BOARD OF DIRECTORS PUBLIC MEETING
Thursday 2nd July 2026, commencing at 11:40am
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 (11:40-12:00)							
Lunch (12:00pm-12:30pm)							
1.	**26/27/117**	**12:30 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**26/27/118**	**12:31 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**26/27/119**	**12:32 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **4th June 2026.**	**D**	Read enclosure
4.	**26/27/120**	**12:34 (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.	**26/27/121**	**12:35 (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. To receive an update on the current position.	**N** **N**	Verbal Verbal
Strategic Update							
6.	**26/27/122**	**12:45 (10 mins)**	**Charity Strategy Update.**	F. Ashcroft	To receive an update on the current position.	**N**	Presentation
7.	**26/27/123**	**12:55 (15 mins)**	**Vision 2030:** • **HWWWITF update.** • **AFT update.**	A Bateman/ M. Swindell J. Grinnell	To receive an update on progress.	**A** **N**	Read report Verbal

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Performance Against Annual Plan							
8.	**26/27/124**	**13:10 (35 mins)**	**Evidence of Our Performance:** • **Flash Report.** • **Integrated Performance Report for M2, 2026/27:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman A. Bateman N. Askew A. Bateman A. Bateman M. Swindell D. Jones E. Kirkpatrick Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read report
Unrivalled Experience							
9.	**26/27/125**	**13:45 (10 mins)**	**Mortality Report, Q4.**	J. Grice	To receive the Mortality Report for Q4.	**A**	Read report
10.	**26/27/126**	**13:55 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 24.6.26.** - **Approved minutes from the meeting held on the 20.5.26.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 20.5.26.	**A**	Read enclosures
Collaborating in Communities							
11.	**26/27/127**	**14:00 (10 mins)**	**Collaborate for Children and Young People: Partnerships Update.**	D. Jones	To receive an update on the current position.	**A**	Presentation
Pioneering Breakthroughs							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
12.	**26/27/128**	**14:10 (5 mins)**	**Growth and Opportunities Committee:** • **Chair's verbal update from the meeting held on the 25.6.26.** • **Approved minutes from the meeting held on the 30.4.26.**	M. Jennings	To escalate any key risks, receive updates and note the approved minutes from the 30.4.26.	**A**	Read enclosure
Supporting our People							
13.	**26/27/129**	**14:15 (10 mins)**	**Annual Submission to NHSE NW: Framework for Quality Assurance and Improvement, 2025/26.**	H. Blackburn	To receive an update on the current position.	**A/R**	Read report
14.	**26/27/130**	**14:25 (10 mins)**	**Strategic People Update; including:** • **Lord Mann Review.**	M. Swindell M. Swindell	To receive an update on the current position. To approve the action plan.	**A**	Read reports
15.	**26/27/131**	**14:35 (5 mins)**	**People Committee:** • **Chair's verbal update from the meeting held on the 29.6.26.** • **Approved minutes from the meeting held on the 13.5.26.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 13.5.26.	**A**	Read enclosure
Strong Foundations (Board Assurance)							
16.	**26/27/132**	**14:40 (5 mins)**	**Audit and Risk Committee:** • **Chair's Highlight Report from the meeting held on the 18.6.26.** • **Approved minutes from the meeting held on the 16.4.26.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 16.4.26.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
17.	**26/27/133**	**14:45 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held on the 30.6.26.** - **Approved minutes from the meeting held on the 3.6.26.** - **2026/27 Priority Areas.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 3.6.26.	**A**	Read enclosures
18.	**26/27/134**	**14:50 (5 mins)**	**Board of Directors – Annual Fit and Proper Persons Checks.**	E. Saunders	To provide assurance that annual checks have been undertaken for each Board Director to confirm their continuing compliance with the 'Fit and Proper Persons' requirements.	**N**	Read report
19.	**26/27/135**	**14:55 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read reports
20.	**26/27/136**	**15:00 (4 mins)**	**Any Other Business:** • **Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry.**	All	To discuss any further business before the close of the meeting. To approve the Board Assurance Statement.	**N** **D**	Verbal Read enclosures
21.	**26/27/137**	**15:04 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 3rd September 2026, LT1, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in June 2026: 437: Deed of Variation – Bevan Britan 438: Deeds for the Blue Light Road – Project Co. 439: Deed of Variation Laidrah 1 and 2 re land. 440: Alder Hey PFI Project

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M2, 2026/27	E. Kirkpatrick
Communications Report, Q1	R. Murphy
AFT Programme: Policy Framework	J. Grinnell

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 4th June 2026 at 9:35am**
In Lecture Theatre 1, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer/Deputy CEO	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Ms. S. Almond	Consultant Paediatric Surgeon	(SA)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	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 26/27/84	Ms. M. Ashe	Policy Advisor to the CEO	(MA)
Item 26/27/98	Mr. J. Fitzpatrick	Deputy Freedom to Speak Up Guardian	(JF)
Item 26/27/98	Mrs. K. Turner	Freedom to Speak Up Guardian	(KT)
Observing:	Mr. S. Reyne	Engagement Practitioner/LGBTQIA+ Staff Network Chair	(SR)
Apologies	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. U. Das	Director of Medicine	(UD)
	Ms. C. Lee	ACOO, Division of Surgery	(CL)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Director of Development	(DP)

Patient Story

The Chair welcomed Ellen Swan (*Consultant Speech and Language Therapist and Manager Specialist Speech and Language Therapy Network for Deaf People*) and Lois Hatfield (*Highly Specialist Speech and Language Therapist (Deafness)* who were invited to attend June's Board to share Rachel's story and to show the significant impact of their involvement.

Ellen and Lois are part of the Specialist Speech and Language Therapy Network for Deaf People (SSaLTNDP). They are commissioned to work with deaf children and adults across Cheshire and Merseyside (C&M). They worked with Rachel, a newly retired woman, with severe profound deafness from childhood. There had been a change in her circumstances, in that her mother, for whom she cared, had passed away. Following this, she had become more socially isolated and this had resulted in confidence issues.

Rachel had experienced limited access to appropriate support during childhood, resulting in long-term challenges with communication, social isolation and confidence. A presentation was shared that demonstrated the significant impact that specialist intervention had on Rachel's life, including improvements in confidence, independence and social engagement, as well as positive effects on family relationships.

Key learning points highlighted the importance of early intervention, noting that timely access to specialist support can significantly improve long-term outcomes for children and young people (CYP). The presentation also emphasised the value of focusing on functional communication goals, environmental adjustments and wider support**,** rather than solely clinical interventions.

A moving video testimonial from the patient's sister was shared with the Board, describing her and Rachel's experiences of deafness and communication, as well as their reflections on the team's intervention.

The Chair thanked Ellen and Lois for sharing Rachel's story highlighting that the work undertaken with CYP has the potential to fundamentally shape outcomes across the life course. The contrast between earlier missed opportunities and later intervention was recognised as a compelling reminder of the value of timely, specialist support.

26/27/77 Welcome and Apologies

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

26/27/78 Declarations of Interest

The following declarations were made:

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

26/27/79 Minutes of the previous meeting held on 7th May 2026.
Resolved:
The minutes from the meeting held on the 7.5.26 were agreed as an accurate record of the meeting.

26/27/80 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 26/27/58.1: *National Oversight Framework Update, Q3 (Explore a process for feeding back on improved figures rather than metrics remaining red all year. Raise this issue with the National Oversight Group, especially in terms of infection metrics)* – This action has been addressed. **ACTION CLOSED**

26/27/81 Chair's and CEO's Update

The Chair reported on engagement with volunteers during Volunteers' Week. A range of celebratory activities took place, including social events and recognition initiatives. The Board was advised, however, that the ongoing organisational Change Programme has created some uncertainty regarding the role of volunteers. In particular, there were emerging concerns that volunteer activity may be perceived as impacting on paid roles. The Chair noted that there is a need for further reassurance and clarity to ensure volunteers remain fully integrated and appropriately valued within services.

Attention was also drawn to the insights gained through engagement with volunteers regarding patient experience and operational challenges. Issues such as the limited availability of wheelchairs were raised, with families sometimes reluctant to return equipment due to concerns about access. In addition, volunteers had provided a broader perspective on the needs of children and families, including instances of unmet basic needs, which the Chair described as concerning. These observations were noted as important intelligence in understanding the lived experience of patients and informing service improvements.

The Chair informed the Board of her visit with the CYP Forum and advised of the increasing confidence of members, as demonstrated through their involvement in a wide range of activities. It was confirmed that representatives of the forum have been invited to attend Trust Board on an annual basis.

26/27/81.1 Action: KMC

Congratulations were offered to the Chief Digital and Transformation Officer, Kate Warriner, on being recognised as one of the top 50 digital leaders in the NHS.

Reference was made to the Board development session held on 3.6.26 with NHS Elect. The session provided an opportunity to reflect on how the Board works together and the priorities needed to support the organisation moving forward. It was agreed that further time for reflection would be valuable, alongside face-to-face discussion and cross-Board deep dives into more complex issues. The session also prompted questions on governance, the role of sub-committees and how they can become more strategic and forward looking, as well as how the Board operates within the changing external environment. The importance of reinforcing the Trust's mission for CYP, supporting deputies, and strengthening communications and engagement internally and externally was also highlighted. The session was considered highly productive.

John Grinnell briefed the Board on the national provider CEO's meeting with the new Secretary of State and Social Care, James Murray. During the meeting the Secretary of State emphasised continuity with the existing strategy and confirmed his commitment to the NHS 10-year Plan, including the work already undertaken and the priorities ahead. Key areas of focus for the Secretary of State include the modernisation of the NHS, the use of data and data sharing to support the evolution of NHS services, the Health Bill and the development of a single patient record. The Secretary of State has also been meeting with resident doctors and whilst progress towards resolution is being made, the situation remains uncertain and continues to require active organisational planning and mitigation.

Application for Advanced Foundation Trust Status

The Trust has received formal notification that its application for AFT status has been successful and is effective from the 1.6.26. The six new AFT's are awaiting guidance from NHSE and discussions are planned to understand the approach being taken by other successful organisations. Time will be set aside over the coming weeks to define what AFT status could mean for Alder Hey, with initial reflections to be discussed during July's Trust Board. A meeting with the ICB has been scheduled for w/c 8.6.26, and stakeholder engagement has already taken place, including discussions with the NHS Confederation. It was emphasised that AFT status is an opportunity to enable Alder Hey to do things differently for CYP. The Board recognised this as a significant milestone with long-term implications for the organisation.

26/27/81.2 Action: JG

Attention was drawn to the positive changes in deprivation data across Merseyside and the implications for Vision 2030 were queried especially as deprivation is a key focus for the Trust's Vision 2030 Strategy. It was reported that while improvements are evident, at a macro level child deprivation remains a significant issue and requires a continued focus. Further work is required on early years investment and a deeper understanding of the data is important in shaping future priorities

A concern was also raised regarding the wider national context in relation to racism, including the potential impact of a forthcoming local by-election and the political narrative that may develop around this. It was felt that the Trust should consider its response to potential scenarios affecting access to services and staff experience of racism.

The Board discussed the importance of Alder Hey positioning itself nationally and internationally, recognising its status as one of the world's leading children's hospitals. It was noted that AFT status provides an opportunity to strengthen the Trust's external profile and consider links with comparable national and international organisations operating with similar freedoms. The Board agreed that a more systematic approach will be required to support this engagement and ensure the Trust maximises the opportunities associated with AFT status.

It was felt that the Trust should take time to celebrate achieving AFT status, recognising it is an external endorsement of Alder Hey's hard work and the contributions it makes year on year.

The Chair emphasised the importance of ensuring communications for staff are undertaken in a way that engages colleagues and clearly explains what AFT status means for Alder Hey, including its implications and opportunities.

Southport Public Inquiry (Phase 2)

The Trust submitted its application to the Inquiry ahead of the 15th of May deadline and is awaiting an outcome. The Board was advised that a number of organisations are engaged in the process and, as such, timelines for responses may be extended. Hill Dickinson will seek clarity on the status of the submission and the anticipated timescale. In the meantime, an interim report has been submitted in response to recommendation 53 arising from the Public Inquiry.

Resolved:
The Board noted the updates.

26/27/82 CYP System Update

The Board received an update on developments across the CYP system. It was reported that the Integrated Care Board (ICB) remains in a period of transition, with significant changes to its senior leadership structure. Whilst this has resulted in some disruption and uncertainty, it was confirmed that CYP is clearly represented

within the new arrangements, with identified clinical and executive leadership roles providing assurance that CYP remain a system priority.

The Board was informed that the Trust remains well connected across system partners and continues to play an active role in shaping developments. It was noted that there is an opportunity for the organisation to act as a system leader and convenor for CYP services, with increasing influence over how services are designed and delivered across C&M. Work is progressing across system priorities, including urgent and emergency care and wider service integration, alongside a growing programme of digital developments aligned to national priorities.

It was reported that engagement with primary care is progressing via the tripartite partnership, with the three major trusts undertaking discussions with primary care colleagues. A number of meetings have already taken place, with further sessions scheduled w/c 8.6.26. From a PLACE perspective, it was noted that changes within the ICB are expected to cause some disruption.

Global - The Board was informed that the Trust is expecting international visitors from Vietnam, Peru Cancer Centre and Toronto SickKids.

Non-Executive Director, Geral Meehan (GM), informed that Board that Ofsted have recently undertaken an inspection of Liverpool City Council's services for CYP, with the final report scheduled for publication on the 7.7.26. The forthcoming publication represents an important development for the local system with potential implications for partnership working, service quality and safeguarding arrangements across Liverpool. GM felt that the Trust should be sighted on the outcome to consider any relevant findings in the context of its ongoing engagement with system partners.

The Chair highlighted the importance of communicating with staff to keep them informed of the positive work that is underway both internally and externally.

Resolved:
The Board noted the CYP system update.

26/27/83 Health Bill Briefing Note

The Board received a briefing on the proposed Health Bill (2026) which highlighted key reforms, strategic implications, principal risks, and recommended Board actions.

A key area of focus for the Board is the proposed abolition of Councils of Governors**,** which was recognised as a significant legislative change for foundation trusts. It was acknowledged that, whilst the final shape of the legislation is still subject to change, the Trust will need to prepare for a revised model**.** In this context, the Board emphasised the importance of working closely with the Council of Governors to support understanding of the changes and to shape future

arrangements that maintain a strong voice for patients, families and the wider community.

It was noted that the Trust intends to maintain a fully constituted Council of Governors in the interim, ensuring that current statutory responsibilities continue to be discharged while the legislation progresses.

Discussion highlighted broader implications of the Bill, including opportunities for system working and data sharing**,** including the development of a single patient record. In addition, the proposed abolition of Healthwatch was noted, with members raising concerns about how the public voice will be captured and represented in the absence of existing structures. It was agreed that the Board would carefully consider how Alder Hey engages with its stakeholders going forward.

Resolved:
The Board noted the briefing on the 2026 Health Bill.

26/27/84 Clinical Strategy 2026-2030

The Board received the Clinical Strategy 2026–2030 for approval, noting that it sets out the Trust's approach to delivering and transforming clinical services over the next four years. The strategy recognises the challenges the Trust faces, and how they will be navigated, and has been built from the ground up and guided by the expertise of the organisation's clinical workforce, the voice of CYP, and with the support and collaboration of key stakeholders. It was confirmed that the strategy has been approved by the Safety and Quality Assurance Committee (SQAC).

The Board discussed the need to strengthen the strategy's focus on health inequalities**,** emphasising the importance of clearly articulating the Trust's role as an anchor institution and how it will directly address inequalities through its services. Board members highlighted the need to ensure that health inequalities are fully embedded within clinical pathways, including consideration of poverty-proofing services and reducing variation in access and outcomes.

The Board also emphasised the importance of ensuring the strategy is translated into practical delivery and understood by staff and stakeholders**.** There was support for developing a more accessible versions of the strategy, including a child-friendly version and simplified materials for staff, to support engagement and implementation across the organisation.

It was further noted that the strategy should be closely aligned with key programmes to ensure a coherent and integrated approach. The Board highlighted the importance of linking the strategy to measurable outcomes and demonstrating how progress will be tracked and evidenced over time.

The Chair highlighted the importance of strengthening the report to ensure the Clinical Strategy is translated into clear and accessible key messages for staff across the Trust. It was noted that the Trust's data should be used more effectively to inform how the organisation addresses the issues identified, including health inequalities and variation in outcomes. It was agreed that the actions identified through the discussion should be taken forward and a final version of the strategy be shared with the Board for approval.

26/27/84.1 Action: MA

Resolved:
The Board received and noted the Clinical Strategy 2026-30.

26/27/85 Vision 2030 Update

Transformation Programme

The Board received an update on progress with the delivery of the Transformation Programme. This included developments in outpatients, strategic work, scoping of the neighbourhood programme, and progress with POIZ and the data environment. It was noted that a single plan on a page has been developed for the five transformation programmes, supported by clear milestones and a scorecard that will be incorporated in the Integrated Performance Report from July onwards. Work is also taking place to balance the scale of change, strengthen communications, and reflect further on the Trust's approach to co-design with teams.

It was reported that work is underway to develop a workforce heatmap as a key tool to strengthen planning, risk management and staff experience. Planning is also taking place as the Trust transitions into Phase 2 of How We Will Work in the Future.

HWWWITF

The Board received an update on How We Will Work in the Future operating model. It was pointed out that the programme was intended to support improved organisation and reduce running costs, with £2.6m identified in association with the programme. Transition has commenced, although some elements, including recruitment to the deputy Chief Medical Officer role and finalisation of roles and appointments will continue through to September. Reflection is underway on the scale and pace of organisational change, including how colleagues have been communicated with and involved in designing the new structure, with learning to be taken from this process.

The Board recognised the significant effort being made by colleagues and the emotional impact of the Change Programme on staff. As the majority of organisational change moves towards completion, it was noted that there will be an opportunity to take stock, ensure appropriate support is in place, and help leaders and teams embed successfully into new roles and ways of working. Board members emphasised the importance of reducing uncertainty for staff as quickly as possible, ensuring that teams not subject to further change are clearly informed of this. It was noted that visible leadership, repeated reassurance and clear messaging is essential in supporting colleagues through the next phase of implementation.

Digital, Data and Technology Update

The Board was provided with an update on progress on Digital, Data and Artificial Intelligence (AI). The following points were highlighted:

- The patient portal has gone live, with approximately 45,000 families registered. While some initial implementation issues had been identified, work is underway to consider the next stage of development, including opportunities linked to new outpatient models, etc.

- The first Non-Executive Director (NED) led cyber group has taken place, with reporting arrangements via the Finance, Transformation and Performance Committee (FTPC). The group has reviewed the relevant Board Assurance Framework (BAF) risk, and work is underway to separate and further develop the risk to strengthen oversight and assurance.
- Progress is being made with Advanced Voice Technology (AVT), with 87% of outpatient letters now being generated using this approach.

The Chair sought assurance on the checks and balances in place for the use of AVT, particularly in relation to clinical outputs. It was confirmed that appropriate human review remains essential before any outputs are finalised, especially where clinical sign-off is required.

NED, Bola Owolabi (BO), drew the Board's attention to the recent Care Quality Commission (CQC) position statement on the use of AI in healthcare. It was noted that the guidance emphasises the need for robust assurance arrangements, particularly in relation to clinical safety, governance and oversight of digital tools. Organisations must be able to evidence appropriate processes throughout the AI implementation lifecycle, with clear scrutiny and accountability for safe use in clinical settings. The Board was advised that AI tools implemented by the Trust are reviewed by safety officers and supported by a robust DPST process. It was confirmed that the Trust will review the CQC recommendations.

26/27/85.1 Action: KW

The Chair emphasised the importance of clear communication to ensure staff are informed about developments across the Trust and the timescales.

Resolved:
The Board noted the updates.

26/27/86 Evidence of Our Performance

Flash Report

The Board received the Flash Report for M2, which has been reformatted to improve clarity and support focused discussion on key performance issues. Performance remains strong against a number of national standards, including the new community access standard, and improvement was noted in reducing the backlog of clinical letters.

The Board was advised of a number of ongoing operational challenges. In particular, concern was raised regarding the imbalance between demand and capacity within neurodiversity services, including delays in initiating ADHD medication, which was identified as a significant risk. Attention was also drawn to the continued challenges within dentistry, where long waiting times persist, and in follow-up care, particularly within surgical services, where a cohort of patients who have gone beyond two years for review. It was confirmed that work is underway to address these issues, including engagement with commissioners regarding investment, service redesign and the appointment of a consultant dentist who will work across Alder Hey and Mersey Care to contribute to improving service resilience and supporting efforts to reduce waiting times in dentistry.

Reference was made to the cohort of patients waiting more than two years for a follow-up appointment. The Board requested assurance that the work underway is mitigating this issue.

26/27/86.1 Action: SA

Integrated Performance Report

People

- Staff turnover has increased due to voluntary redundancy (VR).
- Total workforce was below the 2026/27 WTE plan by 29.83, although delivery of the planned workforce trajectory remains challenging.
- Short-term sickness absence increased to just over 6% in May, while long-term sickness absence continues to decrease.

Community and Mental Health Division

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

Division of Medicine

- The oncology 'Closer to Home Care' bus is now operational and has received positive feedback from families. The pilot will continue until September, when it will be reviewed.
- A change to IPC reporting was highlighted. A discussion is to take place with the relevant team regarding this matter.
- There is to be a focus on follow up appointments which the team will prioritise.

Division of Surgery

- The second week long pilot was conducted to increase day case activity, resulting in 13 patients who would usually have required an overnight stay being discharged on the same day. The pilot included the first ever total hip replacement performed on a day-case pathway, where the patient was successfully treated and discharged on the same day.

Finance

It was reported that M1 was challenging for the Trust, with industrial action contributing to activity pressures and a loss of approximately £300k in income. Surgery was off plan as a result of industrial action and other areas of concern, with further variances reported across other Divisions. These issues have been reviewed by the Oversight Group.

The Board was advised that similar pressures are continuing into M2 therefore further work is to be undertaken to understand this position and to forecast for M3.

The Chair highlighted the importance of showcasing the success of the first total hip replacement undertaken on a day-case pathway at Alder Hey, noting that this aligns with work to reposition bed capacity on Ward 3 and supports the aim of enabling CYP to return home sooner rather than having to remain in hospital.

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Resolved:
The Board:

- Noted the Flash Report for M2.
- Noted the content of the IPR for Month 1.

26/27/87 PALS and Complaints Report

The Board received an update on performance against complaints and PALS targets in Q4 2024/25 and a thematic analysis of the top reasons for complaints and PALS. The following points were highlighted:

- Whilst formal complaints have increased year on year, there has been a gradual reduction in the volume of complaints being received on a monthly basis.
- The Board was advised that the Division of Medicine has continued to report the highest number of formal complaints; however, this was balanced by strong performance in managing these cases, with timely responses provided to CYP and their families. This was recognised as a positive indicator of responsiveness and effective handling of concerns.
- Although formal complaints have increased, PALS contacts have been decreasing. It was acknowledged that this presents an opportunity to strengthen early intervention and local resolution processes, with a view to addressing issues earlier and reducing escalation into formal complaints
- Examples of lessons learned have been included in the report, alongside details of compliments received. It was noted that further work is required to strengthen reporting, particularly through the inclusion of patient demographic data to support more detailed analysis.

A question was raised about whether AI-generated complaints were affecting the NHS more widely. It was reported that, while AI can result in lengthy complaint submissions, direct contact with parents is often needed to understand the underlying issues. Returning to this personal approach was considered important in identifying concerns more effectively and improving how complaints are managed.

It was queried as to whether there may be scope to automate simple acknowledgements, particularly as a practical opportunity to improve response times. The Board was advised that complaints submitted by email or online receive an automatic acknowledgement, while voicemail messages require a call back from the team. It was agreed that the process for acknowledging voicemail complaints should be strengthened going forward.

Resolved:
The Board noted the Compliments, Complaints and PALS Report for Q4.

26/27/88 Nurse Staffing Annual Report 2025/26

The Board received the Nurse Staffing Annual Report for 2025/26 which provides assurance that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff. The following points were highlighted:

- The Registered Nurse leaver position improved in 2025/26, with total leavers reducing from 94.7 WTE to 69.5 WTE. Band 5 leavers also reduced from 53.16 WTE to 37.9 WTE, reflecting the positive impact of the Lead for Nurse Retention role. However, Band 5 retention remains an area of concern when compared with paediatric peers.
- The reduced recruitment phase for students that the Trust trains was highlighted as a challenge therefore the Trust is going to explore alternative models going forward.

- Monthly safer staffing data shows that registered nurse (RN) fill rates remain broadly stable and generally above the 80% threshold. Health Care Assistant (HCA) fill rates are more variable, with HCA day fill below 80% throughout the year. There were three red-rated shifts in 2025/26, all managed through daily safer staffing review, redeployment and escalation processes.
- It was reported that the Trust is developing a new HCA recruitment and retention plan. The first stage has commenced, with a "one-stop" recruitment day held in April 2026. This has been aligned with a new organisational training pathway to support suitable candidates who do not yet meet the full job description requirements. Further aspects of the plan will launch in the coming months, including monthly learning sessions and enhanced career conversations.

