changes but no risk to not achieving plan.

Digital Transformation programme progressing well. Approach to benefits realisation currently under review and a supporting paper is in development.

6. Corporate risks (15+) linked to BAF Risks (as at 27th July 2026)

There are currently 37 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
575	Pace of APoC developments (NEW)	4x5	Corporate Services		Jun 2026	Jul 2026
529	Named Doctor for Safeguarding Children	4x5	Community		Feb 26	Feb 26
038	No neurophysiology consultant in post	5x4	Medicine	2.1	Jul 2023	Oct 2025
455	Breaching waiting time standards in the Eating Disorder Service (EDYS) service	3x5	Community	1.2	Oct 2025	Jan 2026
238	Clinical Coding	4x4	Corporate Services	3.4	May 2025	Nov 2025
491	Risk Stratification Process for whole of Neurodevelopmental service caseload	5x3	Community	2.1	Feb 2026	Feb 2026
271	Safeguarding Nursing Team Capacity	5x3	Community	2.1	Oct 2024	Mar 2026
287	Radiology consultant on-call is at risk of failure	4x4	Medicine	2.1	May 2025	Sept 2025
534	Risk of transmission of waterborne pathogens in the healthcare environment	4x4	Corporate Services		Feb 2026	Feb 2026
341	Named Doctor for Children in Care	4x4	Community		Apr 2025	Apr 2025
539	Safeguarding Multi-Agency Partnership Working	3x5	Community	1.2	Mar 2026	Mar 2026
399	Three Anti Barricade doors not opening outwards on patient bedrooms and faulty swipe entry on patients bedrooms	4x4	Community		Jun 2025	Aug 2025
458	Disruption in patient's supply of medication and / or treatment	4x4	Community	2.1	Oct 2025	Oct 2025
464	Reduced Haematology consultant workforce	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
492	NICU go live delay	4x4	Corporate Services	3.1	Nov 2025	Nov 2025
288	CAMHS Planned Safeguarding Supervision	3x5	Community	2.1	Nov 2024	Nov 2024
520	Pharmacy Capacity	4x4	Medicine	2.1	Dec 2025	Dec 2025

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
524	Reduction or loss of NWNODN funding	4x4	Other – NW Neonatal ODN	3.4	Jan 2026	Jan 2026
525	Potential loss of NWNODN Pharmacy role	4x4	Other – NW Neonatal ODN	3.4	Apr 2026	Apr 2026
543	Delays in timely recruitment	4x4	Community	2.1	Mar 2026	Apr 2026
461	Breaching urgent or routine treatment targets in Sefton CAMHS	3x5	Community	1.4	Oct 2025	Apr 2026
413	Haematology Specialty Nursing Team	4x4	Medicine	2.1	Jul 2025	May 2026
563	Inflammatory bowel disease service delivery failure	4x4	Medicine	2.1	May 2026	May 2026
113	Delay in access to dysphagia service	4x4	Community	2.1	*Apr 2024	June 2026
570	Clinical safety impacted by staffing pressures across CAMHS	5x3	Community	2.1	June 2026	June 2026
1.2 Children and young people not having timely and safe access to elective, urgent and follow up care (5x3=15)						
462	Children and young people will not receive their ASD assessment within the agreed timescale	4x4	Community	1.4	Jul 2021	*Apr 2023
455	Breaching waiting time standards in the Eating Disorder Service (EDYS) service	3x5	Community	1.1	Oct 2025	Jan 2026
1.3 Building and infrastructure defects that could affect quality and provision of services (4x4=16)						
	None					
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
480	Delayed initiation and review of ADHD medication	4x4	Community	2.1	Oct 2025	Apr 2026
461	Breaching urgent or routine treatment targets in Sefton CAMHS	3x5	Community	1.1	Oct 2025	Apr 2026
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
491	Risk Stratification Process for whole of Neurodevelopmental service caseload	5x3	Community	1.1	Feb 2026	Feb 2026
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

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
287	Radiology consultant on-call is at risk of failure	4x4	Medicine	1.2	May 2025	Sept 2025
271	Safeguarding Nursing Team Capacity	5x3	Community	1.1	Oct 2024	Mar 2026
539	Safeguarding Multi-Agency Partnership Working	3x5	Community	1.1	Mar 2026	Mar 2026
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024
520	Pharmacy Capacity	4x4	Medicine	1.2	Dec 2025	Dec 2025
480	Delayed initiation and review of ADHD medication	4x4	Community	1.4	Oct 2025	Apr 2026
543	Delays in timely recruitment	4x4	Community	1.1	Mar 2026	Apr 2026
545	Booking and Scheduling (Care Co-ordination Team) Staff Shortage	4x4	Community		Apr 2026	Apr 2026
413	Haematology Specialty Nursing Team	4x4	Medicine	1.1	Jul 2025	May 2026
563	Inflammatory bowel disease service delivery failure	4x4	Medicine	1.2	May 2026	May 2026
113	Delay in access to dysphagia service	4x4	Community	1.2	*Apr 2024	June 2026
570	Clinical safety impacted by staffing pressures across CAMHS	5x3	Community	1.2	June 2026	June 2026
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 Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust (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)						
492	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)						
238	Clinical Coding	4x4	Corporate Services	1.1	May 2025	Nov 2025
524	Reduction or loss of NWNODN funding	4x4	Other – NW Neonatal ODN	1.1	Jan 2026	Jan 2026

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
525	Potential loss of NWNODN Pharmacy role	4x4	Other – NW Neonatal ODN	1.1	Apr 2026	Apr 2026
318	Failure to deliver the Appropriate Places of Care programme (NEW)	5x4	Corporate Services		Jun 2026	Jul 2026
3.5 System working to deliver 2030 Strategy (4x3=12)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
368	Digital infrastructure capacity and age	4x4	Corporate Services		May 2025	May 2025
556	Single point of failure on remote access solution	5x3	Corporate Services		Apr 2026	Apr 2026
365	Backups stored in one location	5x3	Corporate Services		May 2025	May 2026
559	Unmanaged VPN to building management network	5x3	Corporate Services		Apr 2026	May 2026
574	CMM/System C credentials stored in plain text	5x3	Corporate Services		Jun 2026	Jun 2026

* risk movement data not available pre-move to InPhase

NOTE: the move from Divisions to Systems will go live on InPhase 1st September 2026

7. Recommendations

- to note the updated position with regards to management of the BAF risks.
- approve the revised target scores for the BAF risks aligning with approved risk appetite, subject to confirmation that the scores are supported by current controls, mitigations and assurance evidence.

Erica Saunders
Chief Corporate Affairs Officer

Inability to deliver safe and high quality services.					
Risk Number			Strategic Objectives		
1.1			Outstanding care and experience		
CQC Domains	Linked Risks	Owner	Risk Rating		
Safe		Nathan Askew	Actual	Target	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. Robust reduction programme in the number of medication incidents and near misses 2. The 2030 vision sees a shift towards an experience led organisation without additional resources for delivery of the plan 3. Increased oversight relating to financial pressures is resulting in inability to deliver 2030 Strategy, with the high level of CIP potentially impacting the ability to keep services safe 4. Triangulation of data in relation to inequalities 5. Lack of systematic collection of outcomes data 6. Safeguarding supervision 7. Risk of adverse incidents resulting from unnecessary NEWTs transfers between AH and LWH pending opening of the new unit

Action	Description	August 2026	
		Due Date	Action Update
☒ 4. Inequalities data	4. PEG to consider reporting to highlight any inequalities	30/09/2026	
☒ 5. Outcomes Data	5. Clin Eff to develop systematic approach to PROMS, PREMS and CROMS	30/09/2026	
☒ 6. Safeguarding Supervision	6. Adequate resource to provide the level of safeguarding supervision required	30/09/2026	Business Case in development
☒ 7. risk of adverse incidents resulting from unnecessary NEWTs transfers between AH and LWH	monitored through SQAC, though the board is aware of the reasons for the delay. The mitigations can only be fully implemented with the opening of the new unit.	30/09/2026	
☒ 1. Medication Errors and Near Misses	1. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2027	Dashboard in place with insight into the causes of medication errors and a proactive reduction plan monitored through Patient Safety board.
☒ 2. Patient Experience	2. Experience Strategy Group established to evaluate resource required. SQAC will have oversight of ambition and achievements of the Group	31/03/2027	PEG continues to report into SQAC
☒ 3. Financial pressures – potential impact	3. Monitoring via FIP decision docs and EQIAs.	31/03/2027	no further controls required, monitoring controls are in place. RMF taken on responsibility for review of FIP decisions

Children and young people not having timely and safe access to elective, urgent and follow up care.				
Risk Number			Strategic Objectives	
1.2			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
Effective		Adam Bateman	Actual	Target
			15	4
				- Finance Transformation & Performance Committee - Safety and Quality Assurance Committee
Description				
With a growth in demand for elective, urgent, diagnostics 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 diagnostics care include: - Weekly oversight and management of waiting times by specialty & senior sign off before external submission - Activity plans for 26/27 adjusted to achieve national diagnostic targets - Transformation programme to re-imagine diagnostic care services as part of the Clinical Strategy	- Weekly Performance Report to Executive Directors - The NHSE DM01 weekly waiting time submission is reviewed and signed off by the Head of Performance - Diagnostic performance is included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board
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 26/27 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 - Attendance at weekly Cheshire & Merseyside wide performance meeting
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	August 2026	
		Due Date	Action Update
3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self-check in model for some patients, using a digital solution 1. Improve timeliness of care and experience through a same day emergency care centre	Deploy Ambient Artificial Intelligence to improve productivity	30/03/2026	The deployment of AVT (Ambient AI) technology in the ED department is ongoing. Key actions undertaken so far include - Technical assessment of hardware requirements to enable implementation in the ED setting - Development of document templates to support the AVT output in the ED setting - Development of AVT app and discussion with Trust IG lead in relation to using own device requirements Deployment of AVT and subsequent impact/benefits assessment is being tracked through the Lyrebird AVT board chaired by Ian Gilbertson
		30/03/2026	Draft paper in progress currently meeting with suppliers to identify most suitable opportunity.
		01/09/2026	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.
2. Open Same Day Emergency Care Centre	Expanded Paediatric Assessment Unit	31/12/2026	Delays related to building and estate works for ground floor expansion. Current anticipated opening of SDEC August 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

Building and Infrastructure defects that could affect the quality and provision of services				
Risk Number			Strategic Objectives	
1.3			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
Safe		Rachel Lea	Actual	Target
			16	4
Assurance Committee				
- Finance Transformation & Performance Committee - Safety and Quality Assurance Committee - Speciality Governance Meetings - Trust Strategy Board				
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	August 2026	
		Due Date	Action Update
☒ Appropriate Legal Advice	Continue to seek appropriate legal, commercial and technical advice	31/05/2026	The commercial position has progressed positively following execution of the Letter of Intent and agreement in principle of the settlement and standstill arrangement. The proposed agreement provides Project Co with an initial three-month period in which to deliver a defined set of agreed objectives. Subject to successful delivery, the arrangement will continue for a further 15 months, allowing both parties to resolve outstanding contractual matters while maintaining progress on key operational improvements and remediation works. The commercial position has progressed positively with agreement of the Letter of Intent and an in-principle settlement/standstill arrangement.
			The proposed agreement provides Project Co with an initial three-month period to deliver a number of agreed objectives. If these are achieved, the arrangement will continue for a further 15 months, allowing both parties to resolve outstanding contractual matters while maintaining progress on key operational improvements.
			Formal notification issued to Project Co covering all matters. No responses received to date. Risk: Continued delay in remediation, increasing exposure to operational and financial impacts. Awaiting Mitie to sign standstill.
			Project co have been requested to share plans of monitoring and rectification strategy.
☒ Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	31/05/2026	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. Proposal yet to be shared	31/12/2026	Weekly defects and issues meetings continue. The defects tracker has now been issued, although further validation and reconciliation are required. Legal discussions regarding contractual responsibility for the identified defects remain ongoing.
☒ Combined Heat & Power	Combined Heat & Power non-operational for ~18 months.	24/03/2027	The CHP plant has been unavailable for approximately 20 months. The plant was recommissioned during May and operated for approximately one week before further issues were identified. Investigations and associated remedial works remain ongoing.
☒ Air & Ground Source Systems	Clear plan, timelines, and performance assurance from Project Co.	31/03/2027	Ongoing performance and reliability issues remain unresolved. Root-cause analysis and a fully developed long-term remediation programme are still awaited from Project Co.
☒ Chillers	Persistent performance issues with no confirmed delivery programme for full reinstatement.	31/03/2027	Performance issues remain unresolved. Project Co has provided an outline recovery programme; however, confirmed delivery dates and adequate programme assurance remain outstanding.
☒ Tap Filters / Defects	Tap filters agreed as mitigation, funded by Project Co, with 30-day replacement cycle.	31/03/2027	Tap filters agreed as mitigation, funded by Project Co, with 30-day replacement cycle. Legal position on defects under review. Fortnightly defects meetings in place; defects tracker issued. Risk: Lack of contractual clarity, timelines.
☒ Water Safety	Enhanced monitoring, tap filter regime in place.	31/03/2027	Legal position on defects under review. Fortnightly defects meetings in place; defects tracker issued. The Water Safety Group continues to monitor and manage out-of-range water temperatures. A further report has been received from the SPV Board and is currently under review. Remediation of the dosing system remains ongoing, with no confirmed completion date. Tap-filter mitigation remains in place and continues to be funded by Project Co, with filters replaced on a 30-day cycle

Increased waiting times for Specialist Mental Health community services.				
Risk Number			Strategic Objectives	
1.4			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
- Carling - Effective - Responsive - Safe - Well-Led		Lisa Cooper	Actual	Target
			15	4
Assurance Committee				
- Finance Transformation & Performance Committee - Safety and Quality Assurance 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 relocations.	Minutes available for each meeting saved on Teams
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)

Gaps in Controls / Assurance

1) Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to reduction in capacity. This is due to difficulties recruiting as a result of national workforce shortages; increased sickness, and delays with recruitment processes due to vacancy control. There is also an increase in maternity leave, with backfill being fixed term and less hours than substantive post which can be difficult to fill.

Action	Description	August 2026	
		Due Date	Action Update
☒ MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/08/2026	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	31/08/2026	work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025
☒ Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	30/09/2026	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
☒ Mental Health Waiting Times - Trajectory for improvement	In November 2025, NHS Medium Term Planning guidance set out a commitment to reducing waiting times and improving access to Mental Health Services for children and young people introducing a new measure of Referral to full clock stop. A full clock stop is defined as contact (direct or indirect) + Intervention recorded with SNOMED code or Care Plan + Outcome measure (ROM). Nationally, there were 100,000+ CYP reported as waiting over 104 weeks for a full clock stop in October 2025 with Alder Hey reporting 415. To note, there are 0 CYP waiting over 104 weeks for intervention within Alder Hey - these are DQ/reporting issues. There are two trajectories currently in place for providers: 1) 0 children and young people waiting over 104 for full clock stop - by 31.03.2027 2) By March 2027, providers will have at least 50% of CYP referral spells receiving a full clock stop within 4 weeks.	31/03/2027	

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		
- Safe - Well-Led		Melissa Swindell	Actual	Target	Assurance Committee
			16	4	People and Culture 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. Risk of failure 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 to effectively run the organisation 7. Not having a sustainable workforce will impact upon culture (links to BAF 2.2)

Control description	Control assurance (How is this control monitored?)
Apprenticeship Strategy	Apprenticeship Strategy implemented
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to PC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	reviewed at EDI steering group and monitored at People Committee also reported in the statutory WRES and WDES
Financial Improvement Programme	Monitored at FTFC
Health and Wellbeing Forum	Health and Well being Forum Terms of Reference - reporting through to People Committee
High quality mandatory training delivered and reporting linked to competencies on ESR. Online portal enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - 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
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Workforce Efficiencies Programme	Monitored at FTFC, and People Committee

Gaps in Controls / Assurance
1. Training/development 2. Sickness absence levels higher than target 3. Lack of alignment of people services to the organisational systems (HWWWTF) 4. Consistency of inclusive practices to increase diversity and progression opportunities across the organisation 5. The national and regional requirements to reduce NHS financial deficit, which is directly impacting on WTE

Action	Description	August 2026	
		Due Date	Action Update
☒ 3. Lack of alignment of people services to the organisational systems	3. Through HWWWTF, we will strengthen our approach to talent management, succession planning, and recruitment.	30/09/2026	
☒ 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 2 members of the HR team have been repurposed solely to support the management of sickness absence.	31/12/2026	Focus on reduction in sickness absence continues. Dedicated teams still in place. Due to actions taken LTS has reduced by over 1%, short term absence remains a challenge and actions taken in relation to this include: manager training, compliance with RTW interviews and managing the impact of organisational change with is being cited as some of the reasons for a spike in short term sickness.
☒ 4. Consistency of inclusive practices.	4. A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2027	EDI Plan is monitored at both People Committee and EDI Steering group and is progressing against plan.
☒ 5. The national and regional requirements to reduce NHS financial deficit, which is directly impact	5. Monitored through Financial Improvement Programme	31/03/2027	The WTE continues to be closely monitored and reported to both FTP Committee and People Committee. Target Operating Model, will also address the Trust workforce plan and consultation on wave one is close to completion. Trust Voluntary Redundancy Scheme has just been launched and will close April 2026.

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families					
Risk Number			Strategic Objectives		
2.2			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Caring - Safe - Well-Led		Melissa Swindell	Actual	Target	Assurance Committee
			12	4	People and Culture 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
Executive-led organisational change programme governance	
Executive-led organisational change programme governance	HWWWF reporting to Transformation Board, People Committee and Trust 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 Connected Leadership managers and leaders briefings and all staff Connecting Alder Hey meetings	Internal Communication reports to People Committee
Regular Schwartz Rounds in place	Monthly Schwartz Steering Group meetings
Restorative just and learning principles embedded into key employment policies including Disciplinary Policy	People Committee reports
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Staff Networks	EDI Steering Group and People Committee
Staff surveys analysed and followed up	2025 Staff Survey Report - main report, divisional reports and team level reports
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to People Committee
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Director of Culture & OD and enables shared thinking about teams in need of support and joint working where indicated.	Newly revised People Paper to include data relating to fragile teams
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered
Working together with teams following organisational change	

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 - lack of aligned communications approach that is responsive to organisational needs - lack of control of system decisions and pressures regarding the financial environment - potential for cultural deterioration during organisational restructuring

Action	Description	August 2026	
		Due Date-	Action Update
☒ 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	Action parked
☒ Cultural change and integration plan	Cultural integration plan to be developed to support new leadership teams and enable effective merging of services and teams and support transition to new empowered clinical leadership model for the organisation.	30/09/2026	Induction sessions booked with first session to be completed with exec team on 23rd June to focus on 4 strategic shifts and accountability framework. First induction session with new SLT and execs planned for 7th July with a focus on orientation to the new systems, space for reflection on impact on them as leaders of changes, introducing the new accountability framework and forward look to development programme and support to enable team transitions (focussed on in workshop 2 later in July).
☒ 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.	30/09/2026	All current Thriving Teams data now shared with divisions and teams (where staff survey data available). Support being offered to fragile teams based on this data. Thriving Teams toolkit being developed this quarter to be shared with all new leaders to support implementation of Thriving Teams Index and to provide early intervention and information for leaders.
☒ Safety culture programme	Safety culture programme of work to be agreed and developed with the Patient Safety leads and Chief People Officer to reflect need for an integrated safety culture including both patient safety as staff safety as key to an adaptive safety culture. Safety culture training to be developed and implemented with teams as part of this wider programme to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	30/09/2026	Pilot session with sunflower house cancelled due to lack of staff availability with new date being arranged. Development programme pilot challenging to pilot in context of organisational restructure and impact on team functioning and capacity. Staff more focussed currently on navigating change. Safety culture programme development group to continue to secure pilot sites so that the programme can be rolled out wider in due course.
☒ Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	26/10/2026	New values implementation plan progressing well with outstanding work relating to sign off of Values in action guide (at People Committee in July 2026), values based recruitment being embedded, and values fully aligned with patient experience strategy and measures. Values working group to regroup in August to consider outstanding actions with a view to closing the group in October 2026.
☒ Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards. Thriving Staff Index and Thriving Teams Index to be developed.	31/10/2026	Develop new system level culture risk dashboard to include: turnover, sickness, FTSU, pulse data, ER cases, vacancy rates & team risk indicators. Propose new system culture assurance reviews with new system leads to discuss above and consider areas of risk and work together on intervention plans. Meeting to be set up between Director of Culture and new system leads in September when all leads in place.