The Chair requested that the report's findings be used to provide assurance to colleagues that staffing levels are sufficient and national metrics are being met. The Board was advised that sickness absence affects staff availability, increases workforce pressures and may contribute to perceptions of insufficient cover on shifts.

The Board considered the report to be comprehensive, while noting that sickness absence on the wards remains high and has a direct impact on how staffing levels are experienced during shifts. It was agreed that sickness absence should be subject to further discussion.

Thanks were offered to all those involved in the compilation of the report.

Resolved:
The Board approved the Nurse Staffing Annual Report for 2025/26.

26/27/89 Infection, Prevention and Control, Q4

The Board received an update on infection, prevention and control for the reporting period: 1.1.26 to the 31.3.26. The following points were raised:

- A reduction in C. diff infection rates was reported, reflecting the impact of targeted interventions. It was reported that cleaning products have been simplified, modern equipment has been provided to the Cleaning Team, enhanced cleaning procedures are in place, and audit and assurance arrangements have been strengthened. It was also noted that changes in oncology practice have contributed to the sustained reduction in infection.
- Attention was drawn to the ongoing concerns in relation to Gram-negative bloodstream infections, particularly within oncology. It was highlighted that these infections are largely associated with long-term vascular access in a cohort of highly vulnerable and immunocompromised patients. Targeted interventions are being implemented on oncology to address this issue, including; enhanced adherence to aseptic and no-touch techniques and regular review of the necessity for vascular access devices.

Reference was made to infections linked to long-term vascular access, and clarification was sought on whether the increase was associated with patients being immunocompromised. It was pointed out that national reporting frameworks do not fully account for the complexity and clinical risk profile of certain patient cohorts, particularly those who are immunocompromised and require prolonged vascular access. As a result, organisations may appear to perform less favourably

in national metrics, despite the elevated risk being linked to the nature of the patient population. This issue is being discussed at a national level, to consider how performance measures and reporting frameworks could be refined to better reflect paediatric case-mix and complexity.

The Board noted the progress being made. The Chair asked that thanks be conveyed to the cleaning team for their excellent work and that they be made aware of the importance of the service they provide. It was suggested that a member of the team be invited to a future Board meeting to share their experiences.

26/27/89.1 Action: KMC

Resolved:
The Board noted the Infection, Prevention and Control update for Q4.

26/27/90 Mental Health Act Annual Report, 2025/26

The Board received the Use of the Mental Health Act Annual Report for the period: 1.4.25 to the 31.3.26.

The number of CYP subject to the Mental Health Act during the reporting period remained low, with a reduction compared to previous years and a return to pre-pandemic levels. This was attributed to strengthened system arrangements, including the availability of 24/7 crisis care services and improved specialist provision, which reduced the need for detention within the acute setting.

It was reported that 9 CYP were detained under the Act during the year, including 4 CYP who were brought to Alder Hey under Section 136. A reduction in the use of Deprivation of Liberty orders was also highlighted as a positive development.

Overall compliance with statutory requirements was reported to be strong. 8 incidents occurred, primarily relating to the use of paperwork. Actions have been taken to address this issue, including the introduction of the Thalamos system to improve accuracy and reduce administrative errors. Since then, there have been no further incidents.

The Board was advised that CQC visited Sunflower House unannounced on the 16.4.26 to review the use of the Mental Health Act 1983 for detained CYP and to ensure their needs were safeguarded. The review identified one issue relating to the funding of the Independent Mental Health Advocacy service, which has been funded directly by the Trust rather than the local authority (LA). This has since been resolved through engagement with the LA, who now fund the service. The review was reported and monitored via the Safety and Quality Assurance Committee.

Reference was made to the 'Next Steps' section in the report, and it was suggested including a reference to the Public Inquiry to provide transparency and assurance. It was pointed out that the timing of the Inquiry publication meant it fell outside of the reporting period for the current report. However, it was agreed that Such references should be included in future reports.

Resolved:
The Trust Board received and approved the Mental Health Act Annual Report for 2025/26

26/27/91 Use of Restrictive Physical Interventions Annual Report, 2025/26

The Board received the Use of Restrictive Physical Interventions Annual Report for the reporting period: 1.4.25 to the 31.3.26. The following points were highlighted:

- There were 355 incidents during the reporting period relating to 25 CYP.
- Ethnicity data has not been recorded, despite being requested, and this has been identified as an action for 2026/27.
- There were 323 restraints recorded on the Tier 4 Unit and 0 clinical holding.
- 272 incidents were reported as no harm in the reporting period. There was 1 reported moderate harm incident regarding the use of restrictive physical intervention and clinical holding in relation to CYP, staff, or others (parent/carer/visitor). On review, this was changed to low harm.
- A total of 83 incidents, involving low harm were reported which is a decrease from 2024/25 and highlights improvements to safe management and reducing risks. Of the low harms reported, 15 related to staff being hit during the incident of restraint The remaining 64 related to CYP through self- harm acts or through fighting against holds during incidents.

Resolved:
The Trust Board noted the Use of Restrictive Practice Annual Report for 2025/2026.

26/27/92 Quality Account, 2025/26

The Board received the Quality Account for 2025/26 for ratification purposes, prior to publication on the Trust's website and NHS Choices website by the 30.6.26.

It was noted that the Quality Account reflects the Trust's achievements across quality priorities and particular attention was drawn to the external feedback received, including input from the ICB and Healthwatch. It was noted that the feedback was constructive and provided appropriate challenge, with positive recognition that the ICB's response did not raise any recommendations. The Board was advised that a detailed discussion has also taken place on the Quality Account during SQAC.

Thanks were offered to the Associate Director of Nursing and Quality, Jackie Rooney and contributors for the significant work undertaken to produce the report.

Resolved:
The Board received and ratified the 2025/26 Quality Account.

26/27/93 Safety and Quality Assurance Committee
Resolved:
The Board noted the Chair's Highlight Report from the meeting held on the 25.3.26 and the approved minutes from the meeting held on the 22.4.26.

26/27/94 Mass Casualty Major Incident Plan

The Board received the Mass Casualty Major Incident Plan for ratification purposes. It was felt that the report was presented in a very clear format and thanks were offered to Jacob Gray for the work that has been undertaken to significantly strengthen the document.

It was noted that the document contains sensitive information therefore appropriate arrangements will be needed to manage publication in line with governance requirements.

Attention was drawn to a matter that arose from the Southport Inquiry involving Aintree, relating to staff access to patient records. It was queried whether the Trust's action cards should be reviewed to make sure it is clear who is responsible for deciding who should have access to medical records at an early stage in a major incident.

The Board was advised that during a major incident, the Data Protection Officer (DPO) would normally coordinate a communication to remind colleagues of their responsibilities. A review would then be undertaken, with input from the DPO, the Impresario and the Caldicott Guardian, to determine whether any records should be restricted. It was suggested that this process could be formalised through the EPRR policies and reflected within the tactical command action cards.

26/27/94.1 Action: NA/JG

Resolved:
The Board ratified the Mass Casualty Major Incident Plan.

26/27/95 Liverpool Neonatal Partnership Board

The Board received the co-Chair's report from the LNP Partnership Board that took place on the 19.5.26, and the approved minutes from the LNP Operational Board that took place on the 21.4.26.

It was reported that the new leadership team are working well together, but the programme is currently in a holding pattern. This position reflects a dependency on external decision-making, particularly in relation to funding, which is limiting the pace of progress at this stage.

A request for additional funding has been submitted to specialist commissioners; however, a response has not yet been received. It was noted that this presents a number of ongoing risks, particularly in relation to key service components such as pharmacy provision. A meeting with commissioners has been scheduled for July to progress these discussions and seek greater clarity.

It was confirmed that the partnership is continuing to progress. This includes developing joint governance arrangements and training procedures.

Resolved:
The Board noted the update.

26/27/96 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 these issues. The following points were highlighted:

- There continues to be a significant level of activity across the Trust**,** driven by organisational change, with SALS and OD teams providing ongoing support to staff navigating uncertainty and transition.
- The Trust continues to prioritise leadership development and support

aimed at building capability and creating a stronger, more connected leadership community across the organisation aligned to the organisation's "How We Will Work in the Future" programme.

- The Trust has successfully achieved 'Bronze' status within the Northwest Race Equity Assembly Anti-Racist Framework. It was reported that work is being undertaken to address families experiencing racism from other families.
- The Trust has launched its 'Stoma Friendly Toilets', an important initiative led by the ACE Disabilities and Long-Term Conditions Staff Network.
- 'Learning at Work' in May saw the Trust celebrating 'Learning at Work Week' and the roles colleagues fulfil across the Trust. Activities included International Nurses Day, a focus on wellbeing, and learning opportunities including learning how to line dance, promoting physical fitness. As part of our biannual celebration of learning and recognition of long service circa 80+ colleagues were welcomed to a recognition event; which received extremely positive feedback.
- It was reported that the Head of EDI, Angie Ditchfield, is leaving the organisation, with arrangements in place to ensure continuity of the Trust's EDI work. Thanks were extended to Angie for her contributions.
- It was confirmed that the Trust has achieved Marmot accreditation in recognition of its commitment to health equity. Congratulations were extended to all colleagues involved in securing this accreditation.

It was felt that it would be beneficial to receive a briefing on the widening participation work that Katherine Birch (KB) is leading on.

26/27/96.1 Action: KB

Reference was made to the sessions being arranged by SALS and OD to support staff through organisational change. It was noted that these sessions provide an opportunity for Executive colleagues to engage directly with staff and hear their experiences.

The Chair drew attention to the 'Leadership and Development' sessions being delivered across the organisation and encouraged NED involvement. It was suggested that NEDs could support staff development by sharing their leadership experience, insights and external perspectives.

The Chair referred to the Trust's achievements set out in the update and emphasised the importance of communicating this information internally and externally.

Resolved:
The Board received and noted the content of the Strategic People update.

26/27/97 People Committee

The approved minutes from the meeting held on the 26.3.26 were submitted to the Board for information and assurance purposes.

The Board was advised that, going forward, the Committee will meet monthly to ensure there is sufficient time to consider the volume of content it receives.

It was reported that a programme of targeted deep dives has been agreed to reassess key risks, supported by a broader evidence base including qualitative

and quantitative data. Outputs will be brought back to Committee and Board to ensure risk scoring is accurate and reflective of current exposure.

During meetings the Committee discusses moral, culture and staff experience on a regular basis. It was pointed out that the organisation does not currently have a sentiment indicator to track how colleagues are feeling. Given the scale of the organisational change, it is felt that a more systematic approach is required to monitor sentiment.

Resolved:
The Board noted the Chair's Highlight Report from the meeting held on the 13.5.6 and the approved minutes from the meeting held on the 26.3.26.

26/27/98 Freedom to Speak Up Update

The Board was provided with a summary of the activities of the FTSU team for 2025/2026 including Q4 data and an outline the actions planned for the coming period.

The Board was advised of the appointment of the Deputy Freedom To Speak Up Guardian (FTSUG), which was welcomed as a positive development for the organisation. The Deputy FTSUG, Joe Fitzpatrick (JF), has been in post since January 2026 and is supporting work to strengthen reporting arrangements, including collaboration with the risk team and the implementation of InPhase to provide a more robust process for capturing FTSU concerns, including anonymous reporting.

JF is also leading on FTSU Champions, with work underway to see what can be improved upon, with consideration being given to the role description, visibility and representation from across the Trust. Attention was drawn to the importance of ensuring that FTSU Champions are representative of the Trust's staff networks. NED, Garth Dallas (GD), placed on record his continued appreciation for the way in which the FTSUG is engaging with the networks. It was confirmed that work will continue to strengthen the richness of the data reported and will remain an ongoing area of focus for the FTSUG.

122 FTSU cases have been reported during 2025/26. Where appropriate, staff have been encouraged to raise matters with their line manager in the first instance. The Board was advised that this data is yet to be included in the report.

The appointment of the Deputy FTSUG was welcomed by the NED lead, Kerry Byrne (KB), who noted the skills and additional capacity that JF will bring to the role. It was agreed that JF's contribution will complement the work of the FTSUG and support progress with planned FTSU developments.

Review Tool for Boards

The Board received a snapshot of Alder Hey's FTSU arrangements against the various parameters set out in the National Guardian's Office review and planning tool, together with suggested areas for improvement.

It was noted that the self-assessment continues to build on previous years' work. It was reported that the role of the Director of Culture has been made more explicit within the assessment, and there is an action to strengthen the triangulation of data, which had previously been limited due to capacity.

Reference was made to Section 6 of the report and the learning from a case review undertaken during the year. It was noted that, while anonymous reporting is supported by the system, it can create challenges where individuals wish to remain anonymous, as this may limit the actions that can be taken. A number of actions had been identified, including a review of the policy, which will be presented to the People Committee for ratification.

Resolved:
The Board noted the FTSU update and received the completed self-assessment annual FTSU improvement tool.

26/27/99 Finance, Transformation and Performance Committee

Resolved:
The Board noted the approved minutes from the meeting held on the 27.4.26 and the FTPC priority areas update for month 1, 2026/27.

26/27/100 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:

- Updates to the People risks are yet to be reflected in the BAF. It was confirmed that updates are currently in progress.
- It was reported that certain components of BAF risks 3.2 and 4.2 need to be separated out.
- The Board was advised that certain risks on the BAF are out of date and require revision to remain relevant and meaningful; Campus and Pioneering Breakthroughs.

Resolved:
The Board received and noted the contents of the Board Assurance Framework Report for April 2026.

26/27/101 Any Other Business

There was none to discuss.

26/27/102 Review of the Meeting

The Chair thanked everyone for their contributions and noted that the meeting had addressed a number of important items. The Chair pointed out that there is a commitment to communicate directly with colleagues across Alder Hey to support delivery of the Change Programme, with clear and targeted messages tailored to different audiences.

Date and Time of Next Meeting: Thursday 2.7.26, 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 JULY 2026							
7.5.26	26/27/64.1	Audit and Risk Committee	*Risks* - 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	**On track July-26**	
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	**On track Jul-26**	**1.7.26 –** An update will be provided during July's meeting.
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	**On track Jul-26**	
ACTIONS FOR SEPTEMBER 2026							
1.5.25	25/26/45.1	People Plan Strategic Update	Landmark Supreme Court Judgment - Provide an update on the implications of this case for the Trust once further guidance has been published.	M. Swindell	Jul-25	**Sep-26**	
6.11.25	25/26/223.1	Alder Hey in the Park Campus	Strategic planning session to be scheduled in the new financial year to explore future	D. Powell	Apr-26	**Sep-26**	

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

Date	Ref	Item	Action	By whom?	By when?	Status	Update
		Development Update	development opportunities for the Campus.				
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	**On track Sep-26**	
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	**On track Sep-26**	
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	Sep-26	**On track Sep-26**	
4.6.26	26/27/94.1	Mass Casualty Major Incident Plan	Look at whether the process used for restricting access to records during a major incident can be formalised within EPRR Policies and reflected in the tactical command action cards.	N. Askew/ J. Gray	Sep-26	**On track Sep-26**	
4.6.26	26/27/96.1	Strategic People Update	Invite Katherine Birch to Trust Board to brief members on the widening participation work she is leading on.	K. McKeown	Sep-26	**On track Sep-26**	
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

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

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

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

Date	Ref	Item	Action	By whom?	By when?	Status	Update
8.1.26	25/26/293.1	Mid Term Plan	Discussion to take place to determine/formalise Assurance Committee responsibility for the new national performance standards.	A. Bateman/ F. Beveridge/ E. Saunders	Apr-26	**Closed**	**4.6.26 –** This action has been addressed. **ACTION CLOSED**
2.4.26		Staff Story - Supporting Community Engagement for Families following Neonatal Care Experience Project	Liaise with Hilary Finlay and Reshma Sule to help them link in with system partners and Rachel Isba, to progress their project.	D. Jones	7.5.26	**Closed**	**4.6.26 –** This action has been addressed. **ACTION CLOSED**
7.5.26	26/27/58.1	National Oversight Framework Update, Q3	Explore a process for feeding back on improved figures rather than metrics remaining red all year. Raise this issue with the National Oversight Group, especially in terms of infection metrics.	A. Bateman	2.7.26	**Closed**	**4.6.26 –** This action has been addressed. **ACTION CLOSED**
Status							
Overdue							
On Track							
Closed							

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**How We Will Work in the Future**
Report of:	Chief People Officer: M. Swindell Deputy Chief Executive & Chief Operating Officer: A. Bateman
Paper Prepared by:	Director of Transformation: N. Palin

Purpose of Paper:	Decision ☐ Assurance R Information R Regulation ☐
Action/Decision Required:	To note R To approve ☐
Summary / supporting information	The Shape of Alder Hey – A Health Care System (Nov 25), Shape of Alder Hey – December 2024
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 R **Pioneering** breakthroughs R **Strong Foundations** R
Resource Implications:	.

Does this relate to a risk? Yes R No ☐

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

Risk Number	Risk Description	Score
3.4 3.1	• Failure to meet financial targets • Failure to realise Vison 2030	20 16

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	R	**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

High-level Board Progress Update — July 2026

1. Executive summary

The How We Will Work in the Future (HWWWITF) programme continues to progress – with the organisational change elements of the programme, and the development of the future operating model. Since the last reporting period a significant milestone has been met with the finalisation of the new system models, which will start going live as of July 26.

Overall financial delivery remains broadly close to the reported total programme plan in the scorecard, with the aggregate position showing a small residual gap. However, the HWWWITF-specific line remains under pressure, with delivery dependent on the further development and implementation of plans across clinical services, medical workforce/job planning, leadership and management, administration and professional services. This means the Board should take assurance from the progress made but note that full delivery remains dependent on continued grip, timely decision-making and clear transition management.

2. Overall programme progress

The programme has continued to progress through a phased approach, with early waves of organisational change either concluded or in implementation, and further work now moving into transition, system leadership and Phase 2 service redesign. The programme remains broadly on track, however the timely commencement and conclusion of the remaining organisational changes, will be required to meet a completion date of Sept 26.

A number of significant milestones have been achieved the over the last two months: -

Progress area	Update
Clinical Service Groupings	The clinical services model has been finalised following extensive feedback, including more than 200 responses.
Governance and scrutiny	The Organisational Change Scrutiny Panel is now operational, supporting a more structured review route for organisational change proposals.
System transition	Systems have been locked in, budget alignment from divisions to systems is reported as complete, and system leaders have commenced in role.
Communications	Connecting Leaders and Connecting Alder Hey sessions have continued to support communication of the change programme.

The table below provides a high-level summary of current progress

Area	Current position	Status
System leadership	System Leadership is completed for AHP and Operational Colleagues, with the remaining appointment of Deputy CMO scheduled for early July.	On Track Positive progress has been made in establishing the leadership infrastructure for the new system model, although some elements remain in recruitment or are currently covered through interim arrangements.
Professional services	Digital and Transformation changes are complete. Campus, People Services and Academy remain in formal consultation, with Finance due to formally launch.	On Track There is clear progress across professional services – with the financial targets exceeded.
Clinical systems and group-level changes	Operations leadership, nursing leadership, medical leadership and clinical administration remain in formal consultation or active implementation.	Work is progressing, but these areas are now critical to the closure of Phase 1 and to establishing confidence for new system leaders.

3. Organisational change position

The programme has made measurable progress in completing or progressing organisational change across several areas. Please note that this phase of the programme is deliberately focused on leadership and management (both clinical and non-clinical).

Category	Number of colleagues impacted	Description
Organisational change complete	191	Complete areas include clinical services senior leadership and professional services Digital and Transformation.
Organisational change in progress	426	In-progress areas include leadership and management, clinical administration and several professional services areas
To start imminently	373	Areas include leadership and management.

Phase 1 has established core components of the new model, but the programme is not yet at a point where all organisational change can be described as complete. The Trust is moving through transition, with a clear need to maintain grip on outstanding organisational change and to define Phase 2 clinical service redesign.

5. Transition Assurance

Following approval of the new operating model, programme activity has focused on supporting a safe transition to systems through coordinated work across the Systems and People workstreams. Transition arrangements are in place and are being monitored through established governance, with Executive oversight of implementation, risks and organisational readiness. As expected for a programme of this scale, assurance continues to mature as new arrangements become embedded, with particular focus on leadership readiness, governance, professional services support and clear communication for staff.

Area of assurance	Current position
Governance	Committee arrangements are being aligned to the new operating model, with proposals being shared through the appropriate governance routes.
Performance and risk	Risk reporting (inphase) the Quality Committee (June 26) – received a recommendation for the safe transitional arrangements for the in-phase system during July and August. Oversight will continue to be reported and any risks will be escalated to the Chief Nurse, AHP and Experience Officer.
Professional services	HR, Finance, BI and other enabling functions are supporting system implementation – have detailed plans in place for 'IT system' movement into the new operating structure.
Leadership readiness	Leadership arrangements are being monitored, with interim arrangements in place where required to maintain continuity.
Staff communication	A programme of communications and engagement is supporting staff through the transition, providing clarity on implementation and ongoing support.

7. Risk Position

The programme risk profile remains stable, with the principal risks relating to delivery of the financial improvement target and maintaining leadership alignment during implementation of the new operating model. Risks associated with transition continue to be actively managed through programme governance, with assurance focused on accountability, leadership readiness, staff experience and the safe implementation of new system arrangements.

Risk area	Current score	Position
Financial target	20	Remains the highest programme risk, reflecting the scale of financial improvement required.
Leadership alignment	12	Ongoing alignment of leadership arrangements remains important to support consistent implementation.
Scope, target and project leadership	12	Programme changes continue to be managed through established governance and change control processes.
Staff morale	12	Workforce engagement and communication remain a priority throughout implementation.
Responsibility and accountability during transition	9	Clear accountability and decision-making arrangements continue to be embedded as systems transition.
Safe transition	8	Transition is progressing with oversight through established governance and risk management arrangements.

Overall, the programme remains within an active delivery phase, with risks subject to regular review through the HWWWITF Board. Current mitigations provide assurance that key risks are being actively managed, although continued executive oversight is required as implementation progresses.

9. Conclusion

The Board is asked to note the progress made in establishing the future system model, progressing organisational change and developing the foundations for transition into the new arrangements. The programme has moved beyond initial design and consultation into a more active transition phase, with several key leadership, organisational change and system milestones either complete or in progress.

The Board is asked to note the following areas that remain a focus for the HWWWITF Steering Group:

Focus	Detail
Transition into systems	The immediate move into systems requires active assurance, particularly around accountability, escalation and practical support arrangements.
Phase 2 clinical redesign	The largest remaining change area relates to clinical service redesign and needs to be formally structured as a programme workstream.
Staff experience and morale	The programme recognises that staff morale may be affected by change and uncertainty; communication and support arrangements need continued focus.

Focus	Detail
System objectives	Initial objectives for each new system need to be agreed with system leaders and aligned to the wider accountability framework.

10. Next steps

Over the next reporting period, the programme will focus on:

1. Completing immediate transition assurance ahead of and during go-live into the new systems.
2. Commence a learning review of phase 1 – commencing in July 26.
3. Agreeing early system objectives with the new system leadership teams.
4. Closing outstanding Phase 1 organisational change elements where possible.
5. Defining Phase 2 clinical service redesign as a structured workstream, including leadership, governance and delivery milestones.
6. Continuing to monitor financial delivery and the conversion of opportunities into confirmed savings.
7. Maintaining active oversight of programme risks, particularly financial delivery, transition accountability, leadership alignment and staff morale.

Flash Report June 2026

Performance is subject to change

Alder Hey Children's NHS Foundation Trust

REVOLUTIONISE CARE

81.4%	212	69.3%	94.6%
ED: % Treated within 4 Hours	Number of RTT Patients waiting >52 weeks	% Patients waiting within 18 weeks (RTT)	Diagnostic Performance

OUR PEOPLE

-34	10.3%	70%
Estimated Workforce Plan	Staff Turnover	% PDRs Completed

OUTSTANDING CARE AND EXPERIENCE

0	0	91.8%	3	tbc
Severe / Fatal Incidents / Never Events	Patient Safety Incident Investigations	FFT – % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed

HIGHLIGHTS

- Sustained performance for % patients waiting under 18 weeks for treatment
- Improved performance of diagnostic under six weeks.
- 0 Never Events, Severe harms or PSIIs
- Good patient experience scores.
- Estimated Workforce below plan.

CHALLENGES

- Decline in the number of patients being seen within 4 hours in the A&E department, 14th consecutive months 80%+ however below current target (85%)

FOCUS / NEXT STEPS

- Plan created towards achieving 95% ED performance.
- Reduce RTT >52 week waits.
- Monitor and reduce healthcare associated infections.
- Recovery action plan for gastroscopy towards diagnostics.