☒ Real-time cultural monitoring during transition	Regular qualitative and quantitative data relating to organisational culture to be collated and analysed to enable real-time monitoring of culture impact during organisational restructure. Data source to include: staff engagement scores, safety culture metrics, sickness absence and retention, FTSU data, SALS data, and feedback gathered through formal consultation events during restructure. Consider implementation of culture impact assessments during organisational change programmes. Focus on closing feedback loops with discipline to ensure that staff voice leads to credible, timely, and visible action	31/10/2026	Scope feasibility of introducing culture impact assessments as part of phase 2 of HWWWITF. Discuss with HWWWITF steering group and develop via task & finish group to be ready to use for next wave of service reviews.
☒ Thriving Leaders framework	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focussed review and development and Operational Leaders programme. NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	21/12/2026	Focus over summer on bespoke Leadership Under Pressure sessions to acknowledge challenges of leadership during period of significant change. First session to be held with execs on 23rd June and to be mirrored with other leaders over the summer months. Thriving leaders programme to be launched with new SLT as part of induction workshop to be held on 7th July.
☒ 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	28/12/2026	FTSU case review undertaken with FTSUG, Chief Corporate Affairs Officer and Chief People Officer. Meetings with staff affected held with Director of Culture and Chief People Officer in July 2026 to discuss impact, detriment and avoidable harm. Key themes feedback to CPO and to be feedback to FTSUG. Output and learning to inform new processes as part of employee relations centre of excellence. Meeting to be set up by CPO with key stakeholders to develop and implement new process

Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust					
Risk Number			Strategic Objectives		
2.3			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Effective - Well-Led		Melissa Swindell	Actual	Target	Assurance Committee
			12	4	People and Culture Committee
Description					
- Failure to embed effective Equality, Diversity & Inclusion (EDI) practices across all functions, which may result in inequitable experiences and outcomes for both staff and service users, including reduced trust, poorer engagement, and variable access to safe, high quality care. - Failure to meet statutory obligations under the public sector equality duty and wider equality obligations.					

Control description	Control assurance (How is this control monitored?)
Accessible Information Standard	
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.
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
Parent Carer Race Equality Framework	Data published on the Trust website
Patient Experience and Engagement Group	PEEG ToRs
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 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. 5. Sufficient EDI resources to support the EDI agenda 6. Lack of systemic reporting on demographic data for the communities we serve.

Action	Description	August 2026	
		Due Date	Action Update
		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.
2. Lack of inclusive leadership behaviour and accountability for embedding cultural change ☒	2. 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	
6. Lack of systematic reporting on demographic data for the communities we serve ☒	Working group created. Training developed and started to roll out to Teams. Communications plan also developed	31/07/2026	
5. Sufficient EDI resources to support the EDI agenda ☒		30/09/2026	
		31/10/2026	Grow to Lead launched in April 2026 and will run until October 2026. The Mutual Mentoring Programme and the LCR Shadowing Programme has now ended and evaluated 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 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
3. Access to career development and advancement of opportunity ☒	3. 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		
4. Limited organisational awareness, training, and governance around legal duties ☒	4. 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.		
1. Recruitment practices do not target diverse communities ☒	1. Launch Recruitment and Selection training incorporating EDI throughout. Revise Recruitment and Selection Toolkit which includes support and guidance on inclusive recruitment practices. Review of recruitment materials to ensure inclusivity. Target recruitment campaigns in under represented community groups working in collaboration with Liverpool City Region Race Equality Hub	31/03/2027	Recruitment practices have been reviewed and resources developed to support candidates and also recruiting managers. Inclusive recruitment training has been launched. Accessible and Inclusive Recruitment Practices working group established. Recruitment and Selection training incorporating EDI throughout now launched.

Failure to fully realise the Trust's Vision for the Alder Hey Campus					
Risk Number			Strategic Objectives		
3.1			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Effective - Safe		Rachel Lea	Actual	Target	Assurance Committee
			6	4	Finance Transformation & Performance Committee

Description
The Alder Hey long term vision for the 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	- Quarterly meeting to take place with key executives to share master plans, schemes and seek input - Feedback into Trust Board - NED sponsor
Funding availability and potential market inflation	Continual monitoring of market inflation and horizon scanning of external funding opportunities.
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
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 chaired by exec lead and supported by DD

Gaps in Controls / Assurance
CAMPUS: 1. Affordability 2. Stakeholder Engagement 3. Potential for unnecessary NEWTs transfers before the NICU opens

Action	Description	August 2026	
		Due Date	Action Update
☒ 3. Opening of the NICU	Monitored through FTPC and Board. Mitigations will only be fully implemented with the opening of the new unit	30/09/2026	
☒ CAMPUS 1: Stakeholder Engagement	Engage with LCC, Friends of Springfield Park and community stakeholders and issue regular Comms	31/12/2026	Stakeholder engagement is continuing.
☒ PARK 1: Adoption of the SWALE by United Utilities	Engage with planning consultants to assist with planning requirements.	31/07/2027	Overflow to the new drain - linked with developer site - due for completion July 2026. 12 month monitoring period then required to July 2027

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment				
Risk Number			Strategic Objectives	
3.2			Collaborate for children & young people	
CQC Domains	Linked Risks	Owner	Risk Rating	
Well-Led		Kate Warriner	Actual	Target
			16	4
Assurance Committee				
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 financial savings with longer term transformation

Control description	Control assurance (How is this control monitored?)
Board Governance	Reports to Board and FTPC Reports to People Committee, SQAC and GO in accordance with programme remit
Executive Portfolios all incorporate elements of Vision 2030 delivery	- Continued executive focus on successful implementation and benefits realisation from HWWWITF Phase 1, alongside progression of HWWWITF Phase 2, Outpatient Transformation, Urgent and Emergency Care and Digital, Data & AI programmes. - Strengthened clinical leadership, programme accountability and delivery oversight to support sustainable implementation and embed transformation into operational delivery.
Executive sponsor roles within the programme	
Financial Improvement Programme governance arrangements	Quarterly portfolio benefits reviews through the Financial Improvement Programme governance arrangements, providing structured challenge and validation of benefit assumptions, delivery trajectories and realised financial benefits.
Medium Term Plan	Medium Term Plan incorporates Vision 2030 deliverables (2025/26)
Programme Assurance Framework (Transformation Portfolio aligned to Vision 2030)	FIP Strategic Command, Clinical Transformation collaboratives, Digital Data & AI Collaborative, HWWWIF Steering Group, Growth and Opportunities Acceleration Group
Semi-independent programme assurance	Internal audits of framework
Transformation Board providing strengthened executive oversight of programme delivery, milestones, risks, interdependencies, resources and benefits realisation.	Transformation Board in place chaired by CEO. Implementation of an integrated Transformation Roadmap, Programme Milestone Plan and Transformation Scorecard, providing greater visibility of delivery progress, dependencies and strategic outcomes.

Gaps in Controls / Assurance
1. Failure to develop capacity for delivery and monitor sequencing of programmes and risk of organisational change fatigue. 2. Failure to build capacity and skills within our workforce to deliver the 2030 Strategy 3. Inability to sufficiently prioritise and focus on key areas of need, leading to mission creep and dilution of the Strategy's intended transformational impact.

Action	Description	August 2026	
		Due Date	Action Update
☒ 1. Ensure the organisation has the skills, capacity and leadership capability deliver Vision 2030	Maintain oversight of workforce capability, capacity and organisational development requirements to support delivery of the Strategy.	30/09/2026	Strategic workforce planning continues through Shape of Alder Hey 2030 and the development of the future operating model. Emerging workforce, leadership and capability requirements have been identified through strategic blueprint development and will inform future workforce planning.
☒ 3. Maintain clear strategic focus and manage the risk of mission creep	Ensure governance arrangements support prioritisation and alignment to the Trust's core mission and strategic goals.	31/10/2026	Review of the transformation programme heading into the second half of the year has commenced. There is an 'away afternoon' planned with Execs, System leaders, and the Transformation Unit to set the agenda for the next 6 months, and support the creation of the 27/28 transformation plan. This will focus the scope of the programme into what can be delivered in year
☒ 2. Maintain organisational focus on strategic priorities and transformational change	Ensure resources, programmes and leadership attention remain aligned to delivery of Vision 2030.	31/03/2027	Development of the Strategic Programme 2026–2030 has progressed, providing greater clarity on priorities, sequencing and delivery focus. This will support alignment of resources and organisational effort against the Trust's strategic objectives.

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust’s ongoing capital commitments.					
Risk Number			Strategic Objectives		
3.4			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating		
• Effective • Responsive • Safe • Well-Led		Rachel Lea	Actual	Target	Assurance Committee
			20	4	Finance Transformation & Performance Committee
Description					
Failure to deliver financial targets in particular the level of efficiency and cost reduction required. Inability to invest in the capital programme due to constrained capital and cash allocation. Detrimental impact due to system performance.					

Control description	Control assurance (How is this control monitored?)
Active engagement within ICB, NHSE both regional and national.	- Attendance at system forums. - Cascade of system and national information on a regular basis. - Advocate for CYP - Hosting of Beyond programme
Capital Management Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend. Updated 5 year capital plan shared with FT&P and Trust Board. Oversight by 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) is one of the key financial transformation programmes and 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.
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 11. Implications of deconstructing the block across commissioners

Action	Description	August 2026	
		Due Date	Action Update
☒ Complete deconstruction of block exercise	Completion of the deconstruction of blocks across all commissioners understanding the full impact. This position will be reported through executive team and FTPC	31/12/2026	
☒ 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	31/03/2027	Completed for 25/26. Monitoring continues to roll forward for 26/27 and therefore completion date updated to reflect ongoing requirement.
☒ 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	31/03/2027	Completed for 25/26. Monitoring continues to roll forward for 26/27 and therefore completion date updated to reflect ongoing requirement.
☒ 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	31/03/2027	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.	31/03/2027	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.	31/03/2027	Completed for 25/26. Monitoring continues to roll forward for 26/27 and therefore completion date updated to reflect ongoing requirement.