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: June 2026

Performance: May 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

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VISION 2030

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

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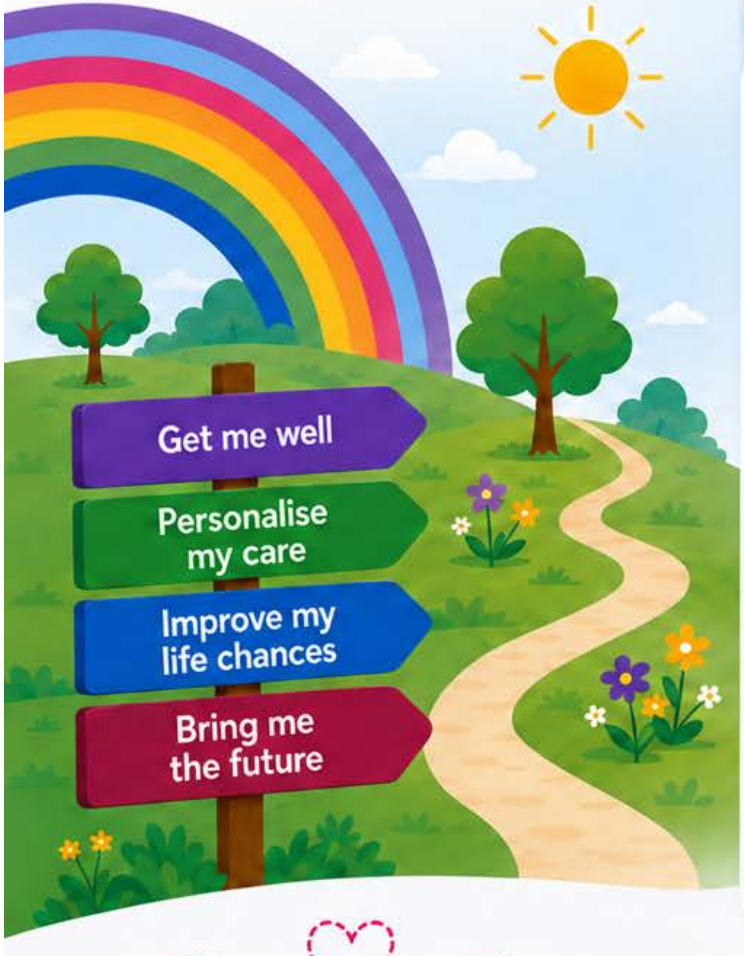
Alder Hey Children's
NHS Foundation Trust



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Compassion
We see you and act

Courage
We speak up and step forward

Commitment
We keep our promises

Community
We lift each other up

VISION 2030

Integrated Performance Report
Executive Summary

NHS
Alder Hey Children's
NHS Foundation Trust

OUTSTANDING CARE & EXPERIENCE

The Trust continues to demonstrate strong performance in key areas of patient safety and experience. Sepsis management remains robust, with all inpatients and 90% of Emergency Department patients receiving IV antibiotics. PALS responsiveness is also strong, with 95% of concerns answered within five days. The use of restrictive interventions has remained lower than previous levels for the past six months, indicating sustained improvement.

There are, however, several areas requiring continued oversight. One serious incident has been reported and is scheduled for review through the PSIR panel to confirm the level of harm and any statutory Duty of Candour requirements. Medication errors resulting in harm have increased, although none have been reported as moderate harm or above; these continue to be reviewed through the monthly Medication Safety Committee to identify themes, learning, and improvement actions. Three cases of C. difficile have also been reported and should remain a focus for infection prevention and control.

Patient feedback remains positive overall, with 91% of Trust FFT responses and 82% of Emergency Department responses rated as good or very good. The Experience of Care Improvement self-assessment has been completed, with gaps and improvement opportunities identified.

Looking ahead, the Trust will support further infection prevention and cleanliness improvements through "Clean Start" week from 15 June 2026, including a guest speaker, policy updates, information on new cleaning products, and staff training.

Key measures	Value	Target
Patients deteriorating from an inpatient bed admitted to PICU	16	n/a
Number of Incidents per 1,000 bed days – No Harm	64	77.8
Number of Incidents per 1,000 bed days – Low Harm and above	19	15.2

REVOLUTIONISE CARE

Performance has improved across several key access measures. The 18-week position for acute services increased again in May, reaching 70% against a plan of 64.9%, while community services improved to 82%, exceeding the year-end plan of 78%. Data quality has also strengthened, with an improvement in the proportion of activity recorded with valid ethnicity information.

However, there are areas requiring focused recovery. DMO1 diagnostic performance has declined for the second consecutive month, with 93% of patients receiving a diagnostic test within six weeks. A&E four-hour performance has also reduced slightly, from 87% in April to 84% in May. Neurodevelopmental assessment performance for children and young people remains a significant concern, with the proportion receiving an outcome within 65 weeks falling from 12% to 6%.

Looking ahead, the C&M Provider Collaborative has requested a recovery plan for gastroscopy services, which is being developed by the Specialist and Acute system. In addition, work has started to implement a Single Point of Access within outpatients by October 2026. This is intended to support timely access by ensuring patients are seen in the right setting first time, contributing to the Trust's wider aim of reducing waiting times and improving access to care.

Key measures	Value	Target
ED % Treated Within 4 Hours	84%	85%
RTT Waiting List Within 18 Weeks*	69.7%	64.9%

VISION 2030

Integrated Performance Report

Executive Summary

NHS
Alder Hey Children's
NHS Foundation Trust

SUPPORT OUR PEOPLE

Mandatory training compliance remains strong at over 90%, demonstrating sustained performance in core workforce training requirements. Workforce capacity continues to be an area of focus.

The review of final voluntary redundancy applications is due to be completed shortly, and the 2026/27 WTE plan remains challenging. Significant work is underway through the HWWWWITF programme to support delivery against the workforce plan.

Sickness absence increased slightly in both April and May and remains a challenging area. This continues to be monitored through regular detailed reporting and targeted actions, including an enhanced Occupational Health training offer and focused support for areas experiencing higher levels of absence.

Looking ahead, the Trust will continue to progress actions to support the WTE plan and strengthen workforce management. The average Time to Hire measure has also been amended to reflect the new expanded 40-day target, covering the period from advert to completion of recruitment checks.

Key measures	Value	Target
Workforce Plan (WTE)	4,198	4,213
Staff Turnover	10.7%	10%
Sickness Absence (Total)	6.07%	4.5%

FINANCIAL SUSTAINABILITY

In May (Month 2), the Trust reported a £1.5m deficit and a £2.4m year-to-date deficit, both in line with plan. No full forecasting exercise was completed in Month 2; therefore, the Trust continues to forecast delivery of a £0.7m surplus, in line with plan, although this remains subject to Elective Recovery Fund and Cost Improvement Programme risks.

The Cost Improvement Programme remains a key area of focus. CIP is £0.7m behind plan in Month 2 and £0.9m behind year to date. Overall, £9.5m of CIP has been transacted in-year, with £8.7m fully developed and in progress, £5.1m identified as opportunity, and a remaining £1.1m gap. Recurrently, £8.4m has been implemented, leaving a significant recurrent gap of £16.1m. Delivery of the full £24.5m savings target is therefore essential to achieving the planned year-end position.

Cash remains in line with plan, while capital expenditure is behind plan due to phasing and pending approval of NHSE strategic funding. The capital allocation is unlikely to be sufficient to meet all requirements, although early prioritisation work indicates that phasing should make this manageable, provided PDC business cases are approved.

Looking ahead, continued cost control and a strong focus on recurrent efficiency will be required. Work will continue with divisions through the Financial Improvement Programme and HWWWWITF programme to identify recurrent savings and benefits for 2026/27. The cash strategy will also remain a priority to mitigate the risk of low cash during the year.

Key measures	Value	Target
I&E Year End Forecast	£0.7m	£0.7m
Recurrent Efficiency Plans Delivered	£4.7m	£3.7m
ERF Income (YTD)	£16m	£16.9m

Integrated Performance Report | June 2026

Alder Hey Children's NHS Foundation Trust

Outstanding Care & Experience: Safe & Caring

Executive Summary

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

Highlights

- 100% of inpatients and 90% of ED patients received IV antibiotics for management of sepsis
- 95% of PALS concerns responded to within 5 days
- Requirement for restrictive intervention has remained lower for six months

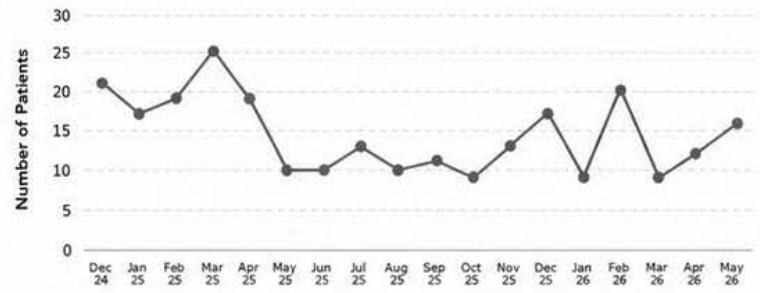
Areas of Concern

- One serious incident reported; scheduled for review of incident and harm level at PSIRP panel. Verbal Duty of Candour undertaken; statutory requirements will be met as required following review and confirmation of harm level
- Rise in medication errors resulting in harm – none reported as moderate or above. Medication Safety Committee meet monthly and review themes, opportunities for learning, and any improvements
- 3 cases of C-diff reported
- 91% of FFT returns for the Trust rated very good / good and 82% of completed surveys in ED
- Experience of Care Improvement self assessment completed with gaps and improvements identified

Forward Look (with actions)

- "Clean Start" week taking place week of 15th June 2026 inclusive of guest speaker, policy update, update on new cleaning products and training

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



Current (May 26)	Previous Month (Apr 26)	vs Previous Month
16	12	↑ 4

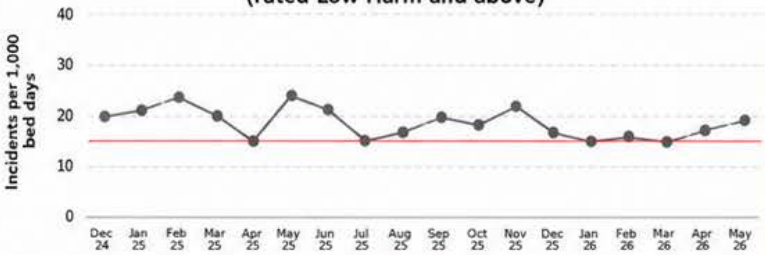
Technical Analysis:

Common cause variation observed with 16 patients deteriorating from an inpatient bed to PICU with an average of 15 a month during the last 18 months.

Priority Actions:

Increase compared to previous two months; all cases reviewed by Response Team. Deteriorating Patient workstream continues to report to Patient Safety Board and SQAC. Current focus on the Safety Culture Development Programme which has been built, and the deteriorating patient education programme which has been devised

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



Current (May 26)	Target Monthly Average	Position
19	15.2	Above Target

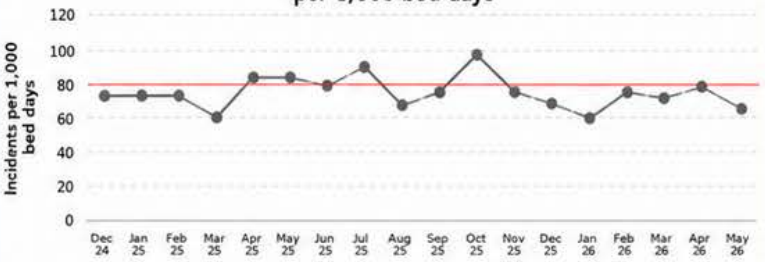
Technical Analysis:

Common cause variation with performance of 19 incidents of harm per 1,000 bed days, with a monthly average of 17 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:

Slight increase compared to previous six months; incident themes reviewed and reported

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



Current (May 26)	Target Monthly Average	Position
64	77.8	Below target

Technical Analysis:

Common cause variation observed with 64 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. Highest rate recorded since Oct-25

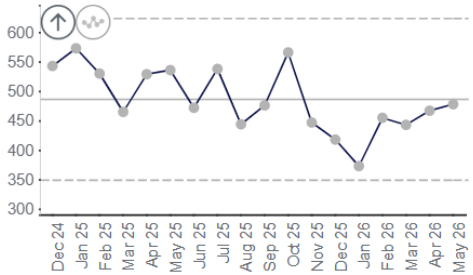
Priority Actions:

Staff encouraged to report incidents of No Harm and Near Misses. Good Catches recognised and disseminated through the weekly Patient Safety Meeting bulletin

Outstanding Care and Experience – Safe & Caring - Watch Metrics

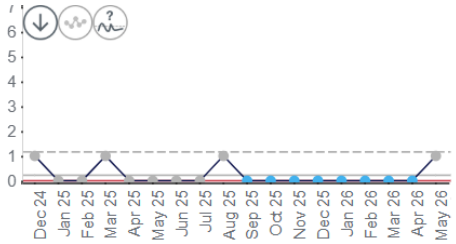
Watch Metrics

Patient Safety Incidents (All)

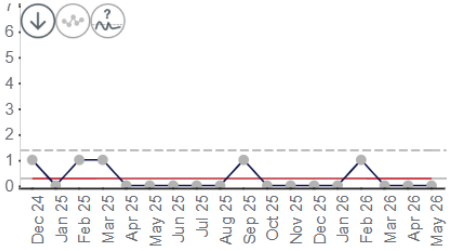


Severe or Fatal Incidents – Physical & Psychological

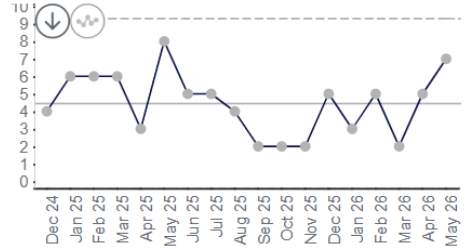
Target: Internal



Number of PSIIs (Patient safety incident investigation) undertaken

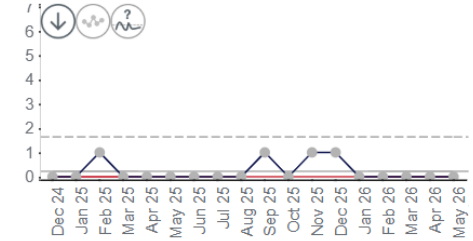


Medication Errors resulting in Harm (Physical and Psychological)



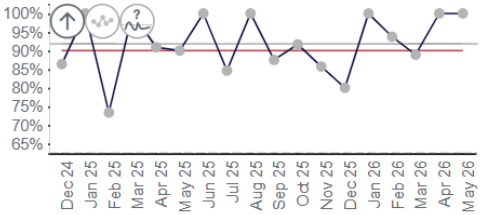
Number of Never Events

Target: Internal



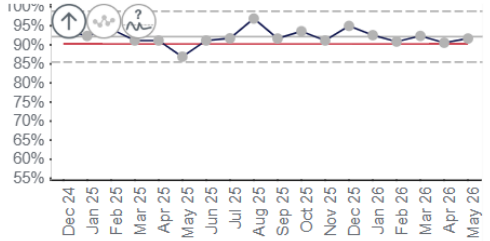
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

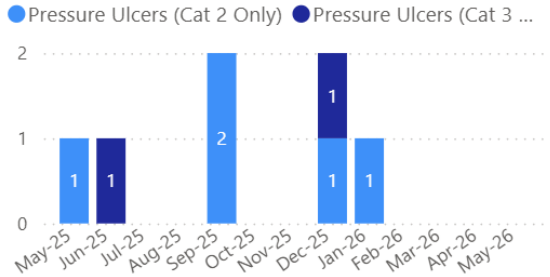


Sepsis % Patients receiving antibiotic within 60 mins for ED

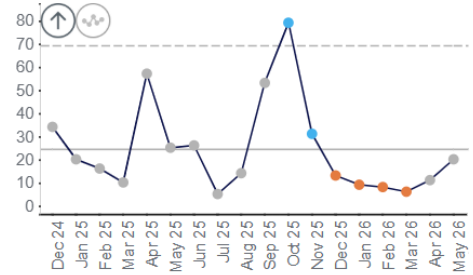
Target: Statutory



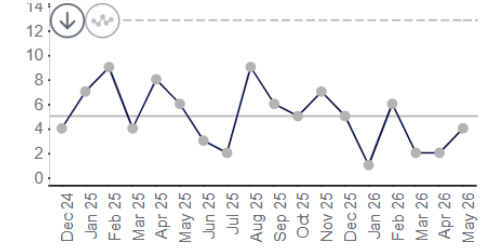
Pressure Ulcers Category 2-4



Recording of restrictive interventions

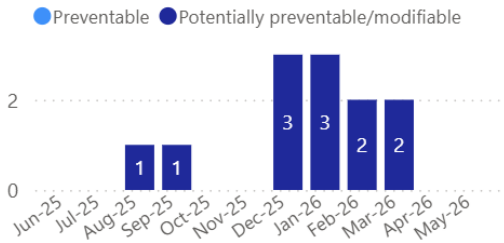


Number of patients deteriorating from HDU admitted to PICU

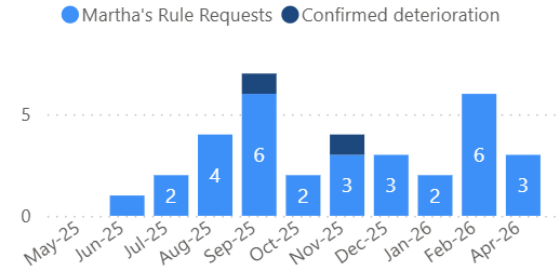


Predictable and preventable deteriorating patients

Not inclusive of all categories



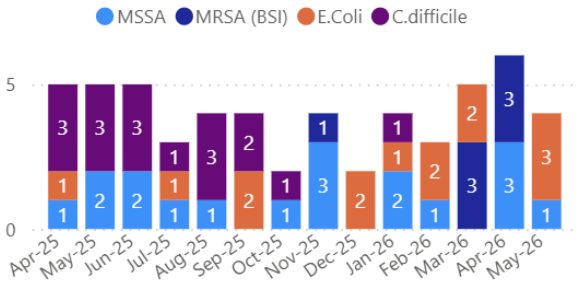
Martha's Rule



Outstanding Care and Experience - Safe & Caring - Watch Metrics

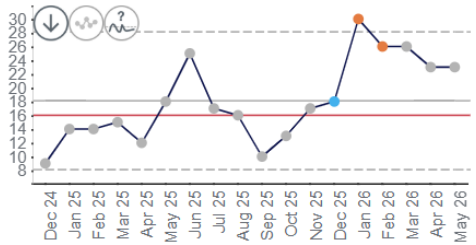
Watch Metrics

Hospital Acquired Organisms



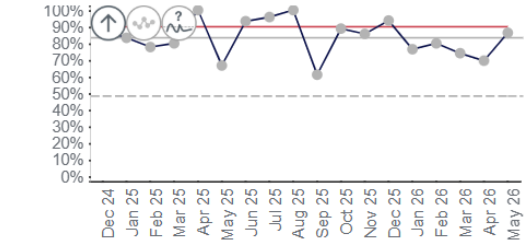
Number of formal complaints received

Target: Internal



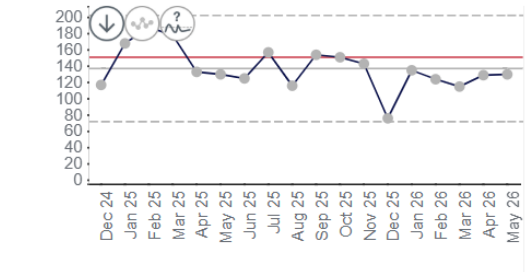
% Complaints Responded to within 25 working days

Target: Internal



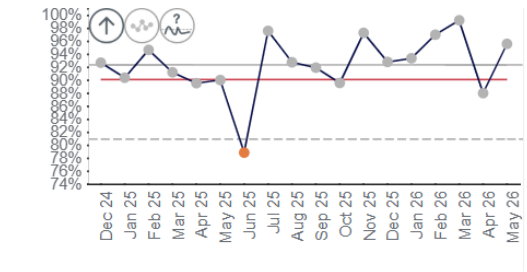
Number of PALs contacts

Target: Internal



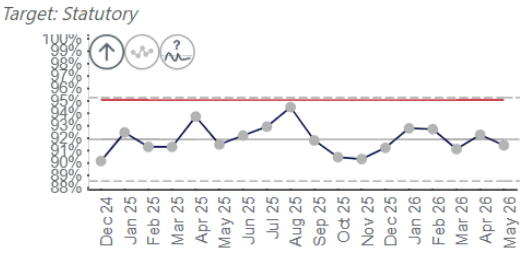
% PALS Resolved within 5 Days

Target: Internal



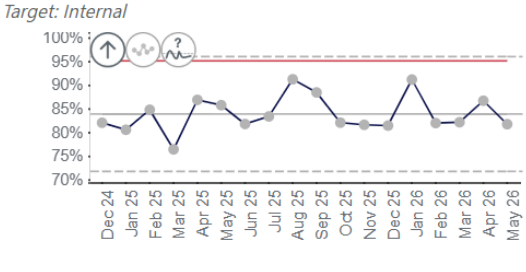
Trust: % of very good/good ratings for 'Overall, how was your experience of our service

Target: Statutory



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

Target: Internal



Integrated Performance Report | June 2026

NHS
Alder Hey Children's
NHS Foundation Trust

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

Highlights

- The 18-week position for acute services in May has increased again, reaching **69.7%** against a plan of **64.9%**.
- The 18-week position for community services has increased to **82%**, against a year-end plan of **78%**.
- There has been an improvement in the % of activity with a valid ethnicity recorded.

What's Working Well

RTT Acute Services

The 18-week position for acute services in May has increased again to **69.7%**, which is above the plan of **64.9%**.

RTT Community Services

The 18-week position for community services has increased to **82%**, which is above the year-end plan of **78%**.

Ethnicity Recording

There has been an improvement in the % of activity with a valid ethnicity recorded.

Areas Requiring Attention

DM01 Performance

DM01 performance has declined for a second consecutive month, falling to **93%** of patients having a diagnostic test within 6 weeks.

A&E 4-hour performance

There has been a slight decline in the number of patients being seen within 4 hours in the A&E department, reducing from **87%** in April to **84%** in May.

Neurodevelopmental assessments

The % of children and young people who receive an outcome from their neurodevelopmental assessment within 65 weeks has reduced from **12%** to **6%**.

Forward Look (Key Actions)

- C&M Provider Collaborative has asked for a recovery plan for gastroscopies. This is currently being worked up by the Specialist and Acute system.
- Work has started within outpatient department to implement Single Point of Access by October 2026. This will support the right patients, being seen in the right place, first time. This will support the Trust aim of reducing waiting times and access to care.

Key Performance Indicators

1 ED: % treated within 4 Hours

Latest (May 2026)

84%

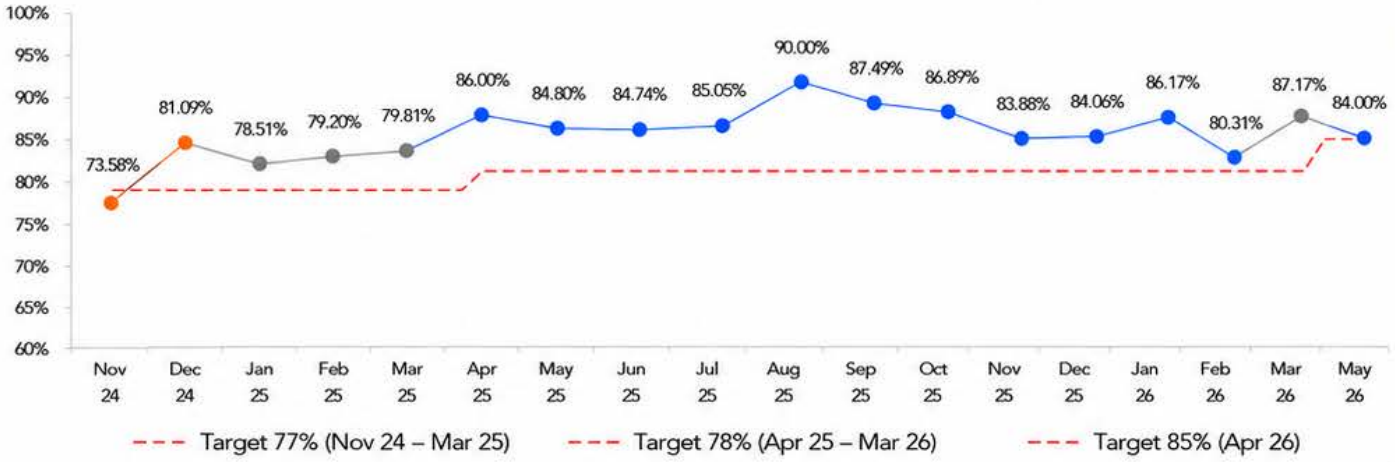
Target (Statutory)

85%

↓ 3.17%

vs Apr 26

(87.17%)



2 RTT waiting list within 18 weeks

Latest (May 2026)

69.7%

Year-end target (Mar 2027)

70.1%

↑ 0.69%

vs Apr 26

(69.01%)

Technical Analysis

1. Slightly below our external target of 85% in May-26 with performance of 84%, a decrease from Apr-26 (87.2%). May-26 performance was -0.7% compared to May-25 (84.7%); however, May-26 experienced +504 extra attendances compared to May-25.