System working to deliver 2030 Strategy			Strategic Objectives		
Risk Number					
3.5			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating		
Well-Led		Danielle Jones	Actual	Target	Assurance Committee
			12	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). June 26 Update: Awaiting a response from RMCH on the refreshed MOU.
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. June 26 Update: we remain host of the Beyond programme.
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy. June 26 Update: The Committee is not longer in existence; however we are working with relevant colleagues in the system to design the optimal governance structures 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
Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for CYP.	June 26 Update: The BMTF system is being co-designed with senior leaders at present. Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25. June 26 Update: No significant updates on the delegation agenda, with expected timeframes to coincide with the abolishment of NHSE in March 27.
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings. June 26 Update: We continue to engage with our ICS colleagues and partners. There is significant change happening at ICS level and we are keeping up to date with this.
Growth and Opportunities Committee oversight of growth element of Vision 2030.	June 26 Update: The GO committee is due to meet again in June, focused on our growth agenda. The committee is embedding and as BMTF develops and evolves the committee will have greater oversight of the collective agenda.
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board June 26 Update: we continue to track developments and report back into relevant forums.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board June 26 Update: The breadth of partnership work is growing, with significant nuances and differences in the purpose and intended benefits. Strategic partnerships will be governed through the GO Committee, but we don't have an agreed definition of what constitutes a strategic partnership. This is an evolving agenda and will need to link to the new BMTF system.
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 June 26 Update: We continue to work in partnership across the system. We are making good progress within our North Mersey Provider Partnership, and are now collectively engaging with Primary care to work on joint priorities. Also through CMPC, we are working collaboratively with our acute care partners on CYP models of care. Our awarded AFT status will support development in this area.
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 June 26 Update: we are maintaining relationships with system regulators, ensuring we are connected despite system changes. Our awarded AFT status will support this agenda.
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	Membership of CMPC provider collaboratives. June 26 Update: we remain a committed and engaged member of the CMPC and its various sub-forums, and continue to ensure CYP voice is prioritised.
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES Partnership Plans developing with CYP focus. June 26 Update: Following the departure of our Strategic Place Lead, we are managing to represent at most Place forums; however we need to consider how and where we can commit limited resources to a growing Place agenda.

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. National mandates, system finance and productivity challenges forcing us to prioritise unexpected programmes of work	
4. System wide capacity & resource to deliver CYP system	

Action	Description	August 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	31/03/2027	No further update this month
☒ 2. Impact of delegation of Specialist Commissioned services into ICBs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2027	Close working with ICB as they develop strategic commissioning approach
☒ 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.	31/03/2027	In the last period we have met as the North Mersey Provider Partnerships with Liverpool, Sefton and Knowsley Primary Care leaders. Strategic engagement with LCC, ICB, Trust Partners, CMPC.
☒ 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)	31/03/2027	Alder Hey influencing national modern service FW for CYP e.g Beyond Board engagement with MSF on 29th July 2026 Alder Hey's planned priorities are closely aligned with national priorities.

Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.					
Risk Number			Strategic Objectives		
4.1			Pioneering Breakthroughs		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Caring - Effective - Safe - Well-Led		John Chester	Actual	Target	Assurance Committee
			9	4	Growth and Opportunities Committee
Description					
Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries. 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	August 2026	
		Due Date	Action Update
☒ 4. Capacity and capability	Create an R&I enabled workforce through the Futures Develop Pillar	31/03/2026	This work will need to be transferred to the new BMTF SLT and a re-articulated risk - BMTF SLT proposal currently under review.

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families

Risk Number			Strategic Objectives		
4.2			Revolutionise Care		
CQC Domains	Linked Risks	Owner	Risk Rating		
Effective		Kate Warriner	Actual	Target	Assurance Committee
Safe			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 Data and AI key components of Vision 2030, Trust technological advancement and associated governance and plans	Digital Centre of Excellence. Relationship with Bring me the Futures system. Digital and Data Collaborative established. AI Strategy in place
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	Skills development network L3 accreditation
Lead NED for cyber security	
Monthly digital service meeting in place	iDigital digital service 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
 - 7. HIMSS 7 re-accreditation

Action	Description	August 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	29/08/2026	Cyber team has now increased by 1 x WTE as part of Digitals Organisational Change and as per review. NED led governance now in place and next meeting in August. DSPT Submission now completed and outstanding audit actions on track to be completed by deadlines.
☒ 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.	30/09/2026	Some key roles have now been recruited to internally. Recruitment remains ongoing and expected to be completed by September.
> ☒ Digital systems review	Digital systems review	30/10/2026	Data migration options appraisal underway as migrating information safely from EMIS to Meditech is more complex than first anticipated. Aiming to have all services transitioned by April.
☒ 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.	31/03/2027	Issues with core data centre migration now resolved and aiming to complete in August. Network tender now completed meaning progression can be made on the refresh business case. Telephony kick off meeting scheduled for July.

BOARD OF DIRECTORS

Thursday, 3rd September 2026

Paper Title:	Corporate Risk Register Report (CRR)
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Risk Management Manager / Facilitator

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☐ Regulation ☒
Action/Decision Required:	To note ☒ To approve ☒
Summary / supporting information	Corporate functions' risk registers via the InPhase electronic risk management system. Divisions' risk registers via the InPhase electronic risk management system.
Strategic Context	Outstanding care and experience ☒ Collaborate for children & young people ☒ Revolutionise care ☒ Support our people ☒ Pioneering breakthroughs ☒ Strong Foundations ☒
Resource Implications:	Resources identified to support management of risks as required.
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
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1. Purpose

This paper provides the Board of Directors with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR) as of 4th August 2026 compared to the previous reporting period (1st – 31st May 2026).

2. Summary CRR:

Total number of open high risks = **32** (excluding BAF, Cheshire & Merseyside Children's & Young People's Partnership and network risks)

High risks	1 st June – 4 th August 2026	1st - 31st May 2026	1st January - 28th February 2026	1st December - 31st December 2025	1st - 30th November 2025	1st October - 31st October 2025	1st September - 30th September 2025	1st June - 31st July 2025
Number of new high risks reported	4	6	4	2	2	2	2	3
Number of high risks closed or removed	2	2	1	0	1	0	0	1
Number of high risks with increased risk score	3	4	4	1	0	1	4	3
Number of high risks with decreased risk score	3	7	1	2	1	2	3	1
Number of high risks overdue review	0	0	0	2	2	1	0	0
Number of high risks with no agreed action plan	4	0	1 (288)	0	0	2 (288 & 462)	0	1 (2643)
Number of high risks with actions past expected date of completion	0	0	4	5	10	2	3	5
Number of high risks with static risk scores	27	22	24	20	22	20	16	21

3. Analysis of CRR to aid Committee review:

Refer to the full CRR provided in Table 3. The following analysis of the CRR is provided to assist the Board in focusing its review of the CRR.

3.1 Risks with external dependencies not wholly within the Trust's control

There are several risks where there is a reliance or dependency on other organisations to enable the Trust to mitigate the risk.

- **Risk 399 (score 16)** – *Inability to meet NHS England contractual obligation of having 10 accessible beds. Inability to admit young people due to reduced capacity* **Theme: External contractors.**
Update 21/08/26 Action plan in place for the remaining doors on the unit to be replaced. Door replacement to be commenced mid-August – one door per day.
- **Risk 458 (score 16)** *Disruption in patient's supply of ADHD medication and / or treatment* **Theme: National drug shortage outside of organisational control**
Update 21/08/26 1 ongoing action regarding transfer of melatonin prescribing to GP once stabilised – Completion date April 2027 - Melatonin guideline to be updated within the next 6 months. Information regarding updates to Cheshire and Merseyside guidance have been shared with the relevant clinician teams. The transfer of melatonin prescribing to primary care will be an ongoing process, with each patient requiring an individual transfer of prescribing responsibility once their treatment is stable.
- **Risk 462 (score 16)** *Children and young people not receiving their ASD outcome within agreed timescale* **Theme: Capacity and demand**
Update 21/08/26 4 ongoing actions (ND profiling tool roll out, digital support, operational review of long waiters and risk stratification process). Timescale for full action plan implementation is November 2026. First phase of using the profiling tool has started in Liverpool, digital templates are still being finalised (initially expected to be completed by May 2026), ND history assessments are being booked as a priority operationally and all new cases have now started to be risk stratified.
- **Risk 464 (score 16)** *If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4.* **Theme: National speciality workforce shortage outside of organisational control.**
Update 21/08/26 1 ongoing action regarding recruitment to a Locum Consultant Paediatric Haematologist – Due date of September 2026 – Approval granted to appoint 2 locum consultant successful candidates – One consultant is currently going through pre-employment checks and the other is expected to start in December 2026.
- **Risk 492 (score 20)** – *NICU go live delay.* **Theme: Reputational**
Update 21/08/26 1 ongoing action to re-establish Programme Board – target date – August 2026.
- **Risk 534 (score 16)** *Risk of transmission of waterborne pathogens in the healthcare environment* **Theme: Patient Safety**
Update 21/08/26 No action plan in place. The water is subject to regular flushing and testing as part of the process for Project Co and Mitie.
- **Risk 570 (score 15)** – *Risk of increased delays in accessing assessment and commencement of treatment resulting in harm to young people* **Theme: Capacity and demand**
Update 21/08/26 3 ongoing actions (review of budget, review of all job plans, align processes across CAMHS Liverpool and CAMHS Sefton due for completion in September 2026 – CAE document completed and returned to executives regarding the budget, partnership waiting list has been validated and team has been emailed regarding the partnership blast which we aim to start August, Sefton & Liverpool CAMHS reviewing processes and ensuring there are the same processes in place to ensure that services align and can meet the demands.