2. Special cause variation with current performance of 69.7% against a year end target of 70.1% by March 2027. This is an increase from April 2026 position of 69% and the 4th consecutive month with an increase.

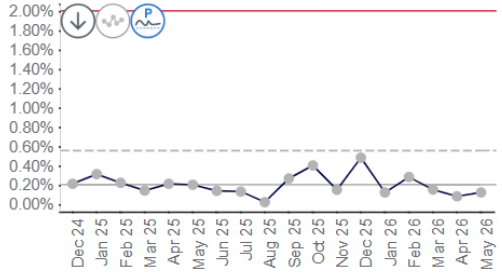
Priority Actions

1. UEC team have created an action plan to achieve 95% by March 2027. Deputy CEO and Deputy COO are working with the C&M system to help implement the C&M UEC CY&P strategy, focussing on digital front door and enhancing PCAS. This will support ensuring patients are treated as quickly as possible in A&E.

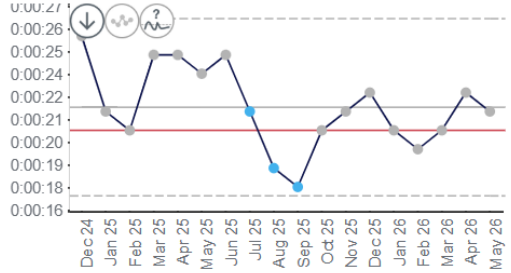
2. The Trust has agreed to implement FDP in outpatients to support oversight of room bookings. This will enhance visibility and support additional clinics where needed. Teams are continuing to implement AVT to increase new capacity and the rollout of patient portal will support reducing the WNB rate.

Revolutionise Care – Effective & Responsive – Watch Metrics

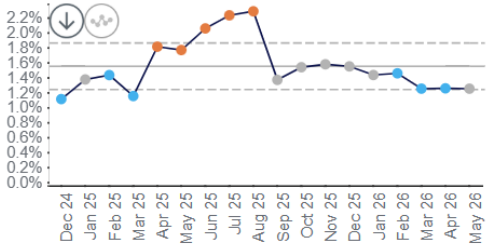
% of ED attends over 12 hours



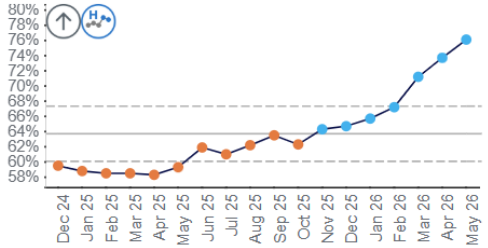
Average Ambulance Vehicle to Handover Time



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

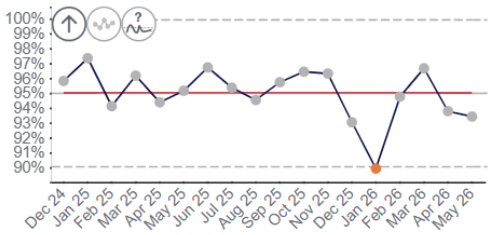


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



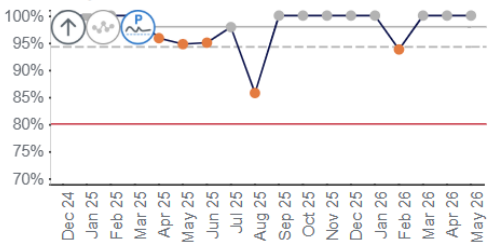
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



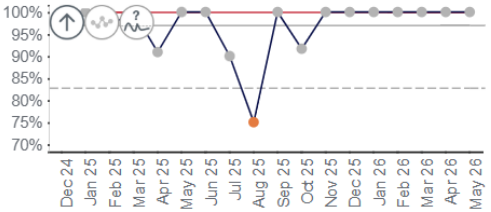
Cancer: Faster Diagnosis within 28 days

Target: Statutory



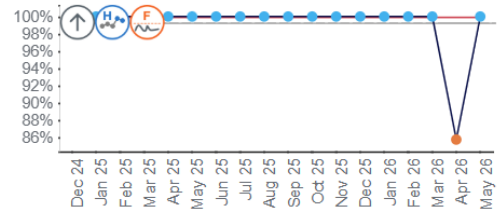
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

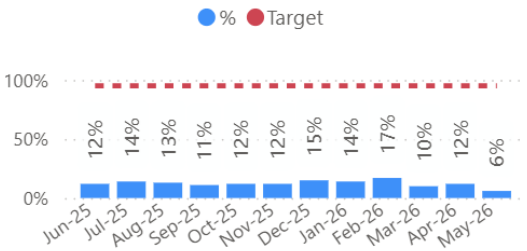


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

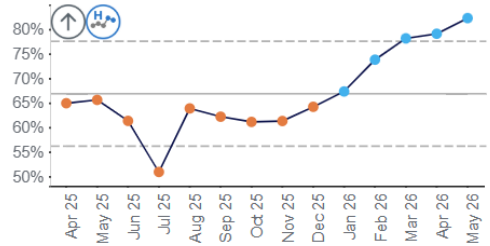
Target: Internal (Stretch)



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

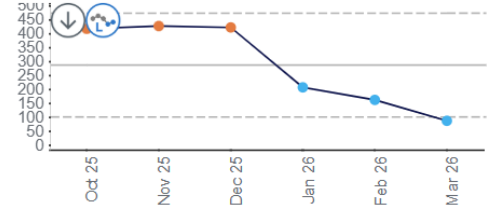


Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less

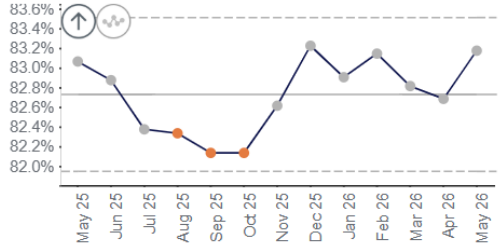


Number of CYP with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period

Source: Published MH NHSe Data



Percentage of activity (ED, IP & OP) with a valid ethnicity recorded



Support Our People

Executive Summary

SRO

- Melissa Swindell, Chief People Officer

Highlights

- Mandatory training compliance remains over 90%

Areas of Concern:

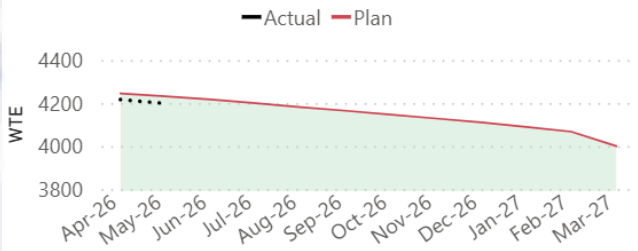
- Total workforce remains an area of focus, with review of final voluntary redundancy applications shortly to be completed.
- Sickness absence has increased slightly in both April and May. The position remains challenging and is subject to regular, detailed reporting and action, including an enhanced training offer from OH, and specific targeted support for areas with high levels of absence.

Forward Look (with actions)

- The 2026/27 WTE plan remains challenging, with significant work underway through the HWWWTF programme.
- Average Time to Hire has been amended to reflect the new expanded 40-day target looking from advert to completion of checks.

Total Workforce - WTE

Target: Internal 26/27



Target (Internal)	Actual (May 26)	vs Plan
4,231.23	4,197.86	↓ 33.37 WTE

Technical Analysis:

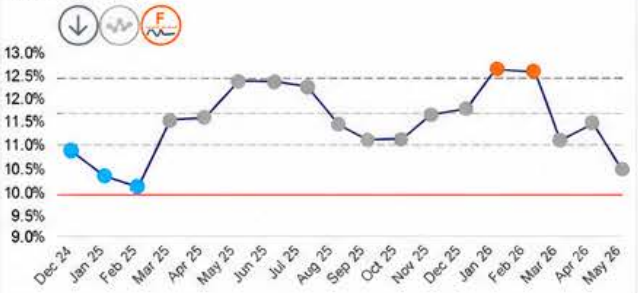
Total workforce for the end of May 2026 was 33.3 WTE below plan. M2 total workforce was 4,197.86, against a plan of 4,231.23.

Actions:

The WTE position remains challenging with an increase in bank usage in May 2026. However, the overall position for May was 33.37 WTE below the budgeted plan. Significant work is underway through the HWWWTF programme, alongside other work, to support achievement of the medium term plan for 2026/27.

Staff Turnover

Target: (Interna)



Target (Internal)	May 26	vs Target
10%	10.7%	↑ 0.7%

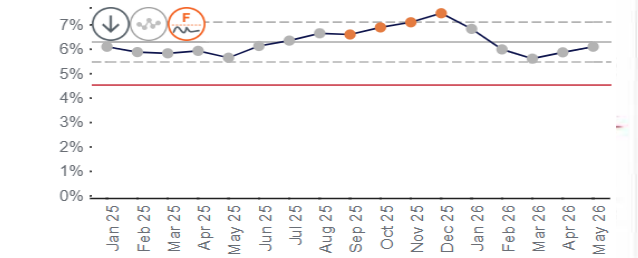
Technical Analysis:

Common cause variation observed with performance of 10.7% in May 2026 against an internal target of 10%. Decrease from 11.4% the previous month however a consistently falling metric.

Actions:

Turnover remains impacted by the end of fixed term contracts, and colleagues leaving under voluntary redundancy. Given significant changes across the workforce, internally we have commenced reporting of voluntary vs involuntary turnover to ensure that themes aren't lost.

Sickness Absence Overall



Target (Internal)	May 26	vs Target
4.5%	6.07%	↑ 1.57%

Technical Analysis:

Common cause variation observed. Total sickness absence in May 2026 is 6.07% which is above the monthly target of 4.5%. First month since Jan-26 above 6%. May-26 is a 0.23% increase from Apr-2026. May 2026 performance comprises STS at 2.23% and LTS at 3.84%. Monthly sickness target is set at 4.5% in 2026/27.

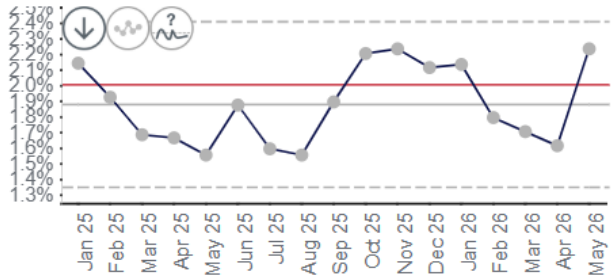
Actions:

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

Supporting Our People - Watch Metrics

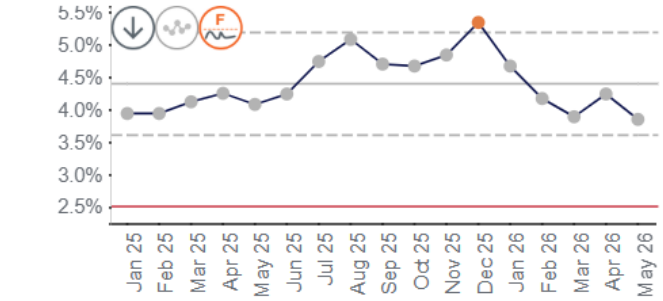
Short Term Sickness

Target: Internal

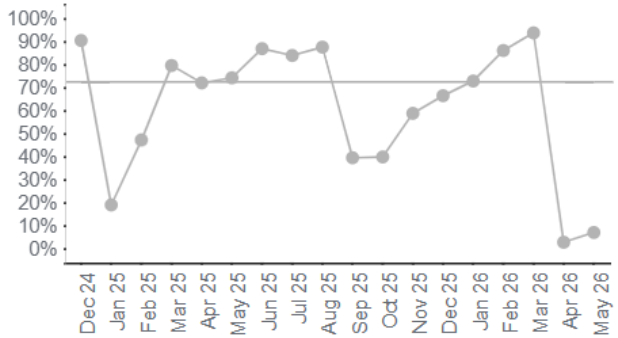


Long Term Sickness

Target: Internal

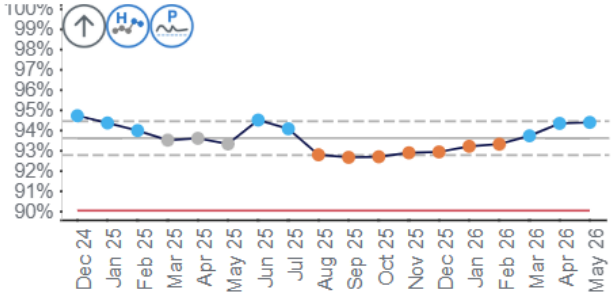


Medical Appraisal



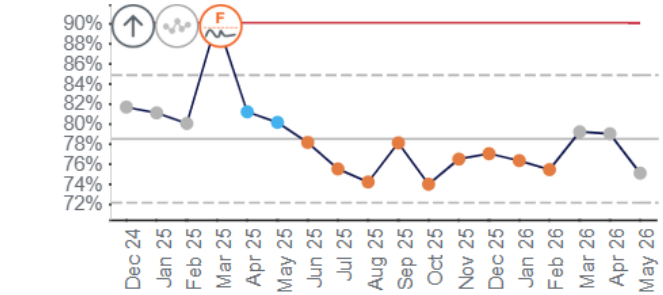
Mandatory Training

Target: Internal



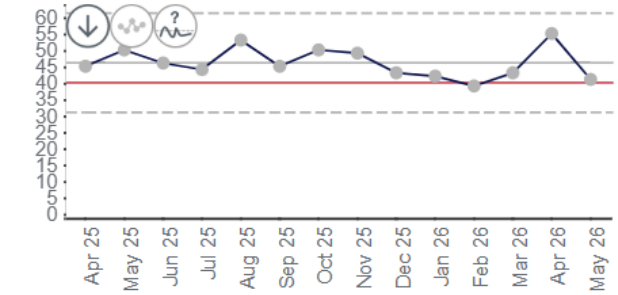
% PDRs Completed (Rolling 12 Months)

Target: Internal



Average Time to Hire

Target: Statuatory



Integrated Performance Report | June 2026

NHS Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

Executive Summary

SRO

Kate Warriner
Chief Transformation and Digital Officer

Alf Bass
Chief Medical Officer

Highlights

- Financial change request approved by LCR Combined Authority to deliver the Alder Hey Secure Data Environment in 26/27. Project Manager commencing on 9th June.
- POIZ legal documentation finalised and submitted for exec review – sign off expected on 9th June so business support to date can be finalised.
- Research Nurse Team Leader won a Nurse of the Year Award at International Nurses Day awards recognising her outstanding contribution to the research areas she supports and wider projects including sustainability and training.
- Confirmation of £11k income from new Lymebid contract with South West London Trust.
- Partnership meeting with national network of NIHR Health Tech Research Centres with Paediatric focus led by Sheffield Children's Hospital.
- Continued development of AI policy and AI 101 training package.
- Successful move of RPA team to digital.

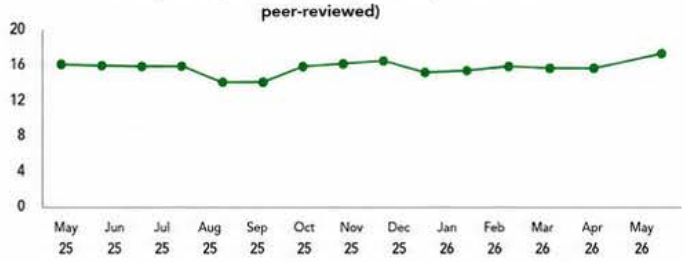
Areas of Concern

- Continued underachievement against research income targets (driven by 3rd MRI, Paediatric Medicines Research Unit and overall commercial trial activity – actions plans in place for all 3 areas).
- Reduction in 26/27 Research Capability Funding compared to forecast (-70%).
- Ongoing need to strengthen governance in innovation processes particularly around prioritisation and clinical governance.

Forward Look (with actions)

- LCR Combined Authority Investment Zone Showcase taking place on 9th June with POIZ representation.
- NIHR Clinical Research Facility Annual report narrative on track for submission by 17th June.
- Rolling internal funding call for research pump-priming activities to be launched in July.
- Research and Innovation presentation at NHS Confed Expo and HLTH.
- Toronto visit to explore HeraAI planned for July.
- Continued focus on delivering against national 150 day study set up targets (to be added to IPR metrics).
- Options for achievement against additional £107k CIP target being finalised.

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



Current (May 26)	Previous Month (Apr 26)	vs Previous Month
17	17	0

Technical Analysis:

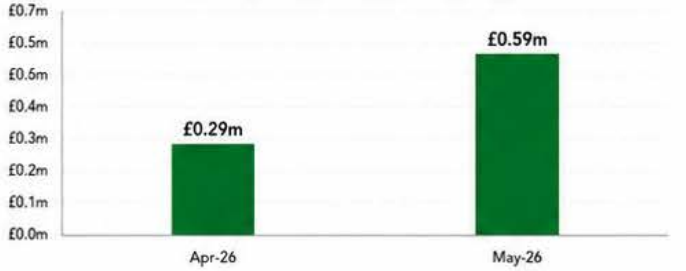
This metric is an indicator of the level of academic leadership we have across AH which will drive pioneering breakthroughs

Actions:

Actions ongoing to finalise rolling internal funding call to support grant writing and engagement activities to boost number of future Chief Investigators.

Proposal to move to a watch metric and replace this metric with GO partnerships.

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



Current (May 26 YTD)	vs Previous Year (May 25 YTD)	vs Previous Year (YTD)
£0.59m	–	–

Technical Analysis:

This metric is an indicator of our commitment to financial sustainability across Research and Innovation

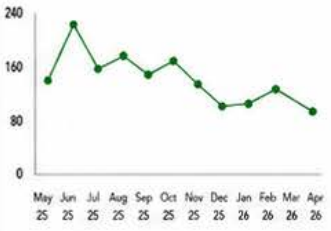
Actions:

Adjusted metric to align with GO financial sustainability metrics.

3. Number of participants recruited to all studies

Current (May 26): 93

12 Month Trend



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

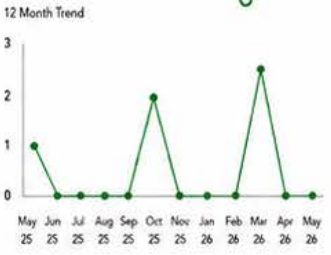
Current (May 26): 34

12 Month Trend

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

Current (May 26): 0

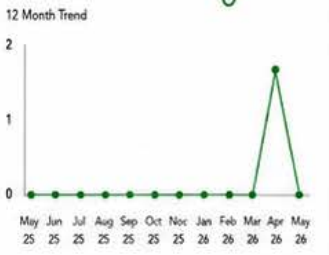
12 Month Trend



6. Number of businesses supported by POIZ

Current (May 26): 0

12 Month Trend



Financial Sustainability: Well Led

Executive Summary

SRO

Rachel Lea, Director of Finance and Development

Highlights

In May (M2), the Trust reported £1.5m deficit and £2.4m deficit YTD, which is in line with plan. No full forecast exercise has been completed in M2 and therefore forecasting to achieve £0.7m surplus in line with plan, subject to ERF and CIP risk. CIP is £0.7m away from plan in M2 and £0.9m YTD. Overall, £9.5m CIP has been transacted in year with £8.7m fully developed and in progress, £5.1m opportunity and £1.1m.a. gap. Currently £8.4m has been ineligible of £16.1m. Cash has remained in line with plan & capital is behind plan due to phasing and awaiting approval of NHSE Strategic funding.

Areas of Concern

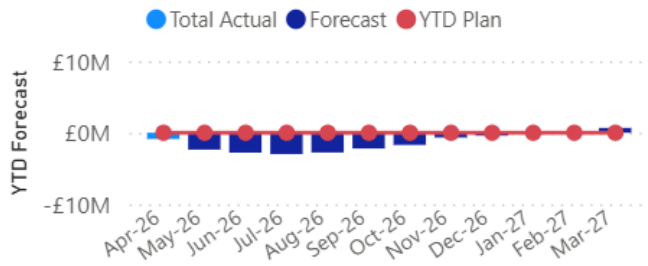
Work is ongoing to deliver full savings of £24.5m and significant work is ongoing through FIP and HWWWITF programme. Forecasting to achieve £0.7m surplus which is in line, so delivery of CIP is essential. It is recognised that capital allocation is unlikely to be sufficient to complete all capital requirements, although early work on prioritisation suggests phasing should make this manageable if PDC business cases approved (in progress).

Forward Look (with actions)

Continued cost control to reach the year end position. Continued focus required on recurrent efficiency. Work continues with divisions on transformation schemes through FIP to identify recurrent savings and benefits in 26/27. Cash strategy will continue to be area of focus to ensure risk of low cash is mitigated.

I&E Year End Forecast

Target: Statutory



Target (Statutory)	Forecast (Year End)	vs Plan
£0.7m Surplus	£0.7m Surplus	→ 0

Technical Analysis:

Current plan is £0.7m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Continue to monitor and drive forward efficiency schemes in progress and opportunity stage. Cost control for arising pressures to be managed through FIP and FPOG meetings.

Recurrent Efficiency Plans Delivered (Risk Adjusted Forecast)

Target: Internal

Target (Internal)	Risk Adjusted Forecast	vs forecast
£24.5m	£17.4m	↓ -£7.1m

Technical Analysis:

Recurrent CIP identified and fully developed is £11.2m (£1.7m improvement from M1)

Actions:

Significant work is ongoing to support the delivery of efficiency targets across the Trust through the FIP and HWWWITF programme.

YTD ERF Income

Plan (YTD)	Actual (YTD)	vs Plan
£16.9m	£16.0m	↓ £0.9m

Technical Analysis:

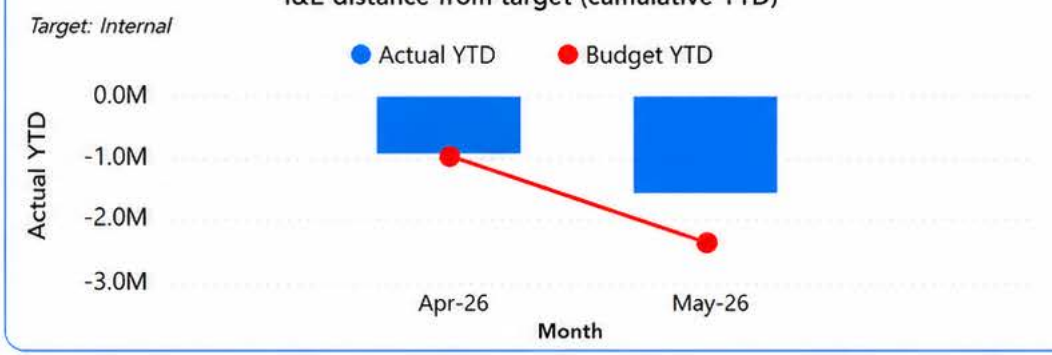
May performance is estimated at 95% in value terms. Actuals of £7.8m against a plan of £8.3m. Main driver being elective variance in surgical specialties. YTD performance is estimated at 95% in value terms. Actuals of £16.0m against a plan of £16.9m, £0.6m of the under achievement is in surgical specialties, £0.3m in medical specialties.

Actions:

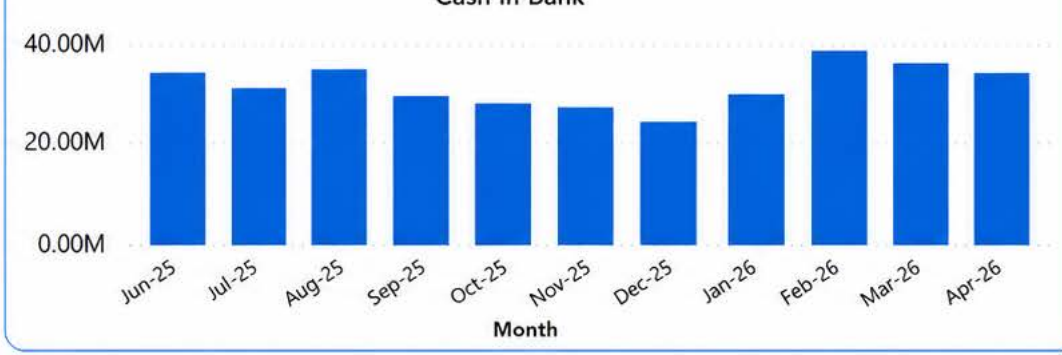
There are exceptional reasons behind the YTD under performance (e.g. high NEL and All.), with the divisions are looking to recover going forwards.

Financial Sustainability: Well Led – Watch Metrics

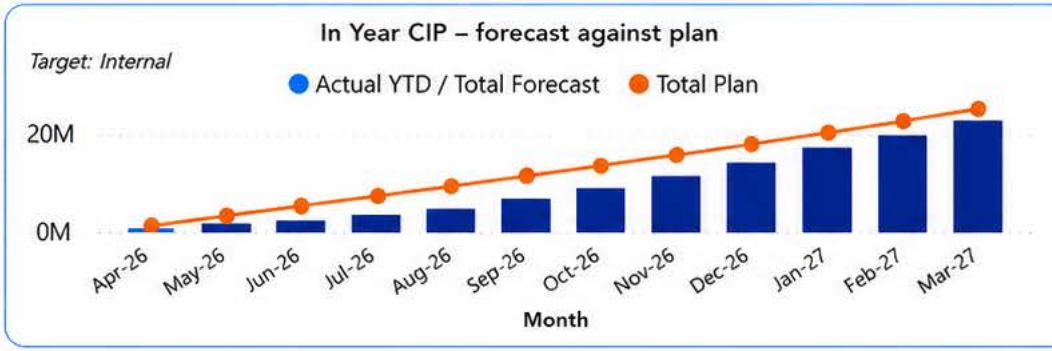
I&E distance from target (cumulative YTD)



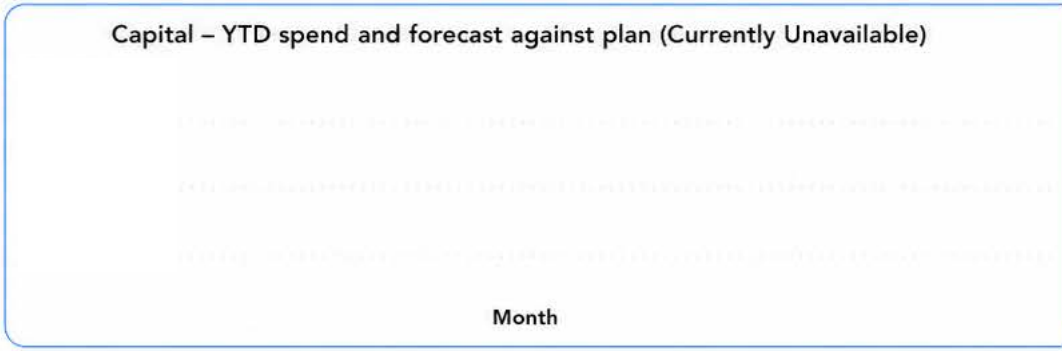
Cash In Bank



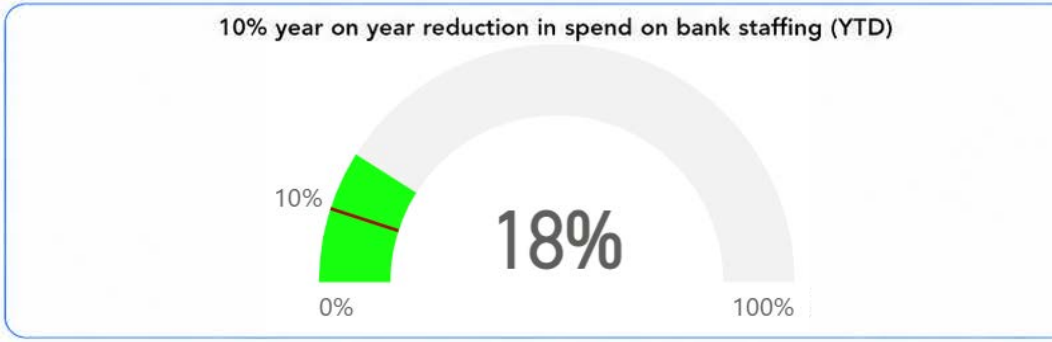
In Year CIP – forecast against plan



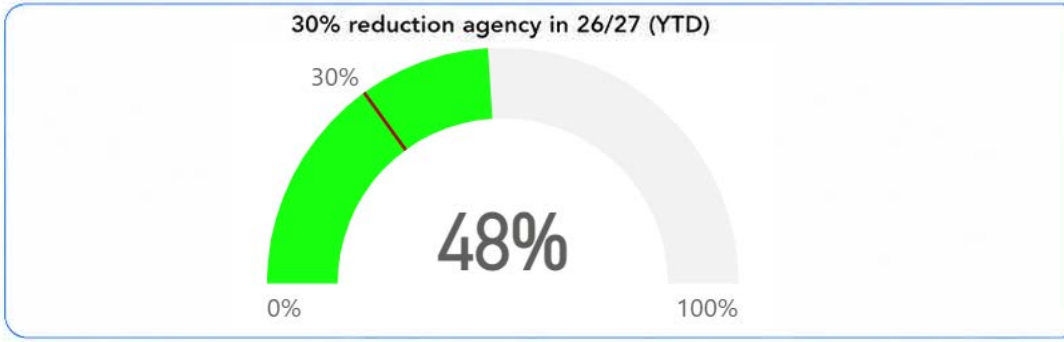
Capital – YTD spend and forecast against plan (Currently Unavailable)



10% year on year reduction in spend on bank staffing (YTD)



30% reduction agency in 26/27 (YTD)



Risk Management: Well Led

Executive Summary

SRO
Erica Saunders, Chief Corporate Affairs Officer

Highlights:

- Sustained performance with risk reviews: 100% of high risks within review date
- Maintained high risks actions position: 0% of high risks with actions past expected date of completion
- Continued positive collaboration with risk owners/teams

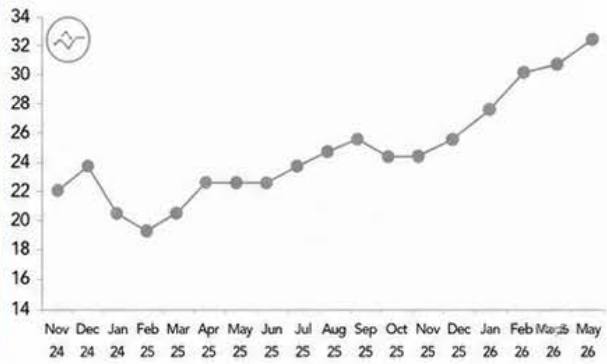
Areas of Concern:

- Continued challenges regarding communication and timescales for the GO LIVE date for transition from the current divisional structure to new systems model
- Updating and alignment of the InPhase apps to the new systems model remains a concern in terms of capacity of teams and potential for inaccurate reporting. The impact including resource and reporting constraints continues to be escalated via the HWWW/ITF workstream.

Forward Look (with actions)

- Awaiting the outcome of the Board review and re-approval of Risk Appetite to determine next steps and enable recommencement of the roll out of risk appetite and tolerances across the organisation.

Number of High Risks (scored 15 and above)



Current (May 26)	Previous (Apr 26)	vs Last Month
32	31	↑ 1

Technical Analysis:

32 high risks on risk register as of 31st May 2026. Breakdown by category is listed below.

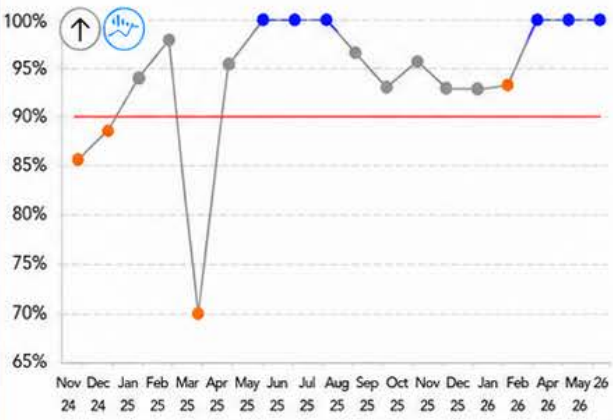
- Quality – Safety = 15 risks
- Workforce – Sustainability = 8 risks
- Compliance and Regulatory = 6 risks
- Commercial = 1 risk
- Financial – Compliance = 1 risk
- Financial – Investment = 1 risk

Actions:

Number of high risks remain fairly static. Continued scrutiny via the Corporate Risk Register and assurance reporting into RMF and ARC.

% of High Risks within review date

Target: Internal



Current (May 26)	Previous (Apr 26)	vs Last Month
100%	100%	→ 0

Technical Analysis:

Sustained performance of 100% of risks within review date for May 2026, 4th consecutive month at 100%.

Risk watch metric: 3.3% (1/30) of high risk with actions past expected date of completion.

Actions:

Monthly progress updates in place for high risks. Divisional and corporate monitoring and oversight continues with a sustained strong performance this month.

DIVISIONAL PERFORMANCE SUMMARY – COMMUNITY & MENTAL HEALTH

NHS
Alder Hey Children's
NHS Foundation Trust

SRO: Lisa Cooper, Community & Mental Health Division

HIGHLIGHTS

- Sefton SEND inspection completed with positive feedback regarding children and young people centred care
- Reduction in number of children and young people reported as waiting over 104 weeks for CAMHS (85)
- Mandatory training compliance has remained above target (97%)
- Staff turnover has reduced (11%)
- Improvement in the number of complaints responded to in 25 days (100%) and PALS resolved within 5 days (92%)
- Community Therapy Services continue to meet 18 week RTT (Community Dietetics – 100%; SALT – 98%; Physio – 100%; OT – 100%)
- Continued improvement in Community Paediatrics RTT (90%)
- No children and young people waiting over 52 weeks for treatment to start in Community Mental Health Services (Liverpool) with improvement in overall access KPIs
- Improvement in number of children and young people seen within 4 weeks in Eating Disorder Service (88%)

AREAS OF CONCERN

- Increase in waiting time for first assessment within Community Mental Health Services (Sefton) (87% within 6 weeks) due to vacancies, sickness and delays recruiting
- Increase in patient safety incidents rated low harm (19) and no harm (87)
- Sickness absence rate has increased (6%)
- Improvement in number of IHA's completed within 20 days of referral (68%) and within 20 days of starting in care (35%) although still under target
- WNB rate has increased (14%) – exploring link to Alder Connect go live
- Timeliness to triage for ND assessments within 12 weeks remains consistent at (71%)
- Ongoing concerns regarding the number of clinical letters due to delays in transcription process – although improved slightly in M2 (74%)
- Ongoing challenges with ADHD medication shortages which is impacting on waiting times for the treatment pathway
- Sunflower House remains a fragile service, primarily due to workforce challenges, cultural factors, and the complexity of presentations. Improvement plan in place and regular meetings with NHS England.

FORWARD LOOK (WITH ACTIONS)

- ☑ ND transformation programme continues with a review of ADHD medication planned and improvement plan to be delivered.
- ☑ Phase 1 of EMIS to Meditech transformation (Community Physiotherapy and OT) go live 08 June 2026

Liverpool Community Mental Health Services performance improvement plan in place

- WNB rate remains high – collaboration with innovation to address inequalities in mental health services and improve access
- Waiting times managed against improvement trajectory.
- Improvement in waiting times
- No children and young people waiting over 52 weeks – with none expected to breach
- Recruitment ongoing, with additional posts requested to mitigate for gaps in service.

MENTAL HEALTH DATA REPORTING – WORK ONGOING

- Improvement in collection of Routine Outcome Measures (89% of choice assessments within last 30 days with ROM) – task & finish group to continue to improve collection and reporting
- Reduction in reported 104+ weeks (85) with further improvement expected
- Paper prepared to revise access and performance KPIs in line with NHSE proposal of standards for access and waiting times for Children and Young People Mental Health Services – work ongoing to update reporting metrics and dashboards, trajectory in development.
- MHSDs Phase 2 (Crisis Care) Meditech developments live – Meditech developments scheduled for June 2026 with BI work ongoing
- IT and Operational Team working with IAPTUS to review scope of IAPTUS to Meditech data migration

FINANCIAL POSITION

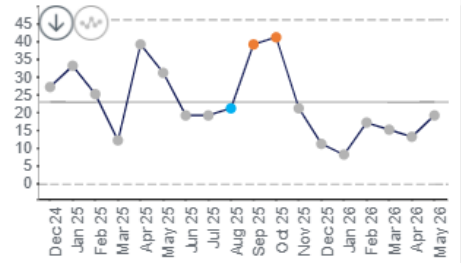
I&E distance from target (Cumulative to date)	£715.6k*

*Divisional positions exclude CIP

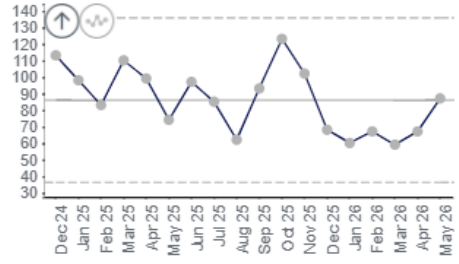
Work ongoing to provide psychological support to children impacted by the Southport critical incident. PIFU discharge pathway agreed to enable follow up until CYP turn 18. Ongoing discussions with ICB regarding funding for this resource.

Divisional Performance Summary - Community & Mental Health

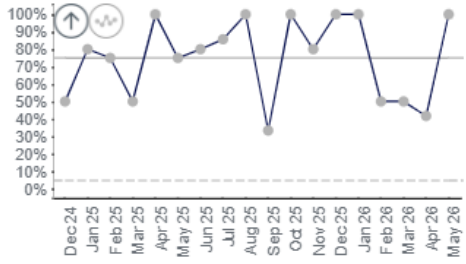
Patient Safety Incidents rated Low Harm & Above



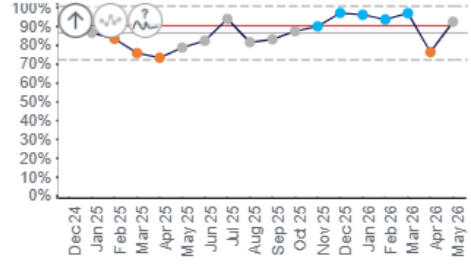
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

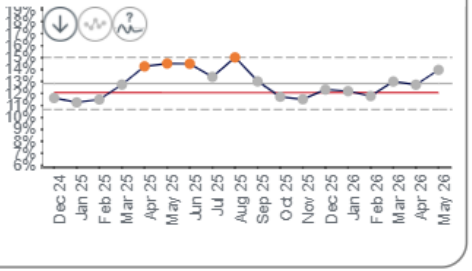


% PALS Resolved within 5 Days

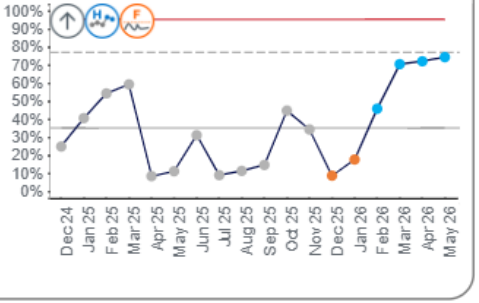


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

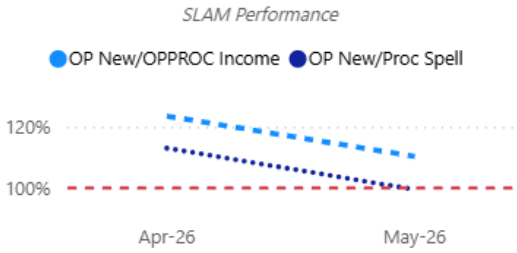


% of Clinical Letters completed within 10 Days

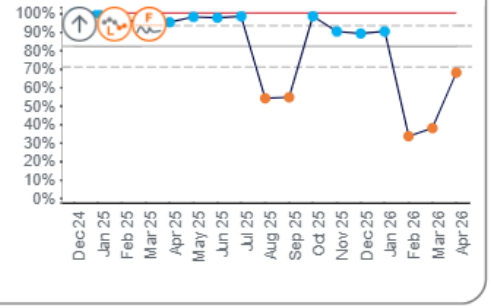


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

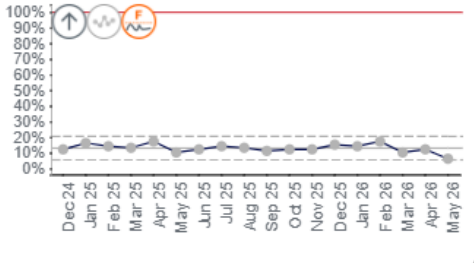
SLAM Performance



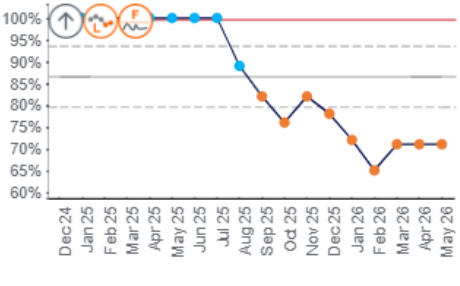
IHA: % complete within 20 days of referral to Alder Hey



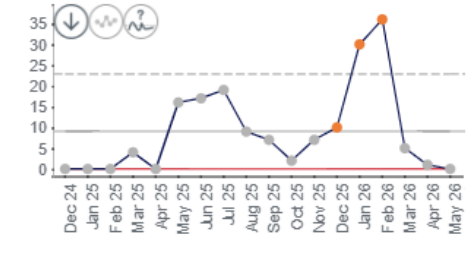
ND Assessment: % waiting <65 weeks for concluded diagnosis



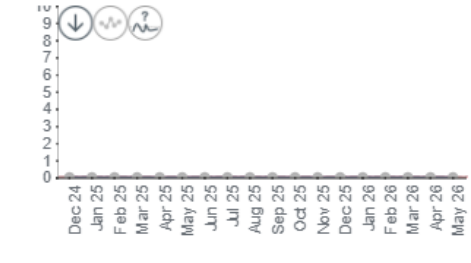
ND Assessment: % triage within 12 weeks



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

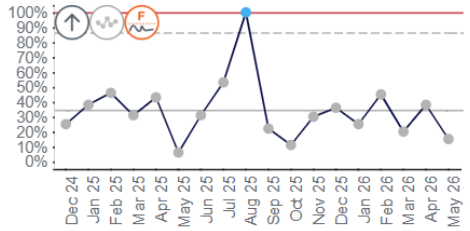


Community Paediatrics: Number of children and young people waiting >52 weeks

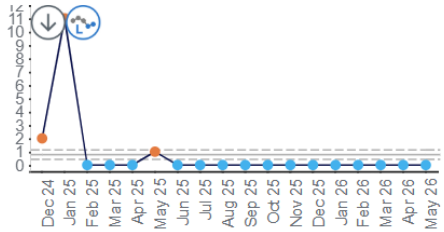


Divisional Performance Summary - Community & Mental Health

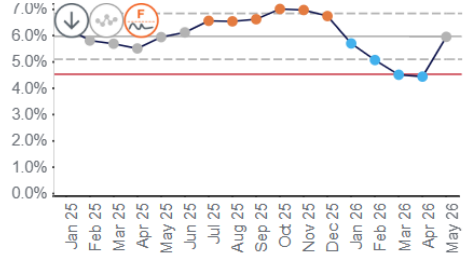
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours



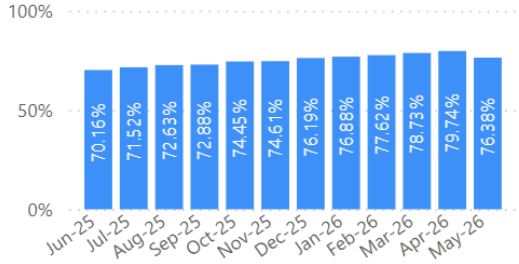
Volume of active outpatient follow up waits - 2 Years & Overdue



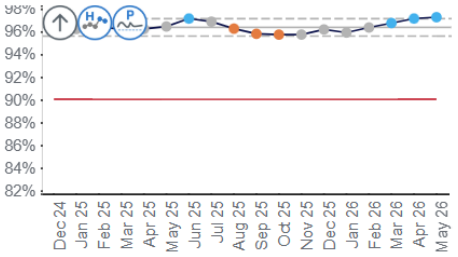
Sickness Absence Overall



Workforce Stability

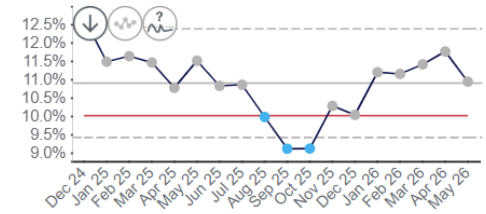


Mandatory Training

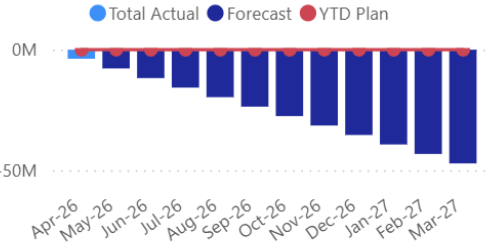


Staff Turnover

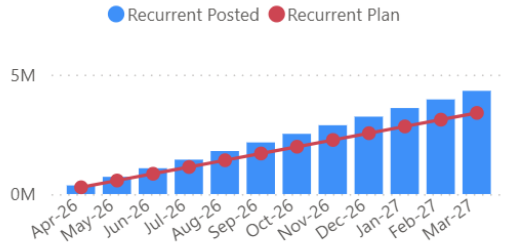
Target: Internal



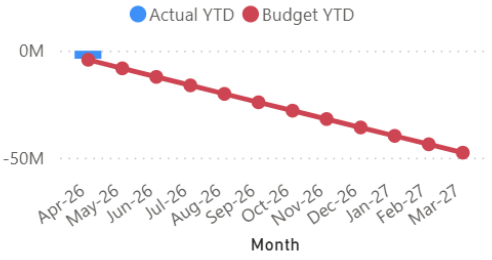
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



DIVISIONAL PERFORMANCE SUMMARY – MEDICINE

NHS
Alder Hey Children's
NHS Foundation Trust

SRO: Urmi Das, Division of Medicine

HIGHLIGHTS

- Further improvement in RTT performance with 75% of children and young people treated within 18 weeks
- Sustained improvement (3 months) of clinic letter signoff with 70% signed within 10 days
- Staff turn over reduced to within target
- 100% of PALS responded to within expected timeframe
- Care closer to home pilot launched in oncology resulting in children receiving treatment in community settings including at home or on the oncology bus

AREAS OF CONCERN

- Number of organisational changes underway impacting individuals and creating uncertainty within the workplace
- Challenge in responding to all formal complaints within the targeted time frame owing to the increase in volume. Performance fell to 75% from 90% previous month
- Further increase in children overdue a follow-up for 2+ years
- WNB rate increased to highest rate in August 2025, 10%

FORWARD LOOK (WITH ACTIONS)

- ☑ Revised plan to address the overdue follow up back log with specific teams
- ☑ Collaboration between nursing, medical and operational leadership teams to review ward 4C reconfiguration plan
- ☑ Care Closer to home pilot in oncology underway until September with initial evaluation expected in coming weeks
- ☑ Continued focus on ED performance working towards 95% target

FINANCIAL POSITION

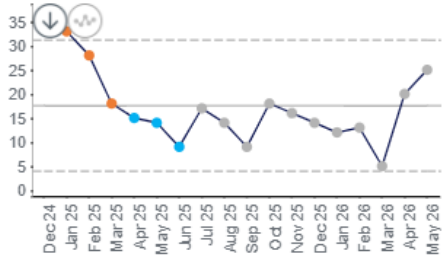
I&E distance from target (Cumulative to date)

-£460.4k*

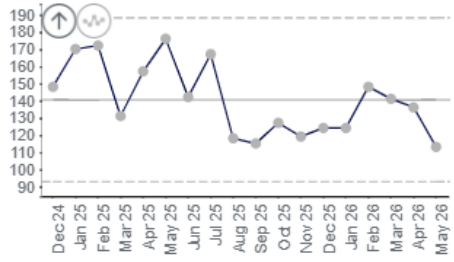
*Divisional positions exclude CIP

Divisional Performance Summary - Medicine

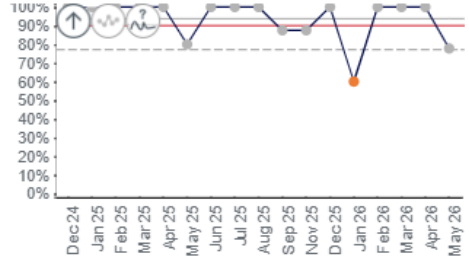
Patient Safety Incidents rated Low Harm & Above



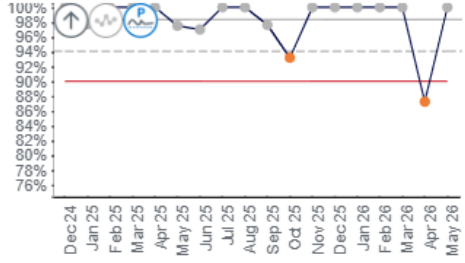
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