- **Risk 574 (score 15)** - *Credentials for CMM pharmacy application stored in plaintext and shared with multiple organisations which could impact patient data confidentiality, the integrity of the data or, in worst case result in the deletion of all data within the database*
Theme: External organisation – 1 ongoing action to meet with System C to plan resolution by 30 September 2026 - Pending meeting date to update credentials.

3.2 Risks within the Trust's control

The remaining risks are within the Trust's control to mitigate, albeit they represent different levels and types of challenge in addressing them (e.g. financial restraints, workforce challenges).

- **Risk 38 (score 20)** - *No neurophysiology consultant in post.* **Update 21/08/26** 2 ongoing actions relating to advertising Consultant Neurophysiologist posts by October 2026 - Outsourcing meeting is to be scheduled to discuss outsourcing options. Exec team have not approved the permanent contract required for our existing Consultant who supports on 5Pa fixed term contract. There has been an interested party for a joint post between AH and WCNN which will need to be advertised - preliminary discussions underway.
- **Risk 288 (score 15)** - *Lack of provision of timely safeguarding supervision require to support safe and effective safeguarding practice.* **Update 21/08/26** 2 ongoing actions (recruitment of band 7 safeguarding specialist nurses and safeguarding supervision business case – Timescale for implementation – September 2026. 2 WTE band 7 posts recruited to and awaiting start dates. Business case has been completed to include additional resource required as part of the Organisation Restructure/Change. This will be shared with the Chief Nursing, AHP and Experience Officer for review and to await outcome to determine next steps.
- **Risk 485 (score 15)** – *Potential for no laboratory haematology/transfusion service due to Increased workload pressures, inadequate staffing levels (training/sickness/vacancies).* **Update 21/08/26** 3 ongoing actions to complete organisational change to introduce on-call rota by August 2026 and extended reception cover by the end of September 2026 and organisational change to increase out-of-hours resilience.
- **Risk 491 (score 15)** – *Risk Stratification Process for whole of Neurodevelopmental service caseload.* **Update 21/08/26** Actions due September 2026 include review of ND service caseload and BI dashboard creation. Risk assessments are being completed for all active cases at the time of the appointment, and overtime is still ongoing for historic cases. However, delays in progression due to staff burnout - Review with Director of Nursing upon return from leave. Progress with BI dashboard delayed due to capacity.
- **Risk 520 (score 16)** – *Pharmacy Capacity.* **Update 21/08/26** 1 ongoing action to recruit staff as per exec paper – due September 2026 – Restrictions to the Pharmacy Inpatient Service remain and there is no real progress in terms of recruitment. Chief Pharmacist is working with the Trust Board to get a salary budget approved, no further recruitment can commence until this is approved. No further progress in relation to recruitment of the vacant held pharmacy technician posts as Clatterbridge Pharmacy Limited (CPL) will be recruiting to these roles via their own recruitment process. From 3rd August, the Pharmacy SLT have agreed with the Associate Chief Pharmacist for Clinical Services that new workstreams to be put in place to enable a clinical service to the surgical wards.
- **Risk 563 (score 16)** - *IBD patients will not be seen, treated or provided acute advice within expected timeframes and pathway* **Update 21/08/26** – 12 ongoing actions – Full action plan implementation by November 2026. Actions include development of a demand and capacity dataset for the IBD service, reinstate MDT meetings, consultant IBD clinics and urgent flare clinics. Work is progressing but lack of staff capacity is hindering progress. Total number of active IBD patients under the service - work started and progressing but lack of staff to support this is hindering progress. Meeting to be arranged to review risk and update progress on actions.

3.3 Risks with a clear action plan and timescale to reduce the risk score

The following risks appear to have a clear action plan which will reduce the risk score following implementation of the actions.

- **Risk 229 (score 16)** – *P-IMP end-of-life server which is no longer supported by the supplier.* **Update**

21/08/26 1 ongoing action to explore funding options – January 2027 timescale - Funding was reviewed and approved and now working through the financials.

- **Risk 238 (score 16) – *Clinical Coding*. Update 21/08/26** 1 ongoing action regarding monitoring of managed service resource and bank hours to be completed by September 2026 - 25 hours a week remain of managed service as to 31st August.
- **Risk 292 (score 15) – *Inappropriate sharing of demographics*. Update 21/08/26** Further actions to be implemented once meeting has taken place for training to align with PDS training. Still awaiting patient portal update – a few data quality queries need to be rectified.
- **Risk 368 (score 16) – *Digital Infrastructure Capacity and Age* – Update 21/08/26** 1 ongoing action to upgrade Avaya hardware and software by November 2026. Majority of VMs have been migrated across - efforts now will concentrate on the remaining 75+ VMs which are experiencing migration issues and will require manual intervention.
- **Risk 529 (score 20) – Update 21/08/26** 1 ongoing action to recruit for a Named Doctor for Safeguarding by 30 September 2026 - This role is currently out to advert on Trac jobs.

4. Recommendations

The Board of Directors is asked to note the content and level of assurance presented in the CRR report outlined in section 3 to aid Committee review.

Table 2

Alder Hey - Corporate Risk Register											
Community & Mental Health	Rare	Unlikely	Possible	Likely	Almost Certain	Almost Certain	Likely	Possible	Unlikely	Rare	Medicine
Negligible											Negligible
Minor											Minor
Moderate					2	2					Moderate
Major				7	1	0	5				Major
Catastrophic			4	0	0	0	1	1			Catastrophic
Catastrophic			4	0	0	0	0	0			Catastrophic
Major				4	1	0	0				Major
Moderate					0	0					Moderate
Minor											Minor
Negligible											Negligible
Corporate & Research	Rare	Unlikely	Possible	Likely	Almost Certain	Almost Certain	Likely	Possible	Unlikely	Rare	Surgery

Table 3: THEMES

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Compliance and Regulatory					Apr-26	May-26	Aug-26
271 Community & Mental Health 07/10/2024	Rainbow - Safeguarding	15 (3x5)	There is a risk that the Safeguarding Nursing Team will be unable to provide a service for children/young people and/or staff in the hospital and fulfil multi-agency safeguarding statutory responsibilities	Use of NHS Professionals to support the team until vacancies can be filled. Vacancies added to recruitment tracker for approval. Explore additional hours of existing team members and NHS Professionals to provide additional safeguarding training sessions on the weekends.	15	15	15
The Safeguarding Nursing Team continues to have two WTE Band 7 Safeguarding Specialist Nurse and 1 WTE Band 6 Associate Safeguarding Nurse vacancies. 1 WTE Band 7 who has been on maternity leave has now returned and is using annual leave to reduce their working week. Of the 2 WTEs Band 7 Safeguarding Specialist Nurses on long term sick leave, one has now returned on a phased return working 3 days. The remaining nurse is due to return w/c 03/08/2026. As per the last risk review the Safeguarding Nursing element of the service continues to be in Business Continuity and is not able to provide the full range of safeguarding services. This continues to impact on the senior nursing leadership team who have reduced capacity to respond to multi-agency statutory partnership working and case reviews. All vacancies have now been recruited to and pre-employment checks being completed. Start dates to be agreed. We continue to use NHS Professionals to cover Band 7 Safeguarding Specialist Nurse gaps where possible. We hope to be in a position to reduce this risk at the next review.							
341 Community & Mental Health 28/02/2025	Rainbow - Children In Care	16 (4x4)	Trust is not compliant with Intercollegiate Document: Looked After Children (Children in Care) December 2020	Associate Director for Safeguarding and Statutory Services and Named Nurse for Children in Care are supporting some aspects of the Named Doctor role.	16	16	16
No progress with regards to mutual aid from Cheshire & Merseyside Integrated Care Board Designated Doctors at Place. Named Doctor for Children in Care role interview took place on 22/07/2026 and pre-employment checks currently being completed. Anticipated the successful candidate will commence in post in September 2026.							
529 Community & Mental Health 02/02/2026	Rainbow - Safeguarding	20 (4x5)	The Trust is currently unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	Senior nursing leadership team in the Safeguarding Team manage cases in the absence of a Named Doctor.	20	20	20
This role is currently out to advert on Trac jobs. Director of Safeguarding and Statutory Services and Named Nurses for Safeguarding to continue to oversee and manage workload.							
539 Community & Mental Health 20/02/2026	Rainbow - Safeguarding	16 (4x4)	The Senior Safeguarding Team are unable to respond to increasing demand for contributions to statutory safeguarding multi-agency partnership working	Requests made to the Local Safeguarding Children Partnerships (LSCPs) to hold meetings virtually via MS Teams where possible to assist the Safeguarding Team to attend partnership meetings. The Safeguarding Team are prioritising partnership work in line with the service Business Continuity Plan.	15	15	16
Business Case has been updated to allow inclusion of all required additional resource following the commencement of Organisational Change. We continue to communicate with our Designated Professionals for Safeguarding at Place and Local Safeguarding Children Partnerships regarding availability and capacity. We continue to prioritise our attendance at multi-agency meetings as appropriate.							

Interviews have now taken place for 2 WTE Band 7 Safeguarding Specialist Nurses and 1 WTE Band 6 Associate Safeguarding Nurse. It is anticipated they will commence in post in November 2026. 2 WTE Safeguarding Specialist Nurses will return to work after long term sickness this month.

We have not formally notified Local Safeguarding Children Partnerships that we are unable to attend all partnership meetings as capacity is starting to recover.