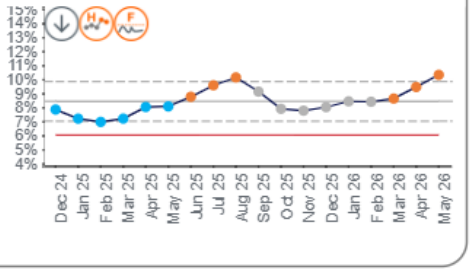


% PALS Resolved within 5 Days

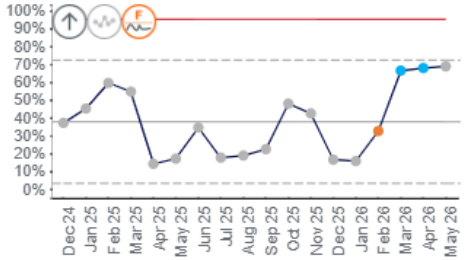


% Was Not Brought Rate (All OP: New and FU)

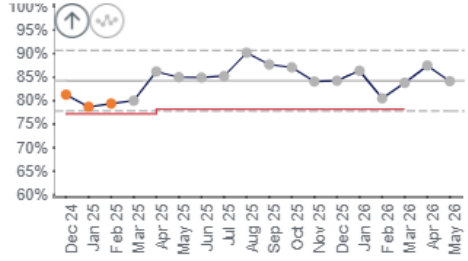
Target: Internal



% of Clinical Letters completed within 10 Days

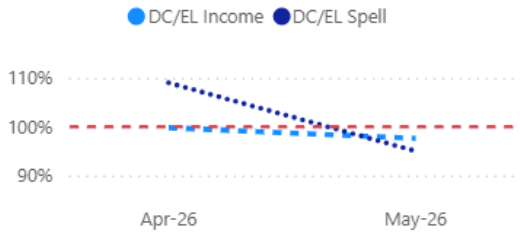


ED: % treated within 4 Hours



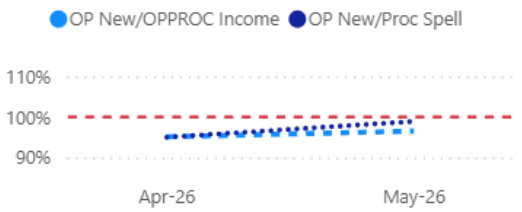
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

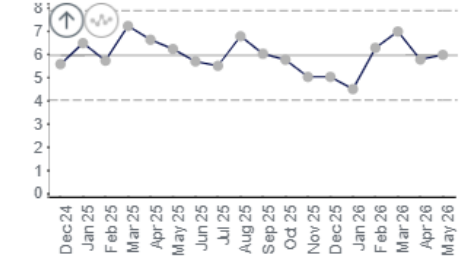


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

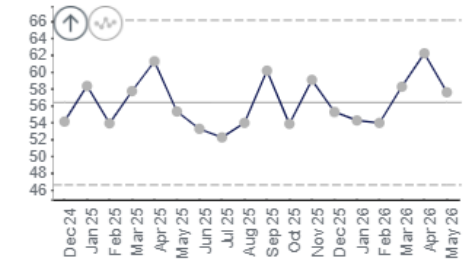
SLAM Performance



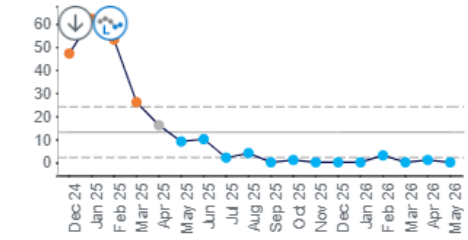
Inpatient Discharges per working day



Day Cases per working day

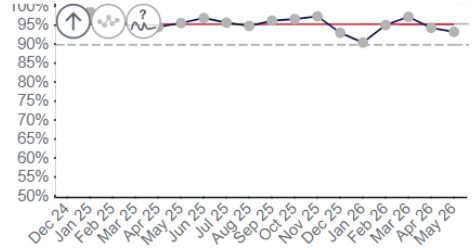


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)

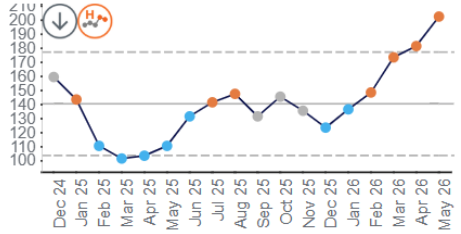


Divisional Performance Summary - Medicine

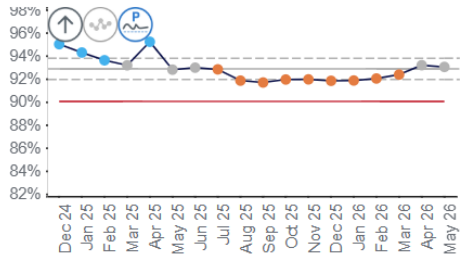
Diagnostics: % Completed Within 6 Weeks of referral



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

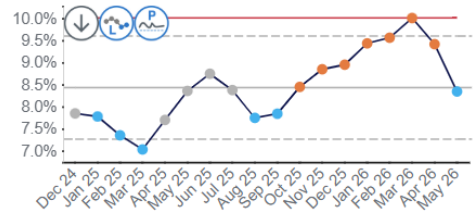


Mandatory Training

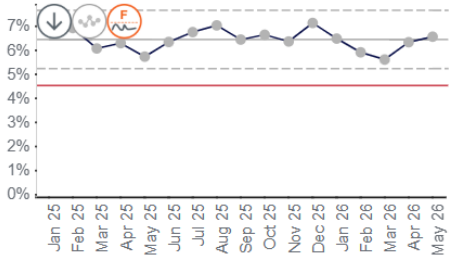


Staff Turnover

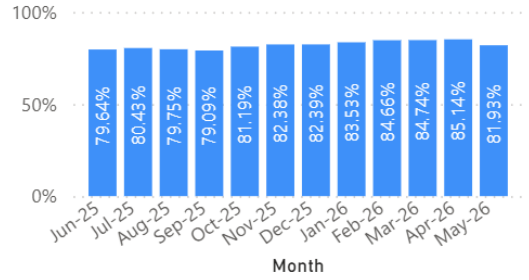
Target: Internal



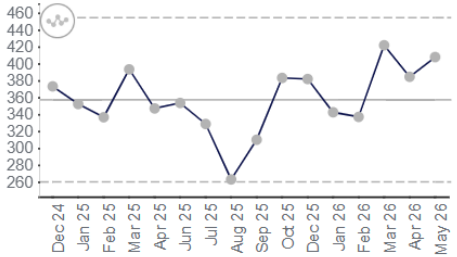
Sickness Absence Overall



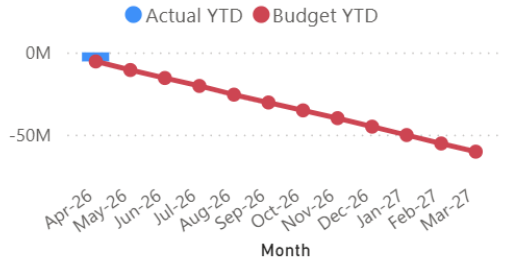
Workforce Stability



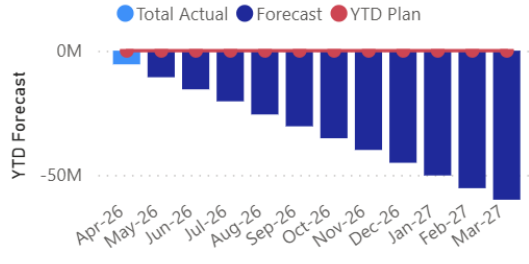
A&E Attendances per ED Consultant WTE



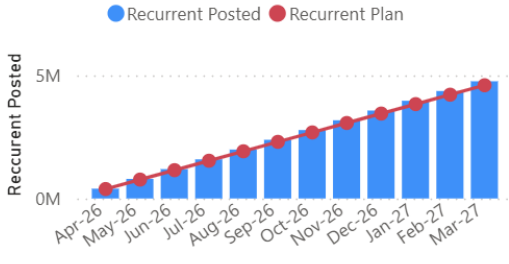
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



DIVISIONAL PERFORMANCE SUMMARY – SURGERY

NHS
Alder Hey Children's
NHS Foundation Trust

SRO: Benedetta Pettorini, Division of Surgical Care

HIGHLIGHTS

- RTT performance continues to improve (68.1%)
- 100% response to PALS
- Mandatory training remains above target at 93%
- 100% compliance with DMO1
- % letters completed in 10 days remains significantly higher for 3rd consecutive month

AREAS OF CONCERN

- Volume of CYP waiting over 52 weeks to access care remains high (211).
- WNB increased to 10% which is consistent with attendance rates during half term. Also noted initial impact with patient portal launch whereby families are not always accessing their invite letters digitally and no longer receiving an additional paper letter.
- Sickness remains above the 5% target at 7% however overall trend since Nov 25 is decreasing month on month.
- ERF M2 YTD performance currently remains behind plan (-580k). 460k of the underperformance is within cardiac services and will be recovered throughout the year. Key drivers are loss of activity due to bank holidays when the team operate two theatres, Increase in non-electives and consultant vacancy in cardiology. Consultant has now started and will be operating from Mid-June.
- Division remains with around 3.8k CYP overdue by 2 years for follow up, key areas include Paediatric Surgery, Plastic Surgery & Audiology.

FORWARD LOOK (WITH ACTIONS)

- Issue arising from patient portal go live around appointment invites to have joint discussion with operational and digital team.
- CYP waiting over 2 years for follow up continues to be a challenge, however volume has not increased further over the past 3 months and actions are underway in specialities. Targeted approach required to agree and action pathways for patients over 18 years old who are two years past their follow up date.
- Key areas of challenge to achieve zero CYP waiting over 52 weeks in 2026/27 are Dental, Chronic Pain and ICC. Recovery plans are in place/being developed with Dental and ICC including successful recruitment into a joint Dental Consultant post with Merseycare.
- Focus on specialties with lower compliance with completion of letters within 10 days.

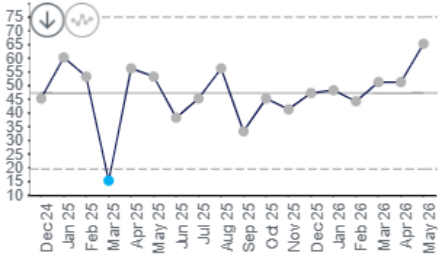
FINANCIAL POSITION

I&E distance from target
(Cumulative to date)
-£938.6k*

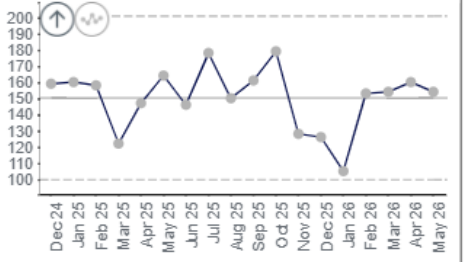
*Divisional positions exclude CIP

Divisional Performance Summary - Surgery

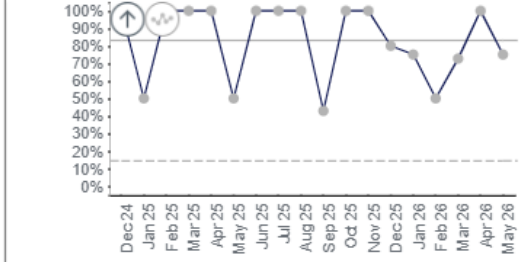
Patient Safety Incidents rated Low Harm & Above



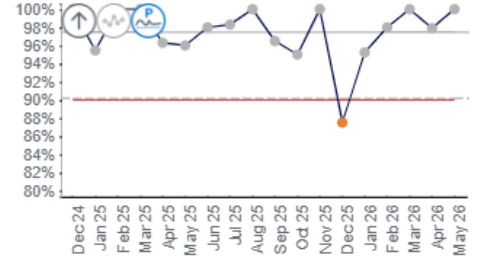
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

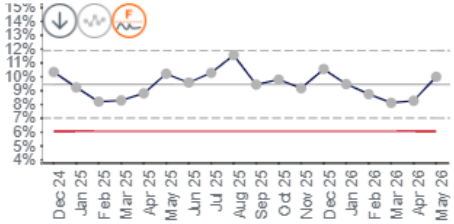


% PALS Resolved within 5 Days

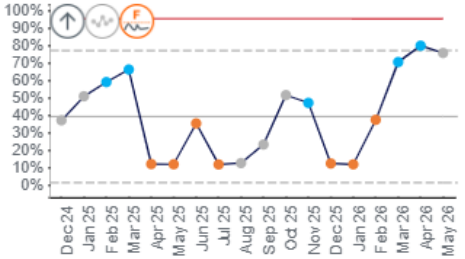


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

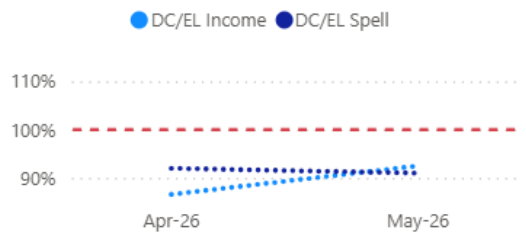


% of Clinical Letters completed within 10 Days



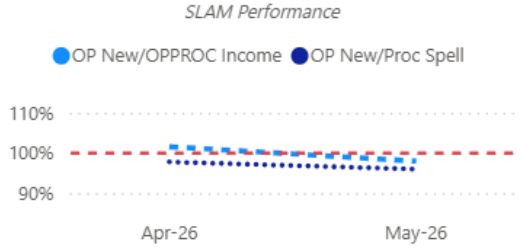
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

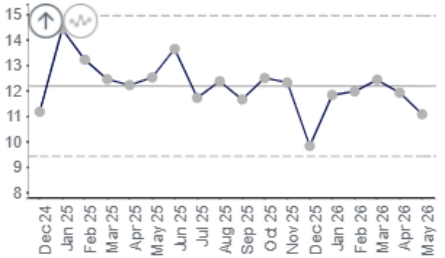


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

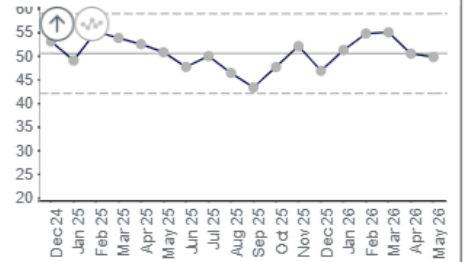
SLAM Performance



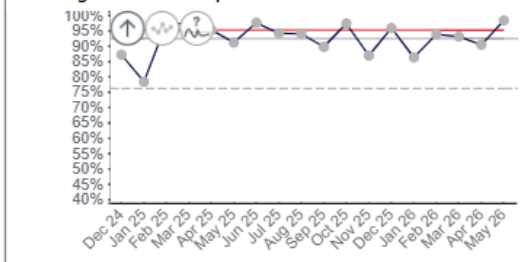
Inpatient Discharges per working day



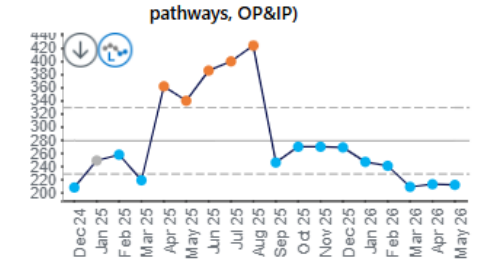
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral

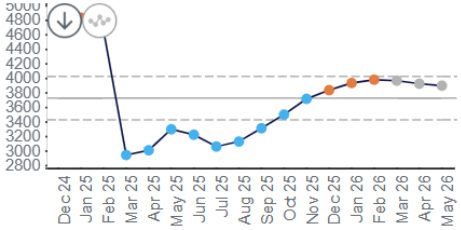


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)

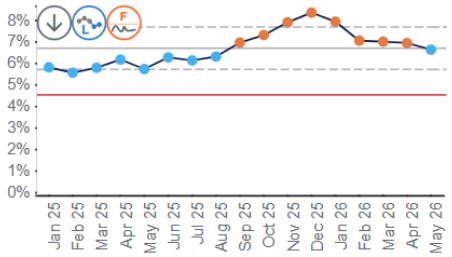


Divisional Performance Summary - Surgery

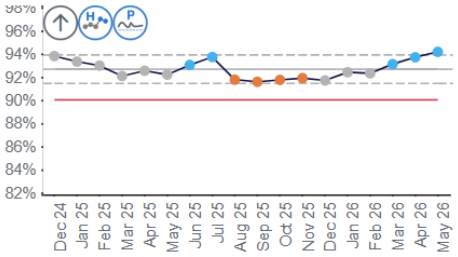
Volume of active outpatient follow up waits - 2 Years & Overdue



Sickness Absence Overall

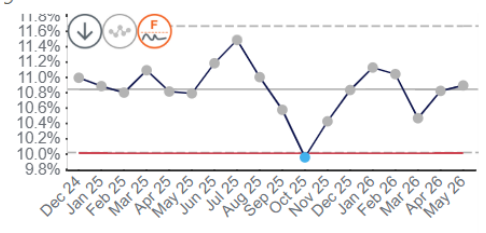


Mandatory Training

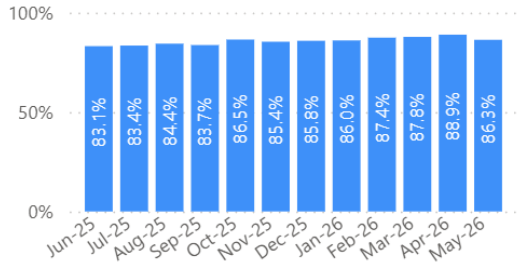


Staff Turnover

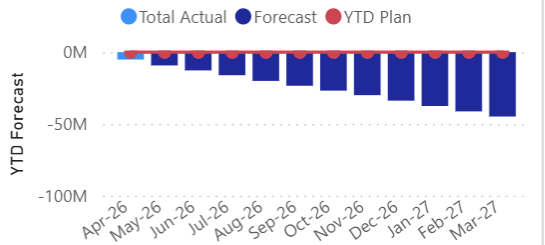
Target: Internal



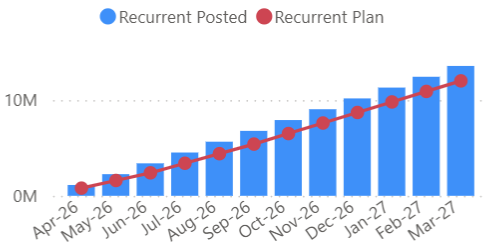
Workforce Stability



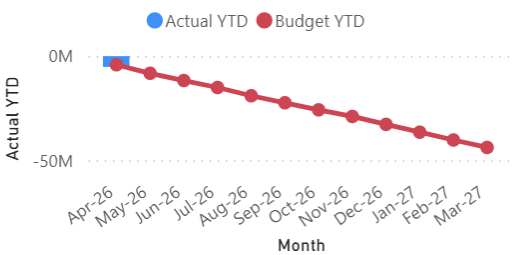
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



DIVISIONAL PERFORMANCE SUMMARY – CORPORATE

NHS
Alder Hey Children's
NHS Foundation Trust

SRO: Erica Saunders, Chief Corporate Affairs Officer

HIGHLIGHTS

The Corporate Services Collaborative is scheduled to meet on 15th June 2026. Highlights from the May data include:

- PDR compliance for B7 remained above target at 95%
- Mandatory training compliance remains above target at 93%
- Overall sickness absence is below Trust target at 4%
- Despite a slight increase in-month, short term sickness absence remains below Trust target at 2%
- Risk Management:
  - 10 high risks (15+)
  - 30 moderate risks
  - 5 low risks
  - 98% of risks within review date (44/45)
  - Digital continue to dominate the risk profile
- Identified/delivered £3.3m CIP

AREAS OF CONCERN

- Overall PDR compliance remains below target at 79%
- Main cost pressures include unachieved CIP, legacy pressures, energy/water, leases, legal fees, security, postage and contract costs.
- Overall PDR completion 79%
- Time to hire during May was 19 days
- £0.8m gap in CIP

FORWARD LOOK (WITH ACTIONS)

- The Corporate Services Collaborative meeting in June will focus on the future shape of the meeting as we move into the Professional Services System.

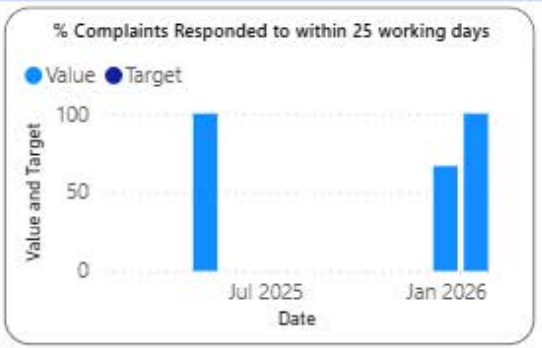
FINANCIAL POSITION

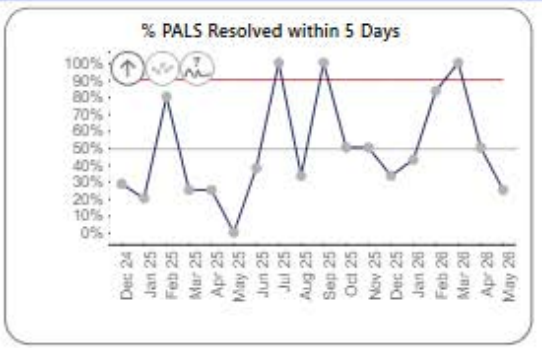
I&E distance from target (Cumulative to date)

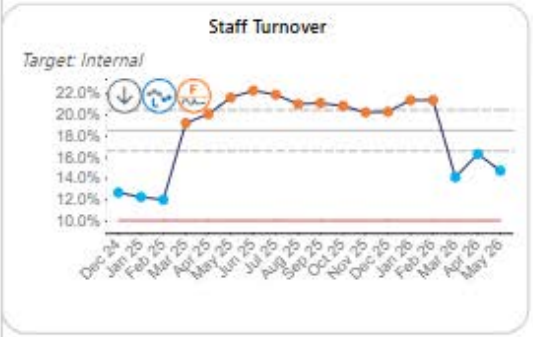
-£576.4k*

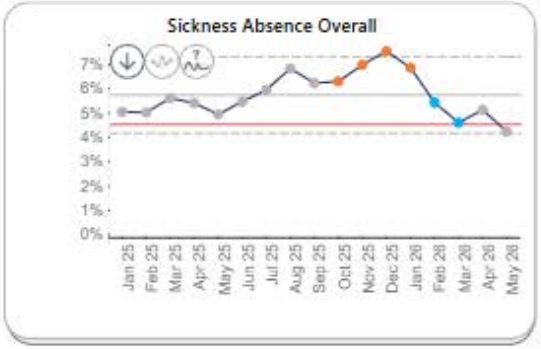
*Divisional positions exclude CIP

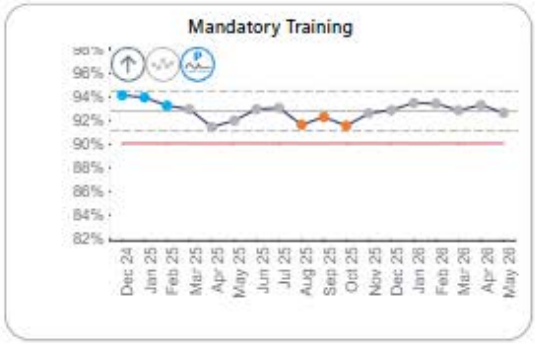
Divisional Performance Summary - Corporate

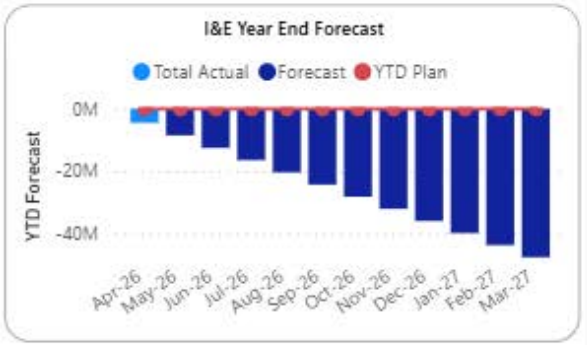


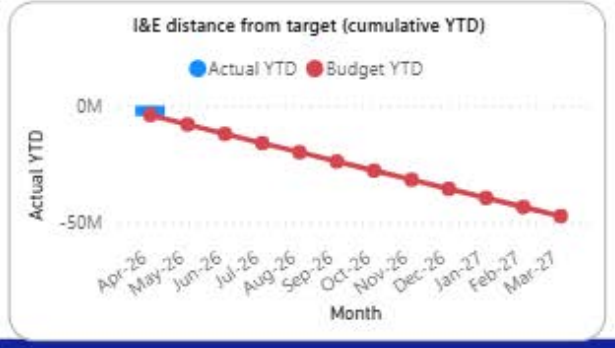












Q4 2025/26 NOF Segment Summary

Jun-26 Published

Trust rank

15 out of 134

Previous quarter's rank: 14 out of 134

OVERALL DOMAIN PERFORMANCE

Effectiveness & Experience	Finance & Productivity	Access to Services	Patient Safety	People & Workforce
1.00	1.38	1.80	2.24	2.47
HIGH PERFORMING	HIGH PERFORMING	HIGH PERFORMING	ABOVE AVERAGE	ABOVE AVERAGE
Overall Domain Segment	Overall Domain Segment	Overall Domain Segment	Overall Domain Segment	Overall Domain Segment
1	1	1	2	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
Patient Safety	NHS Staff survey - raising concerns sub-score	1.20	1.05	1.05	→	10/134
	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

Transformation Scorecard – June 2026/27

VISION 2030

NHS Alder Hey Children's NHS Foundation Trust

Revolutionise Care | **HWWWiTF** | **Digital Data, AI & Advancement** | **CYP System** | **Financial Improvement Programme**

Key Messages

All 5 Programmes have now started, with working groups set up and mobilised. Additional work is required to finalise full benefits and milestones.

Assurance on delivery as well as scoping the scale of the change on staff and the organisation is now required.

Highlights

- Reimagining Outpatient Care launched
- Significant progress being made with patient portal and AVT expansion
- Senior staff within the new clinical systems have started to transition to their new roles

Areas of concern

- Metric development still ongoing
- Some programmes still not commenced.
- Oversight of AVT required to ensure usage and uptake are sustained

Actions & Next Steps

- Outpatients programme to set up all working groups
- Additional work on metric and benefits development required
- Review of Rev Care and Digital interdependencies to prevent duplication

Performance by Programme

Programme / Outcome	Metric	Baseline	Target	May-26	Trend
Revolutionise Care *Right Care, Right Time, Right Place – First Time*	% of A&E attendances who are admitted to an inpatient ward	9.8%	*TBC*	10.4%	↑
	% of admissions to an inpatient ward from A&E with LoS <1 day	20.9%	*TBC*	22.1%	↑
	Attendances to ED per 100,000 pop	1,211	*TBC*	1,286	→
	PCAS referrals for ages 0-5 which managed digital clinical service	*TBC*	*TBC*	*TBC*	–
	% Non-admitted RTT	73.1%	92%	76%	↑
	% PIFU	6.3%	10%	8.7%	↑
	% Advice & Guidance requests which do not result in an outpatient appointment	45.8%	*TBC*	47.8%	↑
HWWWiTF *Thriving people delivering sustainable services*	Reduce WTE Employed	4,215	4,000	4,198	↓

Performance by Programme

Programme / Outcome	Metric	Baseline	Target	May-26	Trend
Digital Data, AI & Advancement *Advancing care for the next generation*	% of Clinical Letters produced via AVT	80%	100%	86%	↑
	Number of AI Projects/pathways Live	5	20	5	→
	Patient Portal adoption	98,87%	70%	49.6% 49,075	↑
	Digitally enabled financial benefits	£0k	≥£500k	£45k	↑
CYP System	*Metrics to be scoped*				
Financial Improvement Programme *Delivering sustainable services*	CIP Delivery – Trust-wide	£0k	£24.6m	£9.56m	↑
	CIP – Bring me the Future	£0k	£193k	£0k	→
	CIP – Revolutionise Care	£0k	£4m	£3.15m	↑
	CIP – HWWWITF	£0k	£10.5m	£2.33m	↑
	CIP – Digital Data, AI & Advancement	£0k	£500k	£270k	↓
	CIP – Financial Improvement Programme	£0k	£9.4m	£4.08m	↑

Trend key: ↑ On track / Improved; → No change / Stable; ↓ Off track / Decline; – Not applicable / No data

TBC: To be confirmed

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**Trust Mortality Report Quarter 4 2025-26**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

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

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

Risk number	Risk description	Score

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

MORTALITY ASSESSMENT AT ALDER HEY
Medical Director's Mortality Report

This report is presented in two sections. Section 1 summarises Hospital Mortality Review Group (HMRG) data, including the number and type of deaths at Alder Hey, year to date, and assesses performance against the group's objectives.

Section 2 provides the Quarter 4 mortality report, including PICU statistical analysis and further review of place of death, teams involved, and expected versus observed deaths.

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

Monthly deaths at Alder Hey between 2020 and 2026 have remained broadly stable, with most months recording between four and ten deaths. Seasonal increases are seen in some years, particularly in March, September and November. Deaths in autumn 2025 and the early months of 2026 were lower than in previous years. This will require continued monitoring, particularly as no major service changes have been identified to explain the reduction.

Figure 1

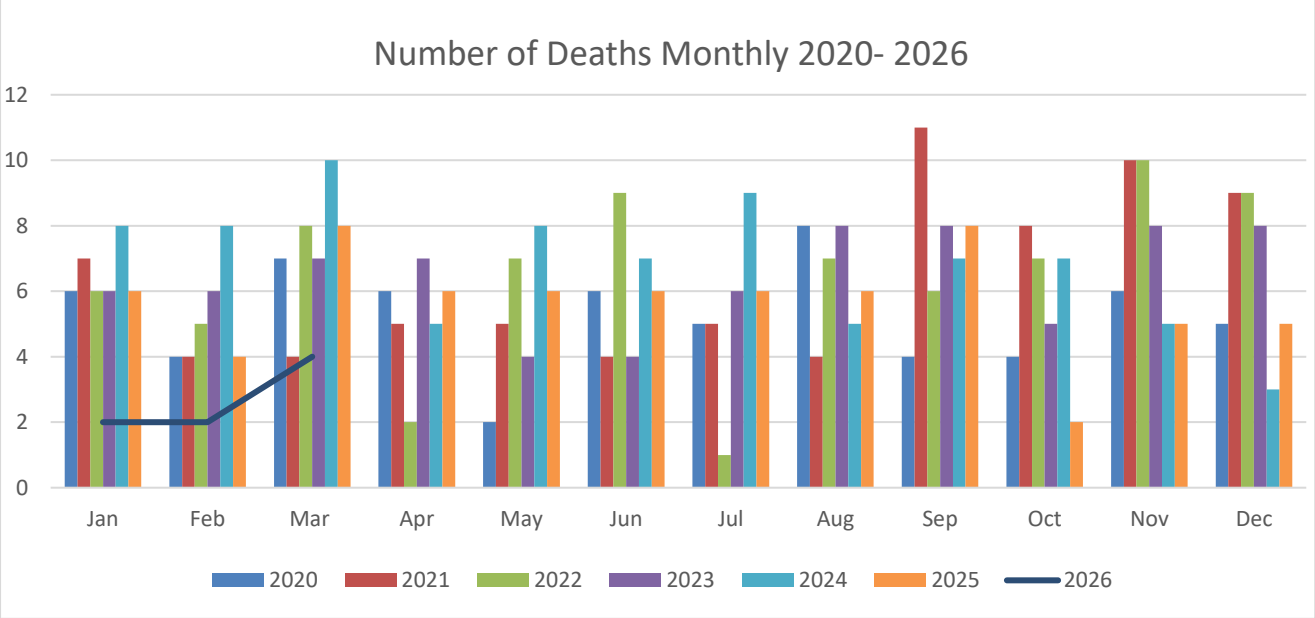


Figure 2

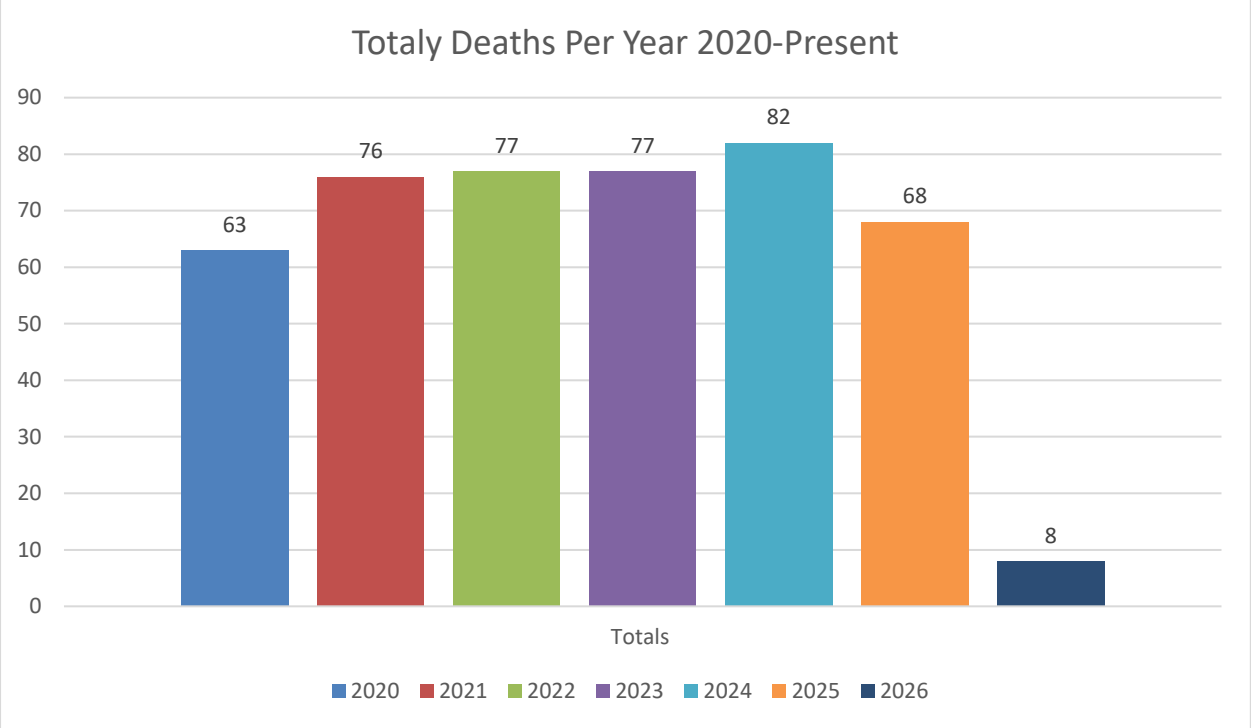


Figure 2 shows total deaths per year from 2020 to 2026. Deaths peaked at 82 in 2024 before falling to 68 in 2025, the lowest total in the period shown. Lower figures in 2020 reflect a change in recording practice, as emergency department deaths were not included until after that year. Overall, the data indicates year-to-year fluctuation rather than a sustained trend, with a notable peak in 2024.

Core Service Updates

The Trust's Child Death Review (CDR) process continues to develop in response to learning from HMRG members, bereaved families and external changes. Key updates for May 2026 are set out below.

1) Mortality coding issues highlighted in the previous report, which affected external benchmarking, are being addressed. Cases from 2025–26 have been clinically reviewed, process weaknesses have been identified and corrected, and the aim is to ensure submitted data more accurately reflects cause of death and supports more meaningful benchmarking.

2) Families provided highly positive feedback on bereavement support during the quarter, highlighting staff commitment to listening to families' wishes and acting on them wherever possible.

3) Cases identified that bone fragility in critically ill infants with prolonged stays may lead to incidental fractures and require careful multidisciplinary assessment. In response, routine bone health and nutritional monitoring in prolonged PICU admissions has been strengthened.

4) Further learning highlighted the need for clear MDT documentation of the rationale for procedural timing when children are clinically unstable, particularly where transfer is required. Families should be counselled clearly about the level of risk before transfer so that expectations are realistic and decisions are fully informed. Ongoing neonatal capacity pressures continue to result in long-distance out-of-region transfers, with potential impact on families and timeliness of care; these concerns continue to be escalated through neonatal ODN and governance routes.

5) Antenatal counselling should take full account of co-morbidities so that families receive a clear and consistent understanding of prognosis. Separate advice from individual teams without a shared view of overall complexity can cause confusion.

6) Feedback also identified a need for greater understanding of the palliative care team's role, so that staff and families have realistic expectations of the service and its prioritisation of the most urgent needs across hospital and community settings.

7) Learning this quarter confirmed the need to ensure appropriate extreme-preterm neonatal equipment is available and accessible in ED. Neonatal services will therefore maintain a dedicated ED neonatal grab bag, with clear ownership and checking arrangements.

8) The respiratory team identified the need for earlier discussions with families of children with life-limiting conditions about the appropriateness of PICU admission and any potential ceilings of care.

9) Earlier use of gentamicin should be considered in septic children with urological anomalies or a risk of resistant organisms.

Current Performance of HMRG - Summary of 2025 Deaths

Figure 3

Number of deaths (Jan. 2025 – Dec 2025)	68 +1 reviewed in LWH
Number of deaths reviewed	68
HMRG Primary Reviews within 4 months (standard)	67/68 (99%)

Performance against the 4-month review standard remains high. In addition to in-hospital deaths, HMRG also reviews hospice deaths where care was primarily delivered by AHCH. The group's multidisciplinary membership, including Alder Hey clinicians, NWTS, LWH neonatology, psychology and the Snowdrop bereavement team, supports timely and comprehensive review.

Most cases are clinically complex and require discussion across more than one meeting. This allows early review while recognising that the CDR process cannot be concluded until related investigations, including patient safety reviews and coronial

processes, are complete. Monthly virtual meetings support wider participation, including from DGH clinicians where appropriate, and help ensure timely discussion and shared learning.

New InPhase Mortality Module

HMRG members have worked with InPhase developers to design the mortality module, which will improve workflow efficiency and provide a central repository for mortality-related information. All cases from the January 2026 meeting were processed through the module, giving clearer oversight of progress across the CDOP pathway. Development remains ongoing as use of the module expands.

Outcomes of the HMRG process 2025

Figure 4: Outcome table

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

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

** 2 still births included in the total but reviewed in AHCH

Potentially Avoidable Deaths

Two deaths reviewed to date in 2025 have been classified as potentially avoidable. Both related to external factors and do not indicate concerns about care provided at AHCH.

Sepsis-related mortality reviews

Sepsis-related deaths have been reviewed through the Trust's established mortality review processes. In the cases reviewed, clinical care was assessed as appropriate, with children having received recommended routine immunisations and no modifiable factors identified.

Learning Disability

The number of learning disability cases over the past four years has varied without a clear trend. As a proportion of all deaths, the percentage has remained relatively stable at 16% to 20% and is 18% in the 2025 cases reviewed to date.

Figure 5

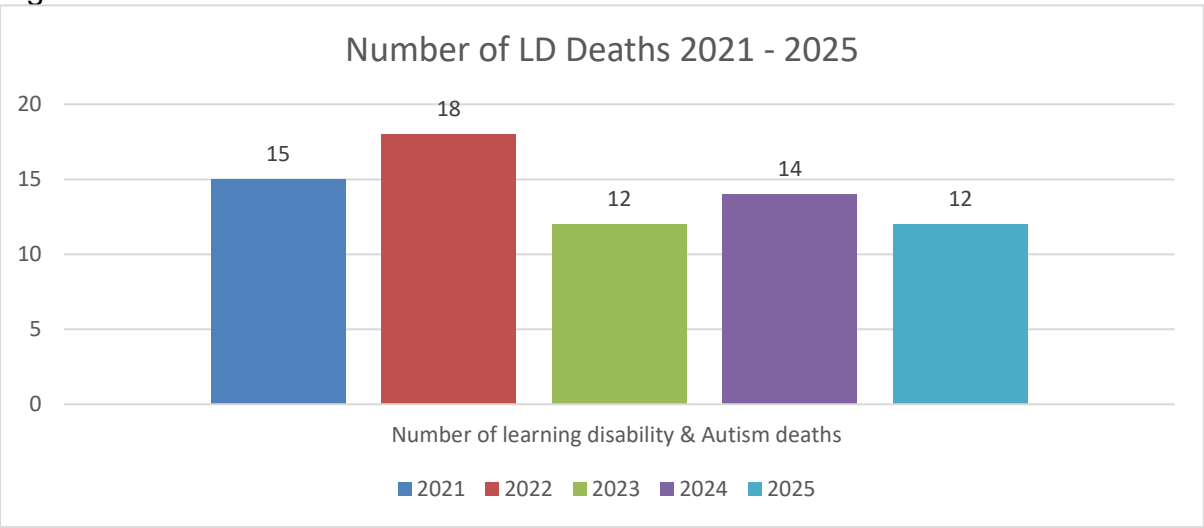
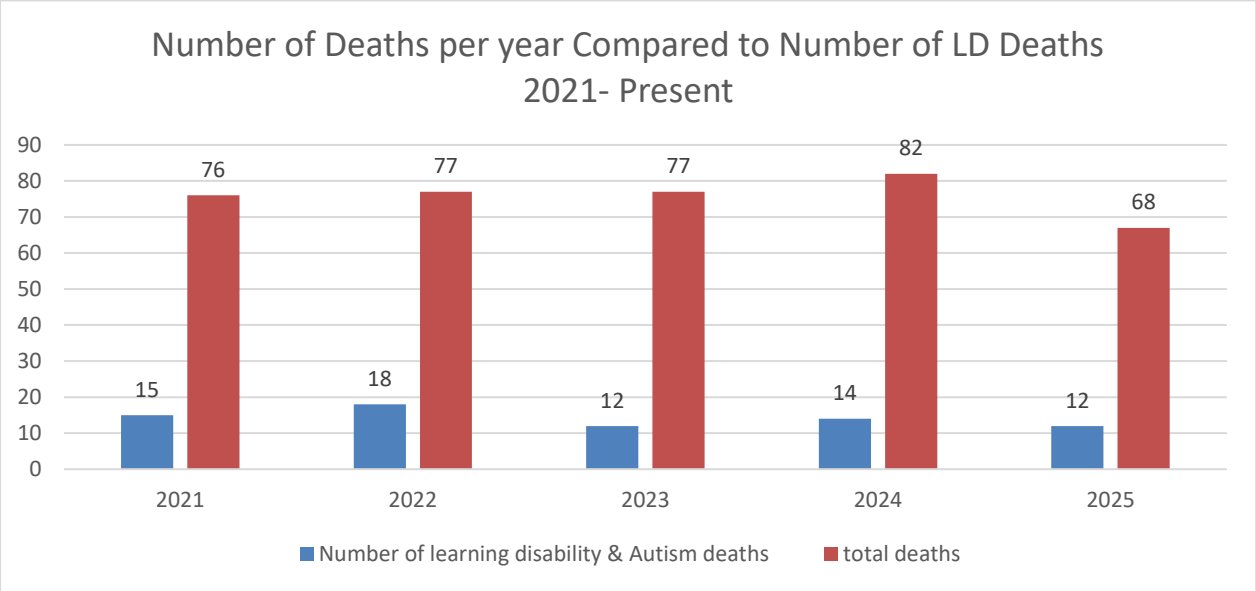


Figure 6



The LeDeR programme was established to ensure comprehensive review of deaths in patients with learning disabilities. Since July 2023, deaths of children and young people aged 4 and over with a learning disability and/or autism are no longer reported to LeDeR and are instead reviewed through standard child death processes, avoiding duplication of case-level review.

The latest national LeDeR report relates to deaths in 2023 and was published in September 2025. It focuses primarily on adults (18+); however, population-level learning about children with learning disability and autism is incorporated through linkage with national datasets including the National Child Mortality Database (NCMD).

A Quarter 4 deep dive is undertaken annually for learning disability cases. In 2025, 12 such cases were reviewed. To preserve anonymity, only high-level causes of death are summarised below.

1) Most children had complex conditions for which no further treatment options were available, and several deaths were coded as inevitable.
2) A small number were sudden unexpected deaths and will be reviewed further once coronial processes are complete to identify any additional learning and amend coding if required.
3) A small number were related to incurable malignancy in children who were receiving palliative care.

No concerning themes or trends have been identified in the learning disability cohort during the year. However, the complexity of this group can make treatment and decision-making more challenging for both families and clinical teams.

HMRG continues to work closely with the Trust's Learning Disability services to ensure relevant findings are shared and acted on, supporting safe, high-quality care for this complex patient group.

Neonates

A neonate is defined as a baby aged under 28 days. Of the cases reviewed to date, 24 neonatal deaths have been recorded, representing 35% of all deaths. Of these, 67% were coded as congenital, genetic or chromosomal anomalies, and the remaining 33% as neonatal/perinatal causes.

Figure 7

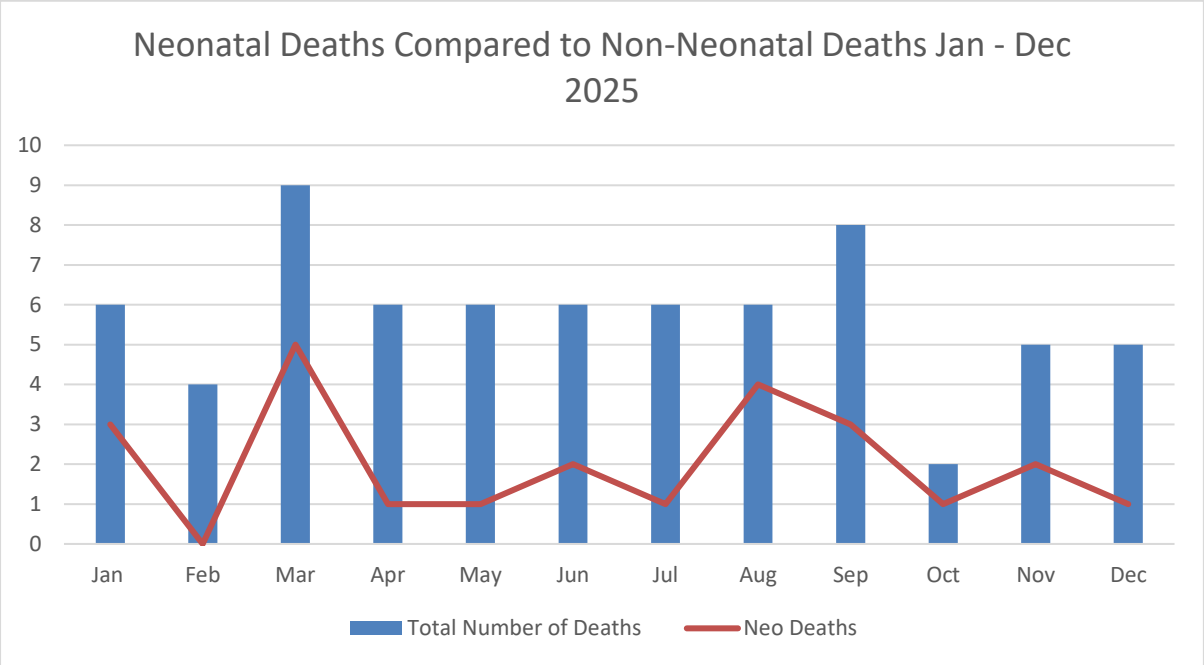


Figure 8

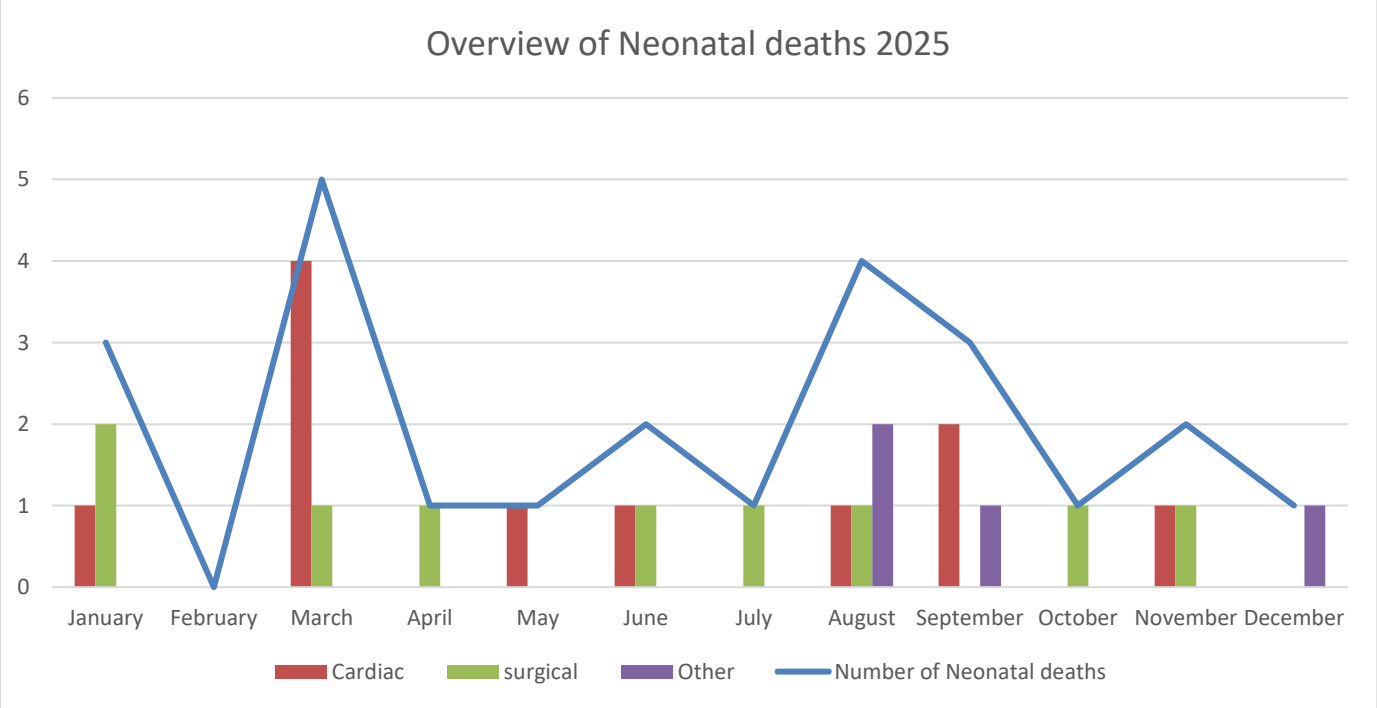


Figure 8 breaks the neonatal caseload down into complex congenital cardiac defects, surgical cases and other categories against the total number of neonatal deaths. Surgical cases mainly involved premature infants with necrotising enterocolitis (NEC), a recognised complication in this population. In 66% of neonatal cases, investigation and clinical assessment concluded that no further treatment

options were available, and care was therefore transitioned to palliative pathways following multidisciplinary discussion and agreement with families.