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Compliance and Regulatory					Apr-26	May-26	Aug-26
556 Corporate Services 03/03/2026	IM&T	15 (3x5)	If remote VPN server is to become unavailable, through patching, cyber-attack or hardware failure, remote users would be unable to access systems and data needed to complete their work	Alerting of server downtime. Security logging.	15	15	15
New VPN solution is stood up, and the team are working with Cloud21 to finalise the configuration - a successful connection has been made so further testing will take place prior to deployment planning.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Technology – Cyber Security					Apr-26	May-26	Aug-26
559 Corporate Services 28/04/2026	IM&T	15 (3x5)	The VPN managing access to the Trust's building management system (BMS), ran by Mitie, is not managed by Alder Hey. We are unable to enforce policy and baseline requirements and can only request this from the provider of the VPN (Intercity Technologies)	Baseline configuration provided to vendor to request certain standards met and evidence of the standards required.		15	15
Baseline approved and to be shared with Mitie. Pending assurance VPN meets requirements.							
365 Corporate Services 21/05/2026	IM&T	15 (3x5)	Backups of corporate (Non-EPR) digital systems are stored in a single location, meaning physical damage to the data centre, due to fire, flood or other physical attack, would mean the loss of data critical to the running of the Trust	Mitie control access and environmental protection of room, protecting against fire and providing adequate cooling. Verify all systems backing up correctly.		15	15
Backups mostly migrated. Ensuring good backups taken and verifying retention policy working as intended/expected (risk is now closed).							
574 Corporate Services 09/06/2026	IM&T	15 (3x5)	Credentials for CMM pharmacy application stored in plaintext and shared with multiple organisations which could impact patient data confidentiality, the integrity of the data or, in worst case result in the deletion of all data within the database	Monitoring of access to machines with credentials and ensuring perimeter network controls working as intended. Limit credential sharing.			15
System C unable to encrypt at the moment keeping task open as risk not reduced.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Financial – Compliance					Apr-26	May-26	Aug-26
238 Corporate Services 03/07/2024	IM&T	16 (4x4)	Risk of financial income due to various issues relating to coding. Risk of clinical reporting	Regular tracking of overall coding backlog to monitor volumes of uncoded activity, particularly towards Freeze activity positions.	16	16	16
Extra resource to support backlog whilst holding 1.6 WTE vacancies and LTS has reduced, with previous 55 hours a week now at 25 hours a week. Backlog peaked at 4,608 in February-26 and currently 1,781 as of 10th August 2026 however currently 1 WTE LTS in August. Vacancies are now advertised externally. AI coding testing plan with independent assessor being explored.							
Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Commercial					Apr-26	May-26	Aug-26
492 Corporate Services 11/11/2025	Campus	20 (5x4)	NICU go live delay due to commercial agreement not being reached	Issue escalated to SPV Board and senior stakeholders. Internal governance oversight through Trust executive discussions and programme oversight meetings. Engagement with contractor (MS) to understand programme impacts and potential demobilisation risk. Legal and commercial advice being considered regarding contractual position and dispute options. Ongoing commercial discussions with SPV and Mitie regarding TVE progression.	16	20	20
Update provided to FTPC (Finance, Transformation and Performance Committee) and Trust Board. The Trust is currently in discussion with Project Co about a final remaining point of negotiation. It is hoped this can be resolved this week. Further updates will be shared with Board.							
Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Financial - Investment					Apr-26	May-26	Aug-26
368 Corporate Services 22/05/2025	IM&T	16 (4x4)	The Trust's digital infrastructure is due for renewal. This currently causes a number of issues in terms of support, capacity and reliability. The infrastructure is ageing which will result in hardware dropping out of support with its vendors, and also, increases the likelihood of failure	Prioritised servers so system criticality taken into account in event of data centre loss. Intercity to produce an 18-month plan for resolution but will require investment from the Trust. Work will shortly commence on producing a Business Case to support for both core switches and wireless. Work planned with Intercity to replace the telephony switchboard hardware and upgrade to the latest version. Databases backed up to Rubrik.	16	16	16
Majority of VMs have been migrated across - efforts now will concentrate on the remaining 75+ VMs which are experiencing migration issues and will require manual intervention.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Workforce - Sustainability					Apr-26	May-26	Aug-26
38 Medicine 06/07/2023	EEG	20 (5x4)	2 vacant Neurophysiology consultant posts from 24th July 2023. Job adverts received no applicants	Activated bedside ports to allow data review for acute work remotely. This improves efficiency and allows us to obtain a more timely report. Nerve conduction studies (NCS)/Electromyography (EMG): Private company (Mediservices Ltd) to provide on-site consultant every fortnight to perform all inpatient/ outpatient NCS/EMG. Electroencephalography (EEG) reporting (outpatients): Rota of two Neurophysiologists has been changed as we now only have 1 Neurophysiologist available. Non-accredited Neurophysiologist contract has not been renewed. The remaining Neurophysiologist continues to work remotely on 0.4WTE. The gap in reporting EEG activity including urgent work is now being outsourced to private companies at a extensive cost to the Trust. Home Video Telemetry (HVT): Both consultants are to report all HVT recordings remotely. Video telemetry are to be reported by our accredited Neurophysiologist.	20	20	20
Meeting is to be planned (date TBS) around scoping for outsourcing but in the meantime, we are losing the consultant who works for the existing outsourcing company as he is going to work for another company. In the meantime, i have sourced other consultants to support urgent EEG reports remotely. But we may have an issue with providing EMG clinics from September. Also, it was agreed to extend the 5PA fixed term contract until December 2026 but the decision to make this post permanent was not approved. Risk manager will put this on the tracker again and discuss with execs. Recruitment of 1WTE Neurophysiologist is still under discussion with little progress noted. There is one possible interested candidate for a shared position between AH and WCNN for which the risk manager will meet with General Manager to discuss. No incident, PALS or complaints with risk rating remaining at 20							
287 Medicine 18/11/2024	Radiology	16 (4x4)	Radiology consultant on-call is under increasing pressure and at the brink of failure. There will be a significant impact on the team and a number of crucial clinical services in the Trust if we are unable to continue in a safe manner	Introduction of locum cover - 1 ongoing slot for vacant IR post and an additional one recently introduced for the injured colleague. An email will be sent to all clinical teams reiterating that between 10pm and 7am, all urgent referrals for ultrasound, fluoroscopy and CT/MRI should be made on a consultant-to-consultant basis. Introduction of Amber week when required to reduce turnaround times but reducing some consultant activity (e.g. ultrasound) so that they can address unreported scans to bring outstanding numbers down.	16	16	16
No PALS/Complaints or Incidents since last review. Staffing levels should start to improve from next month when a newly appointed Consultant begins. Still with the risk of staff burnout and overspend due to locum covers.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Workforce - Sustainability					Apr-26	May-26	Aug-26
464 (Legacy Risk ID 2650) Medicine 26/08/2022	Haematology	16 (4x4)	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4	Lead for haemoglobinopathies and laboratory being covered by other haematology consultants. Additional waiting list initiative clinics put on to ensure elective work is completed in a safe and timely fashion. 1x substantive haematology consultant post advertised. Additional Specialty Doctor and 2 WTE Fellow recruited.	16	16	16
We have been given approval to appoint the 2 locum consultant successful candidates. One candidate will have a delayed start date till December due to current rental restrictions (lives in London). The other candidate is currently going through pre-employment checks, and we are hoping they will start in October. At this point we will be able to reduce the risk.							
480 Community & Mental Health 01/06/2022	ND Treatment Service	16 (4x4)	Delayed initiation and review of ADHD medication	Nurse Prescribers in place for ADHD Service. SOPs in place to support safe prescribing. ADHD medication care pathway for nurse led clinic on Meditech covers patients to the age of 18. Agreed SOP for transition of young people from Alder Hey to Mersey Care.	16	16	16
Medication shortages are still impacting the service. Communications have been sent to parent carers forums. Video is being developed with comms teams to explain the challenges of the shortages and how complex it is to change CYPs medication when one goes out of stock. ND treatment team job plans have been reviewed with increased number of MIC slots available, pilot of micro heart check clinic to commence in Sept to further increase capacity. Paper submitted to ICB for further funding required to meet increased demand.							
543 Community & Mental Health 31/03/2026	Community Division - Division Wide	16 (4x4)	Reduced workforce across the Division resulting in: - CYP not having timely access to assessment, treatment and ongoing care - Burnout of staff	Weekly divisional recruitment meetings held to review and monitor ongoing recruitment. Proactive staff engagement with Human Resources Team and OD Team to clarify issues and support staff. Individual team leaders / heads of service locally review and manage service requirements and to ensure as far as possible safe staffing is in place Ongoing monitoring of key issues and any concerns able to be escalated via Divisional Governance Meeting to Divisional Board / to SQAC (as needed) Monthly listening sessions scheduled and taking place. Feedback sent to Divisional System Director. Regular 1:1 meetings held with Leaders, Managers and Matrons. Listening Events take place when required.	16	16	16
Action closed and moved to a control. No impact on the current risk score.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Workforce - Sustainability					Apr-26	May-26	Aug-26
413 Medicine 22/07/2025	Haematology	16 (4x4)	There is a potential the service provision is reduced with an impact on service delivery due to increased sickness within the haematology specialist nursing service	Occupational Health and HR referrals. HR processes are being followed. 1-1s in place for the team. Monthly team meetings.	9	15	16
All staff returned from sickness. Planned sickness event for surgery in September. Looking at internal cover. Still awaiting feedback re. stage 3s.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Safety					Apr-26	May-26	Aug-26
455 Community & Mental Health 29/09/2021	Eating Disorder Service (EDYS)	15 (3x5)	Risk 455 - Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Legacy risk 2465)	BI Dashboard in place to support monitoring of waiting time. Triage meeting in place to review urgency of referrals. Waiting time data is being presented at the monthly CAMHS business meeting. Daily huddle in place with senior staff each weekday to review staffing levels that day and assessments booked in and plan how best to meet clinical commitments each day.	15	15	15
Risk score reviewed and no change to current score, exec panel feedback has meant delays in recruitment. Currently in a period of high levels of LTS.							
113 Community & Mental Health 01/12/2023	Community Speech & Language Therapy Service	16 (4x4)	Insufficient capacity of the dysphagia team (for all ages) and competence within the team to manage 0-6 months resulting in children needing to be referred to acute speech & language therapy rather than being managed in the community service	Cross locality working to manage triage and case discussion / support in place routinely. Liaison with the hospital-based team for supervision / re-route referrals.	12	12	16
Risk increased to 16 on 16/06/2026 following departures, resignation, sick leave of staff leaving no qualified dysphagia trained SLTs within the Liverpool locality. Actions taken - approach other departments for support; acute team unable to, ND Service based SLTs no longer competent / on LTS, other Trusts report similar difficulties in capacity / staffing / competence. Risk discussed in Divisional Risk Review Meeting on 07/08/2026 - score reduced to 12 due to staff member returning from sick leave. New starter due to take up post end of September 2026. Two therapists have completed the post graduate dysphagia course but not yet signed off. Funding in place for another staff member (one place) to complete the course in November. Additional two actions added.							

288 Community & Mental Health 21/11/2024	Rainbow - Safeguarding	15 (5x3)	CAMHS practitioners who hold specific and ongoing responsibility for safeguarding children may not receive timely and reactive safeguarding supervision and will not receive planned supervision they require to support safe and effective safeguarding practice	Communications have been sent to all CAMHS Practitioners to advise that planned supervision has been temporarily suspended, however reactive supervision is still available daily via the Safeguarding Duty Team. CAMHS Practitioners have been directed to seek immediate and reactive safeguarding supervision as required via the Safeguarding Duty Team which is available Monday - Friday between 8am-6pm. Safeguarding Named Nurses attend weekly CAMHS MDT, to support in identification of concerns and direct to most relevant source for supervision.	15	15	15
Risk reviewed, currently unable to provide 2 WTE Band 7 Safeguarding Specialist Nurses/Practitioner to CAMHS. There is currently 1 WTE Safeguarding Specialist Practitioner providing CAMHS staff with safeguarding supervision. We continue to manage Safeguarding Team resource in line with Business Continuity Plans. All 4 WTE Band 7 Safeguarding Specialist Nurses have now returned from sick leave and maternity leave however they are completing a phased return. The service currently has the following gaps: - 2 WTE Band 7 Safeguarding Specialist Nurse vacancy - Recruited to and awaiting start dates - 1 WTE Band 8a Named Nurse for Children in Care on Maternity Leave - advertised however no suitable candidates so back out to advert. MDT and planned supervisions continue to be managed via the Safeguarding Duty Team as capacity and demand allows. Named Nurses for Safeguarding continue to communicate with CAMHS Clinical Leads so they are sighted on the current plan for supervision. Reactive supervision continues to be requested and delivered via duty at this time. Business Case has been completed to include additional resource required as part of the Organisation Restructure/Change. This will be shared with the Chief Nursing, AHP and Experience Officer for review and we will await the outcome to determine next steps.							
229 Corporate Services 20/06/2024	IM&T	16 (4x4)	Alder Hey Pathology reports are sent electronically to primary care organisations. This process utilises an end-of-life server which is no longer supported by the supplier	Pathology IT team monitor the reporting systems daily to ensure they review any failed reports.	16	16	16
Funding was reviewed at the Capital Planning meeting and approved. We're now working through the financials.							
491 Community & Mental Health 06/11/2025	ND Assessment Service	15 (5x3)	Risk Stratification Process for whole of Neurodevelopmental service caseload - There is a neurodevelopmental assessment and treatment caseload of children and young people (CYP) with unknown and	Every new case will have a full review by clinicians reading the whole case. Completing a risk assessment document and safety plan and assigning a priority status using out ND management form to be routine, enhanced or urgent - this information is visible on Meditech. Any young person currently under CAMHS / EDYS / Crisis Care will have a risk assessment completed and visible on the EPR. Agreed Risk Stratification to identify any children / young people needing to be reviewed urgently agreed with the ICB and available on DMS.	15	15	15

			possibly unmet needs	Every child on the waiting list has been referred by a professional who retain a level of oversight and safeguarding for the child / YP. Referral process specifies that evidence that early support has been implemented to safeguarding children/young people and the family.			
Risk assessment and risk stratification process is still ongoing. Progress has been made and all new cases reviewed at triaged are clinically risk reviewed and stratified for urgency. This process also occurs following every clinical contact to ensure our data on risk is as up to date as possible. SQAC report in development which will detail exact percentage of cases currently risk assessed. Report will be attached once approved.							
461 Community & Mental Health 24/02/2021	CAMHS - Sefton	15 (3x5)	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18-week referral to treatment target for routine)	Low intensity treatments for patients on waiting lists. Weekly waiting time meetings. Crisis Care Team are available 24/7 to ensure urgent clinical need is met for patients waiting for specialist CAMHS. Breach processes in place to ensure contact with children affected by long waits. Offer all available trainee placement for clinical psychologists to increase staffing numbers. BI Reports monitoring waiting times in place.	9	15	15
Risk monitored at weekly wait times meeting, action plan has been to validate the partnership waiting list, this has been completed. Staff have been advised that there will be a partnership blast in September. We have staff who have returned from maternity leave in August and staff who had been on LTS have now returned which provides further capacity in September for partnership appointments. Meeting held 10 th August to discuss the plan for 4 week waits, meeting with admin to finalise process 12th August - once new process confirmed and shared with staff aim to begin in September.							
563 Medicine 14/05/2026	Gastroenterology	16 (4x4)	IBD patients will not be seen, treated or provided acute advice within expected timeframes and pathway	For the past 6 weeks - the service has been supported by an interim emergency plan which provided the opportunity to explore models of service to increase efficiency for implementing needed pathways for patients: Focused on streaming lining access to appropriate clinical advice for patients, patient queries being triaged by a Band 3 admin support. Safety netting provided for patients contacting service. Urgent telephone clinics for IBD patients were provided once patients in IBD inbox had been triaged.		15	15
Risk score remains at 16 because a full review of demand and capacity has not been fully established. Incidents and PALS/Complaints are being reported in relation to IBD service. The service still has a deficit in Nurse specialists, Clinicians (Clinicians are covering junior doctors), Registered doctors' numbers are down by 2. There is also reduced PCO support which impacts on the clinician time.							
570 Community & Mental Health 01/06/2026	CAMHS - ALL	15 (3x5)	Risk of increased delays in accessing assessment and commencement of treatment resulting in harm to young people	Overtime for choices has been agreed and is being provided. Young people on the routine waiting list receive Treatment, Risk Review (TRR) call and pended to waiting list. Breach calls are offered to all urgent young people. BI dashboards used to monitor waiting times also reviewed in performance meetings.			15
Risks continue to be monitored, young people receiving breach calls to review risks, overtime for choices has been utilised and some staff have returned from maternity leave and sick in August which will give us more capacity in September - action plan for partnership blast in September, staff have been informed.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Safety					Apr-26	May-26	Aug-26
520 Medicine 16/12/2025	Pharmacy Clinical Services	16 (4x4)	Pharmacy capacity is severely hampered at the present time. This creates increased risk of errors	Discharge Service - Dedicated team process TTOs for 3A, 4A, 4C, 1C to prevent delayed discharges - Monday to Friday. Rota oversight by Senior Team ensures available staff are allocated to critical care and priority areas. Vacancy panel requests for pharmacists and MARS scheme skill mix review.	16	16	16

			causing serious harm to patients, reputational damage and challenges to reaching targets for cost-improvement and prescription turnaround times	Escalation of risk associated with outsourcing outpatient pharmacy to Board. Management of long-term and short-term sickness.			
Surgical ward service has now resumed however no cover to 4C. Risk to remain until further news on 4C closure expected September.							
399 Community & Mental Health 08/07/2025	Tier 4 Inpatient Unit	16 (4x4)	Inability to meet NHS England contractual obligation of having 10 accessible beds. Inability to admit young people due to reduced capacity	Currently completing full daily door audits. Remediation work completed by external contractor (resulting in the 6 doors operating without failure	20	16	16
Intermittent door audits continue. Remedial works holding. Door replacement to be commenced mid-August - one door per day as initial target. No changes to risk scoring.							
485 (Legacy Risk ID 2419) Medicine 06/07/2021	Pathology	15 (5x3)	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres and ECMO	Close working established with Cardiac surgery team, ECMO and PICU, and Liverpool Women's (neonatal unit). 2 x Band 7 staff filling 1 rota place to help ensure service continuity. 1 x Band 5 BMS is being trained in blood transfusions and will undertake out of hours shifts in the presence of the Acting Haematology Manager later in October. 1 x Band 6 BMS has just started and is being fast tracked through competency assessments in haematology. Fortnightly meeting with HR support and divisional management.	20	15	15
One BMS has left the trust, and we have had some competency issues with new members of the team. Organisational change to introduce on call has stalled due to changes in the number of trained staff.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Safety					Apr-26	May-26	Aug-26
292 Corporate Services 04/12/2024	IM&T	15 (5x3)	Inappropriate sharing of demographics	Process in place for adding Safeguarding flags to records e.g. confirming who information should be shared with. Safeguarding Policies and Procedures in place. Information Governance Policies and Procedures in place. Mandatory Safeguarding Training. Mandatory Information Governance Training.	15	15	15
Awaiting patient portal transfer, data quality issue to resolve prior to move.							
458 (Legacy Risk ID 2455) Community & Mental Health 16/09/2021	Developmental Paediatrics	16 (4x4)	Disruption in patient's supply of medication and / or treatment	Prescription rota in place. Online form in place to allow timely requesting of prescriptions by parents/carers - promoted at parent information session and in clinic letters. Also reinforced with a letter that goes out with the prescription. Additional capacity can be provided by Registrars to do prescriptions if required. BI Report in place to monitor prescription requests and turnaround time for medication. Cleo system introduced which allows for electronic transfer of completed prescriptions, reducing delay in prescriptions being accessed by families.	16	16	16
Risk discussed in risk review meeting - risk manager amended - conversation to be had regarding current target turnaround time and review of risk score.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Safety					Aor-26	May-26	Aug-26
462 (Legacy Risk ID 2431) Community & Mental Health 23/07/2021	ND Assessment Service	16 (4x4)	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard)	Clinical review of waiting list completed monthly and appointments allocated to longest waiters first. Regular performance reports provided to ICB to monitor compliance with standard. SOPs in place to standardise assessment. Risk assessment tools being completed for all complex cases to stratify the wait list and ensure cases that are urgent are seen first.	16	16	16

Risk reviewed and remains high with a growing number of cases over 100 weeks, this is due to sustained increase in referrals with massively out weight the commissioned capacity. The team are concluding 50 % over commissioned capacity each week, and further efficiency work is being completed to create standardised, fixed job plans. These job plans do not have the capacity available to meet the demand and new investment is required. Case submitted to ICB and an expression of interest form to receive a percentage of available funding will be completed by August 21st.							
534 Corporate Services 13/02/2026	Estates	16 (4x4)	Risk of transmission of waterborne pathogens in the healthcare environment	Point-of-use filtration for augmented care areas. Water Safety Plan. Testing of the outlet when a patient is known to be colonised with pseudomonas. Typing sent to UKHSA reference lab.	16	16	16
Action plan received from P Co 18.06.26 and we are now in the standstill period.							

Table 4: NEW HIGH RISKS

Risk ID	Risk Description	Date Opened	Risk Score	Risk Category	Reason / Comment
Medicine					
563	IBD patients will not be seen, treated or provided acute advice within expected timeframes and pathway	14/05/2026	16	Quality - Safety	Risk approved on 04/06/2026.
Further discussion has taken place within the team (12/06/2026) resulted in feelings that the current score of 12 did not give an accurate picture of the current situation. There are controls in place and the scoring needs to demonstrate this so initial score increased to 20, and current score adjusted to 16.					
Community & Mental Health					
570	Risk of increased delays in accessing assessment and commencement of treatment resulting in harm to young people	01/06/2026	15	Quality - Safety	Risk approved on 26/06/2026.
Risk reviewed in Divisional Risk Review meeting on 26/06/2026 - risk description, cause and consequence amended, and risk scores updated following review of controls.					
Corporate Services					
365	Backups of corporate (Non-EPR) digital systems are stored in a single location, meaning physical damage to the data centre, due to fire, flood or other physical attack, would mean the loss of data critical to the running of the Trust	21/05/2026	15	Technology – Cyber Security	Risk increased from 12 to 16 in June 2026.
Risk score increased in June 2026 as backup risk highlighted as part of DSPT assessment. Still unable to progress at that time due to datacentre migration delays. Therefore, the risk was updated to reflect increased time on platform with reduced resilience.					
The risk was closed on 04/08/2026 as backups mostly migrated and the team is ensuring good backups taken and verifying the retention policy is working as intended/expected.					
574	Credentials for CMM pharmacy application stored in plaintext and shared with multiple organisations which could impact patient data confidentiality, the integrity of the data or, in worst case result in the deletion of all data within the database	09/06/2026	15	Technology – Cyber Security	Risk approved on 19/06/2026.
Risk approved at 15 on 19/06/2026. All mitigations for this risk are not within the Trust's control, and external factors are influencing the risk. A longer-term fix has been requested to storing in securely but advised by external organisation this is not on the road map. Risk remains until credentials stored securely.					

Table 5: CLOSED HIGH RISKS

Risk ID	Risk Description	Date Closed	Risk Score	Risk Category	Reason / Comment
Corporate Services					
409	Staff ill health higher than the Trust absence target of 5% (2024/25). Inability to provide safe staffing levels due to absence (legacy risk ID 2077)	02/07/2026	16	Workforce - Sustainability	Discussion with Deputy Chief People Officer held at HR Risk and Governance Meeting 30/04/2026. Agreed that this risk can be closed as this is covered by BAF risk 2.1.
Medicine					
293	Staffing in Biochemistry. POC devices can be used for urgent electrolyte testing. Clinical scientist on-call can support with advice around other testing requirements and off-site referral if needed	15/06/2026	4	Quality - Safety	Biochemistry manager is comfortable that this risk has been sufficiently mitigated following approval of new band 6 role.

Table 6: RISKS WITH DECREASED SCORES

Risk ID	Risk Description	Score	Reason for Decrease
Medicine			
557	There is a risk that the trust will not be able to provide trauma CT scans if contrast agent is not available	5 DECREASED from 15	Further actions completed and controls added. Risk score reduced to 5. Plan now is to agree closure of the risk at the next Radiology Governance meeting. No PALS complaints or incidents since the last review. Assurance in place that Manufacturer is now in increased production.
27	The Metabolic Disease service is fragile and could fail to deliver the appropriate standard of care needed by our patient cohort	10 DECREASED from 15	Risk score has been lowered to 10. No PALS, incidents or complaints since the last review. Additional control has been added due to the recruitment and start of our new General Paediatric Consultant. Recruitment of General Paediatrician with Metabolic specialist interest. Our new consultant has started with the team on the 15th June 2026 and is currently working with the team in depth. The team are also due to attend the North West Metabolic Away Day in Manchester to discuss the future of the service. This will be followed by an Alder Hey Metabolic away day with our Manchester colleagues to ensure a continuity of service and excellent care. The risk will be taken to the next Metabolic team meeting and the next available Governance meeting to confirm that the risk score has been lowered.
Community & Mental Health			
545	There is risk that service quality and performance will be impacted due to current staffing gaps (6.43 WTE vacancies) within the Booking and Scheduling Workforce	12 DECREASED from 16	Fixed term staff have now been made permanent, offering some stability. Plan in place for staff to be redeployed into the team August/September, however, some staff currently on LTS and being managed and supported.

Table 7: RISKS WITH INCREASED SCORES

Risk ID	Risk Description	Risk Score	Reason for Increase
Community & Mental Health			
539	The Senior Safeguarding Team are unable to respond to increasing demand for contributions to statutory safeguarding multi-agency partnership working	15 INCREASED to 16	Risk already high - increased from 15 to 16 on 03/08/2026. Rationale not recorded.
113	Insufficient capacity of the dysphagia team (for all ages) and competence within the team to manage 0-6 months resulting in children needing to be referred to acute speech & language therapy rather than being managed in the community service	12 INCREASED to 16	Risk increased to 16 on 16/06/2026 following departures, resignation, sick leave of staff leaving no qualified dysphagia trained SLTs within the Liverpool locality. Note* Risk score reduced to 12 on 07/08/2026 due to staff member returning from sick leave.
Medicine			
413	There is a potential the service provision is reduced with an impact on service delivery due to increased sickness within the haematology specialist nursing service	15 INCREASED to 16	Risk already high - Current risk score changed to 16 on 08/06/2026 to align to initial score calculation.

Table 8: LONG-STANDING HIGH RISKS (greater than 12 months since identification as a high risk)

Risk	Risk Owner	Risk Score	Risk Description	Date Identified	Progress Update
Community & Mental Health					
462 (Legacy Risk ID 2431)	Lisa Cooper	16	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard)	Jul-21	Risk reviewed and remains high with a growing number of cases over 100 weeks, this is due to sustained increase in referrals with massively out weight the commissioned capacity. The team are concluding 50 % over commissioned capacity each week, and further efficiency work is being completed to create standardised, fixed job plans. These job plans do not have the capacity available to meet the demand and new investment is required. Case submitted to ICB and an expression of interest form to receive a percentage of available funding will be completed by August 21st. Theme: Capacity and demand
458 (Legacy Risk ID 2455)	Lisa Cooper	16	Disruption in patient's supply of medication and / or treatment	Sep-21	Risk discussed in risk review meeting - risk manager amended - conversation to be had regarding current target turnaround time and review of risk score. Theme: National drug shortage outside of organisational control
288	Lisa Cooper	15	CAMHS practitioners who hold specific and ongoing responsibility for safeguarding children may not receive timely and reactive safeguarding supervision and will not receive planned supervision they require to support safe and effective safeguarding practice	Nov-24	Risk reviewed, currently unable to provide 2 WTE Band 7 Safeguarding Specialist Nurses/Practitioner to CAMHS. There is currently 1 WTE Safeguarding Specialist Practitioner providing CAMHS staff with safeguarding supervision. We continue to manage Safeguarding Team resource in line with Business Continuity Plans. All 4 WTE Band 7 Safeguarding Specialist Nurses have now returned from sick leave and maternity leave however they are completing a phased return. The service currently has the following gaps: - 2 WTE Band 7 Safeguarding Specialist Nurse vacancy - Recruited to and awaiting start dates - 1 WTE Band 8a Named Nurse for Children in Care on Maternity Leave - advertised however no suitable candidates so back out to advert. MDT and planned supervisions continue to be managed via the Safeguarding Duty Team as capacity and demand allows. Named Nurses for Safeguarding continue to communicate with CAMHS Clinical Leads so they are sighted on the current plan for supervision. Reactive supervision continues to be requested and delivered via duty at this time. Business Case has been completed to include additional resource required as part of the Organisation Restructure/Change. This will be shared with the Chief Nursing, AHP and Experience Officer for review on 10/08/2026 and we will await the outcome to determine next steps. Theme: Quality - Safety
341	Lisa Cooper	16	Trust is not compliant with Intercollegiate Document: Looked After Children (Children in Care) December 2020	Apr-25	No progress with regards to mutual aid from Cheshire & Merseyside Integrated Care Board Designated Doctors at Place. Named Doctor for Children in Care role interview took place on 22/07/2026 and pre-employment checks currently being completed. Anticipated the successful candidate will commence in post in September 2026. Theme: Compliance and regulatory
Medicine					
464 (Legacy Risk ID 2650)	Urmi Das	16	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and	Aug-22	We have been given approval to appoint the 2 locum consultant successful candidates. One candidate will have a delayed start date till December due to current rental restrictions (lives in London). The other candidate is currently going through pre-employment checks, and we are hoping they will start in October. At this point we will be able to reduce the risk.

			malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4		Theme: National workforce shortage
485 (Legacy Risk ID 2419)	Adam Bateman	15	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	Jul-21	One BMS has left the trust, and we have had some competency issues with new members of the team. Organisational change to introduce on call has stalled due to changes in the number of trained staff. Theme: Workforce shortage
Corporate Services					
229	Ian Gilbertson	16	Alder Hey Pathology reports are sent electronically to primary care organisations. This process utilises an end-of-life server which is no longer supported by the supplier	Jun-24	Funding was reviewed at the Capital Planning meeting and approved. We're now working through the financials. Theme: Quality - Safety
292	Ian Gilbertson	15	Inappropriate sharing of demographics	Dec-24	Awaiting patient portal transfer, data quality issue to resolve prior to move Theme: Quality – Safety
368	Andy Green	16	The Trust's digital infrastructure is due for renewal. This currently causes a number of issues in terms of support, capacity and reliability. The infrastructure is ageing which will result in hardware dropping out of support with its vendors, and also, increases the likelihood of failure	May-25	Majority of VMs have been migrated across - efforts now will concentrate on the remaining 75+ VMs which are experiencing migration issues and will require manual intervention. Theme: Financial – Investment