The Perinatal Mortality Review Tool (PMRT) recommends that reviews are undertaken by the trust where the baby dies. This is not feasible at AHCH because obstetric services are not provided on site. Instead, the hospital of birth completes the PMRT and shares it with AHCH for review by HMRG members. To strengthen alignment between review processes, the HMRG form will be updated to include PMRT findings and summaries. HMRG also continues to advocate for PMRT-based obstetric history review where babies die outside the hospital of birth and will work with partner organisations to promote consistent practice.

Timely and effective communication with families following a child's death

The Snowdrop bereavement team provides ongoing support to families following the death of a child or young person and works closely with palliative care and HMRG to represent the family voice at HMRG.
Requests from families for written summaries of HMRG reviews are increasing. In line with national child death review guidance, detailed audit documentation is not shared; instead, families are provided with a plain English summary designed to minimise distress. This reflects a wider national discussion regarding how best to provide written feedback to bereaved families without causing additional trauma.

The Trust has strengthened its processes to support timely, consistent and compassionate communication with bereaved families. All family requests for feedback are formally acknowledged on receipt and logged via a shared inbox, overseen by designated HMRG members to ensure visibility, tracking and appropriate escalation. A single named consultant is responsible for drafting written responses, with all correspondence reviewed by the Lead Nurse prior to distribution to ensure clarity, accuracy and appropriate tone.

Timeliness of formal responses is monitored; however, responses are dependent on completion of relevant review processes (including internal mortality review, Child Death Review and, where applicable, external investigations). In cases involving multi-agency review, these processes may take many months to conclude. The Trust's approach is to ensure that feedback is accurate, complete and aligned with final findings, while maintaining interim communication and support to families through bereavement services where appropriate.

External Benchmarking

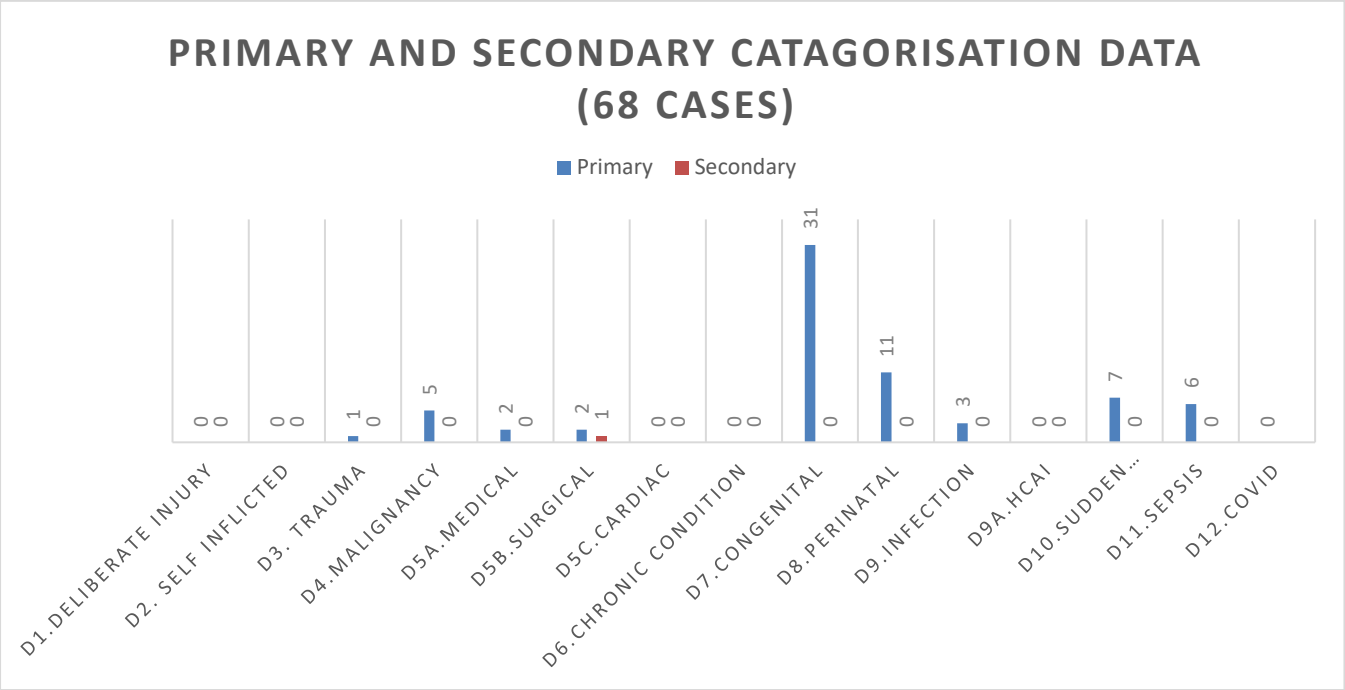
AHCH continues to benchmark against Birmingham Children's Hospital, which has a similar caseload and demographic profile. This supports comparison of trends, shared learning and process improvement. Work is also underway with other trusts to establish a wider mortality network, recognising the benefit of collaboration across organisations facing similar challenges.

Formal external assurance has previously demonstrated a strong and effective learning-from-deaths process, with the 2022/23 MIAA Morbidity and Mortality Review reporting **High Assurance**, indicating robust internal controls and consistent application of learning processes.

Informal benchmarking with statistical neighbours is currently undertaken as a peer-review exercise and therefore does not generate defined outcomes or tracked improvement actions.

Primary and Secondary Categories

Figure 9

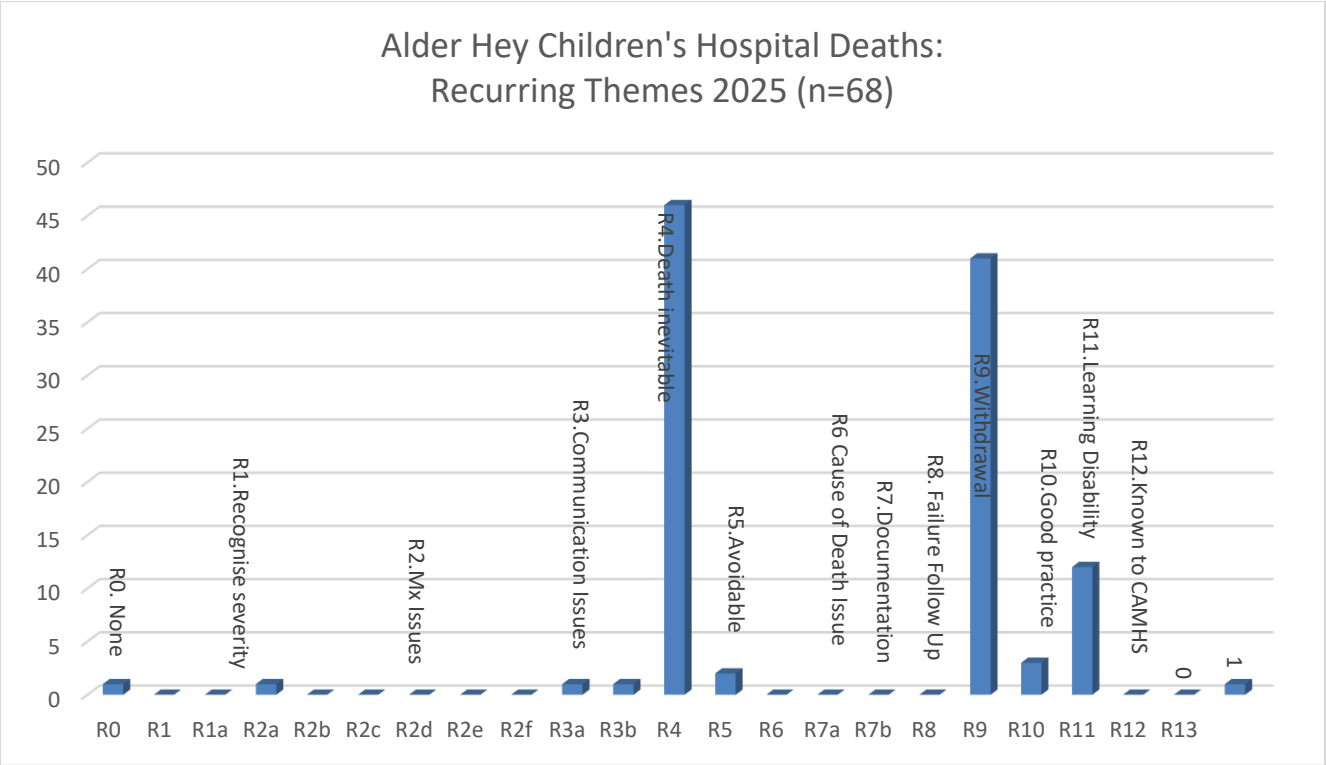


Cases reviewed to date in 2025 show that the largest diagnostic group is D7, covering children with underlying chromosomal, genetic and congenital conditions (46%). The next largest group is D8, covering perinatal causes and infants whose deaths were related to prematurity or neonatal factors (16%). This cohort is discussed further in the neonatal section above.

Chromosomal, genetic and congenital conditions are often complex and affect highly vulnerable children. They may be life-limiting or life-threatening, although care provided by AHCH, wider health services and families has enabled many children to live longer than previously expected.

Recurrent Themes

Figure 10



The main recurrent theme in 2025 to date is deaths assessed as inevitable despite the care and expertise provided at AHCH, accounting for 66% of cases. This includes cases where subsequent review concluded that death was unavoidable. This is not indicative of poor care, as some children are transferred for further investigation and are later found to have life-limiting conditions. The next most common theme is withdrawal of life-sustaining treatment, reflecting shared decision-making with families when ongoing treatment is no longer in the child's best interests.

Learning disability cases and potentially avoidable deaths are discussed in earlier sections of this report.

Section 2: Quarter 4 Mortality Report: Dec 2025 – Feb 2026

External Benchmarking

Standardised Paediatric Mortality Index (SPMI) – HED

The Standardised Paediatric Mortality Index (SPMI) is a paediatric-specific measure of observed versus expected in-hospital deaths, multiplied by 100. A value above 100 indicates mortality above the NHS average, while a value below 100 indicates mortality

below the NHS average. The data presented relates to the most recent available period, December 2025 to February 2026.

Figure 11

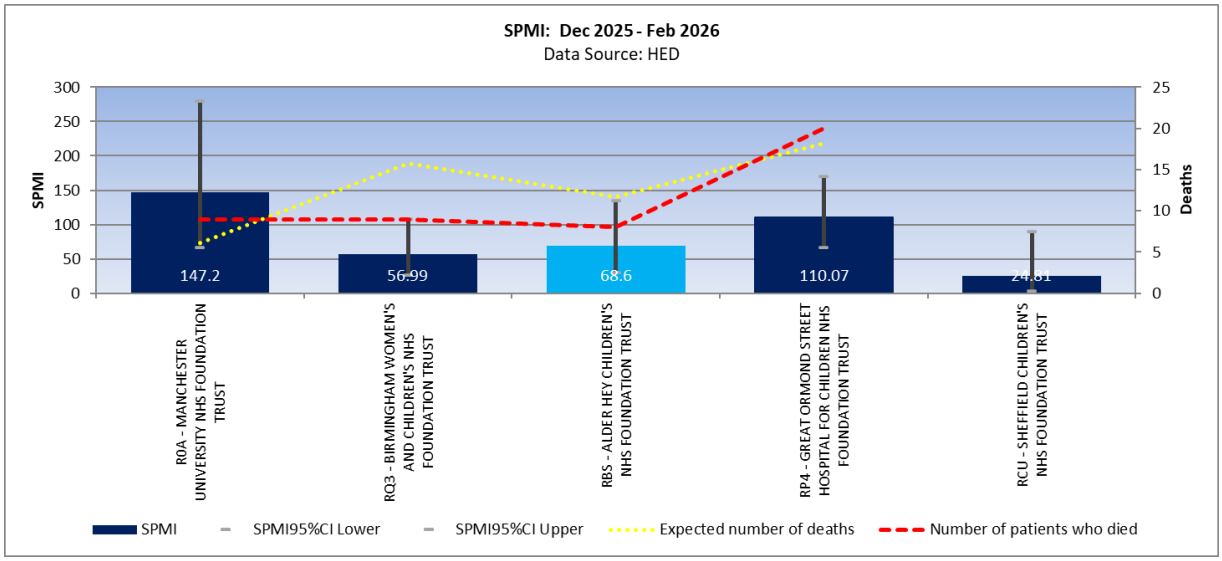


Figure 11 shows that Alder Hey recorded 8 observed deaths against 11.7 expected deaths. This suggests that previous coding issues may now be improving and aligns with the lower than usual number of deaths during the period. Birmingham Children's Hospital, the most comparable trust by caseload and demographics, showed a similar pattern, with the previous quarter's higher-than-expected position appearing to have corrected in the current period.

Figure 12

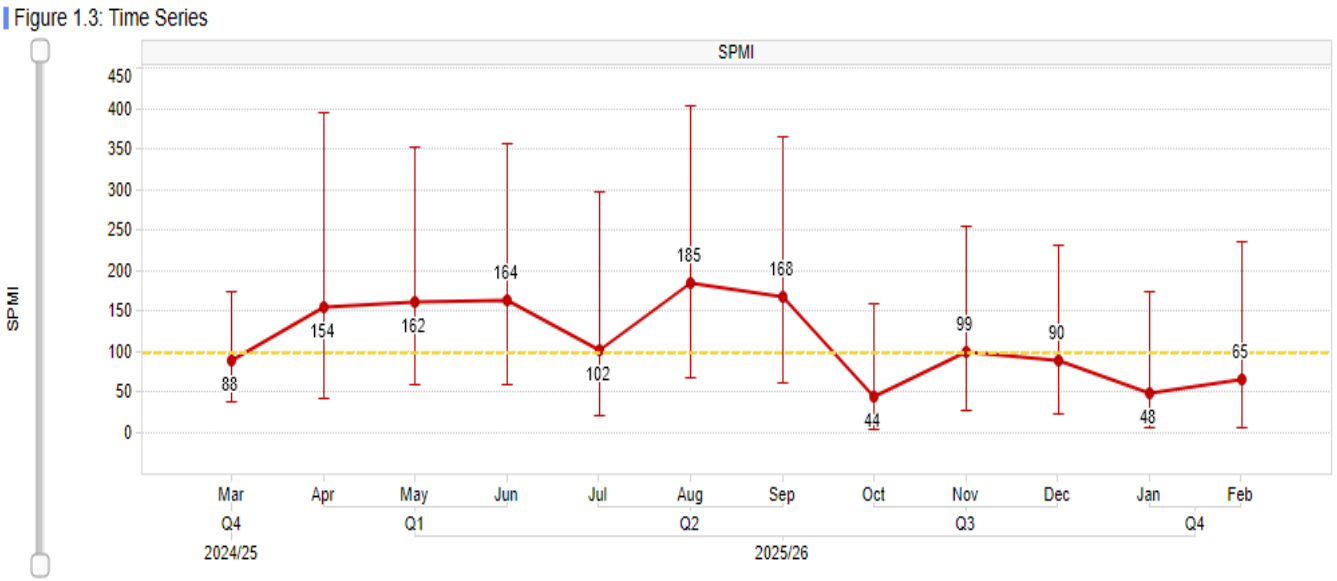


Figure 12 shows SPMI performance over the last year and highlights periods where there were concerns about submitted data. In April to June 2025, incomplete data

affected the expected number of deaths. A further peak is seen in August and September and is expected to reduce once coding corrections are fully reflected, although this is likely to take several months. The current quarter appears accurate, aligns with HMRG review findings, and reflects improved coding quality.

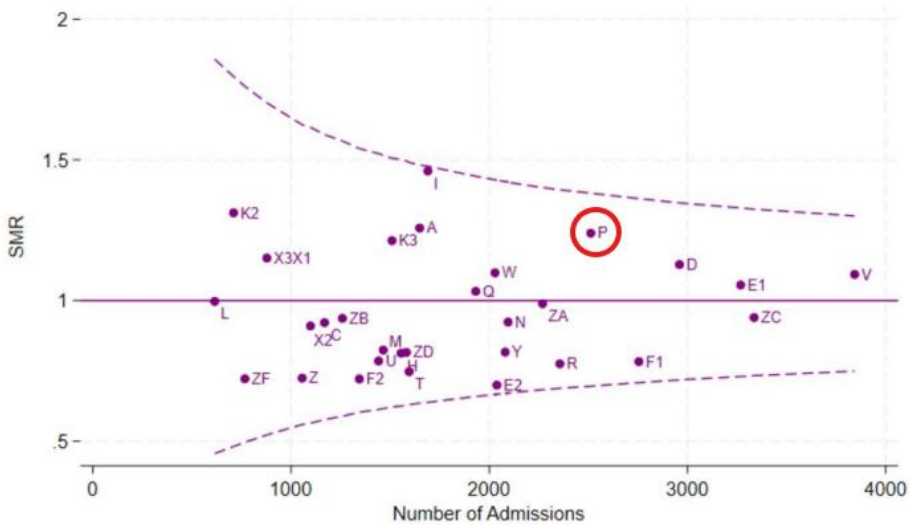
Paediatric Intensive Care Unit (PICU)

Around 85% to 90% of deaths occur in PICU, consistent with other specialist children's trusts. In the most recent PICANet report (covering 2021–2023 and published in 2024), mortality is presented using funnel plots in which each organisation's Standardised Mortality Ratio (SMR) is plotted against admissions.

Across the three-year reporting period, there was no evidence that any PICU had mortality above that expected for the severity of illness at admission. As shown in the funnel plot, all SMR estimates remained within control limits.

Metric 5: Risk adjusted in–PICU mortality

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

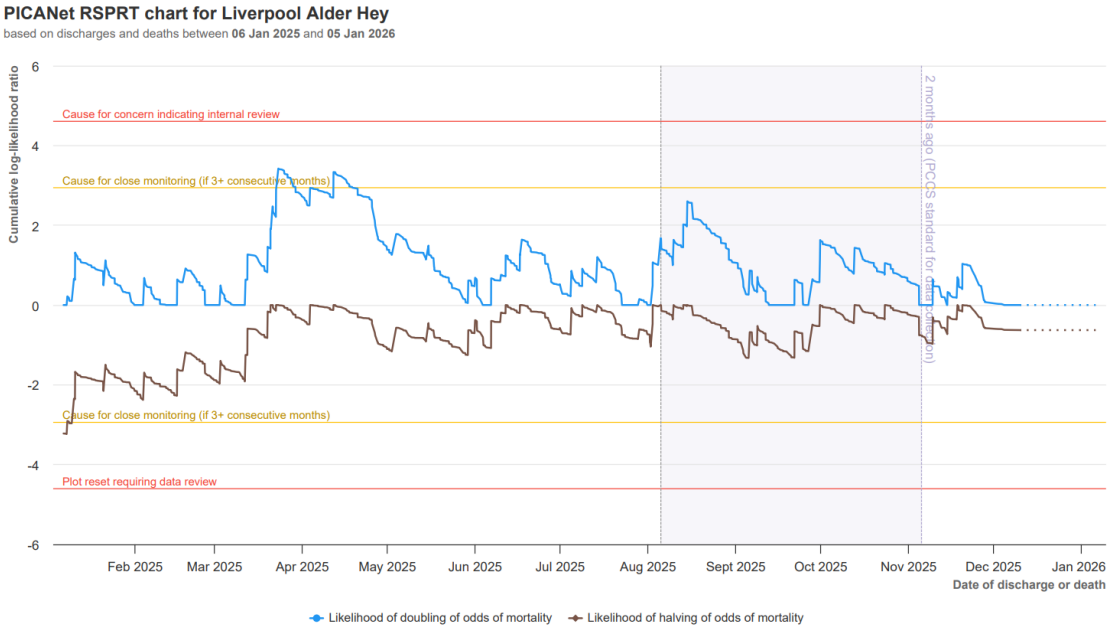


In the funnel plot, Alder Hey is shown at point 'P'. Its SMR remains within the control limits, indicating that mortality is within the expected range.

Statistical analysis of mortality:

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

RSPRT charts show cumulative mortality for the unit against that predicted by PIM3 scores. The area between the orange lines represents expected day-to-day variation, while the space up to the red threshold can be regarded as a warning zone. Until a death occurs, the upper line remains flat and the lower line gradually falls. Each death moves the upper line upwards and the lower line closer to zero. When either line reaches the red threshold, the chart resets to zero. These data are nationally validated through PICANet.



Mortality was low during January to March 2026, with 5 deaths across 244 admissions, equating to a mortality rate of 2%. This resulted in the service crossing the lower threshold for ‘cause for close monitoring’. While this does not in itself give rise to concern, no specific changes in practice, pathways, or case mix were identified during the period that would account for the reduction.

Further refinements have been made to strengthen PICU departmental oversight and learning processes:

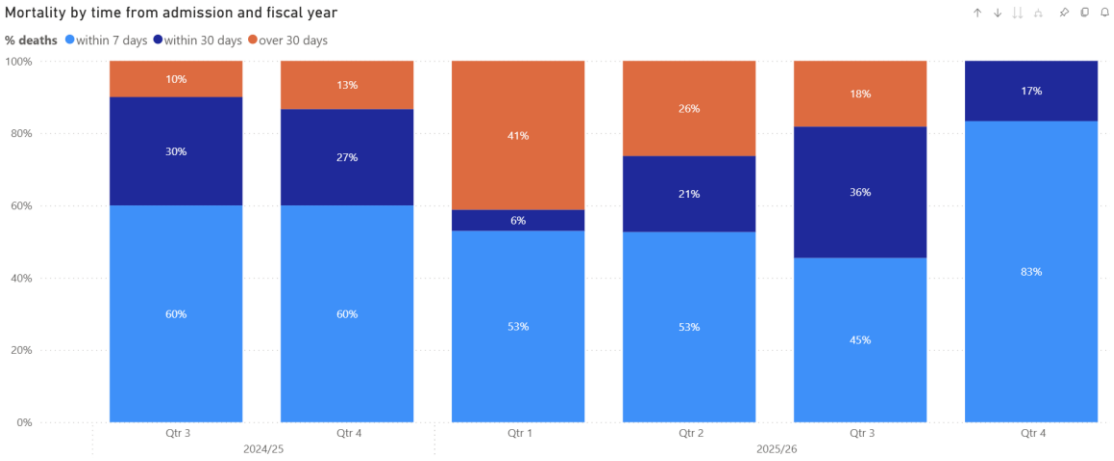
- Cardiac arrests are now subject to a structured, multidisciplinary review in the week following the event, complementing the cardiac arrest prevention initiative for patients identified as being at high risk.
- The department is working towards routine review of patients discharged to other settings for end-of-life care, for example to the ward or hospice. Although these cases are not included in the mortality data, this should support earlier identification of pathway issues and inform the child death review process.

- Relevant specialty consultants are invited directly to provide case-specific feedback where they are unable to attend the meeting.
- Where care is assessed as 'adequate/standard', examples of particularly good practice are now explicitly highlighted in line with the Learning from Excellence principle.

Real-Time Monitoring of Mortality

Mortality is now monitored in real time and analysed by year, ward, specialty, deaths within 30 days of admission, and deaths occurring more than 30 days after admission.

i) The chart below shows mortality by time from admission to death: within 7 days, within 30 days, and over 30 days.



The chart shows that the highest proportion of deaths usually occurs within 7 days of admission, ranging from 45% to 83%. In the most recent quarter, January to March 2026, 83% of deaths occurred within 7 days of admission, 17% occurred between 8 and 30 days, and none occurred after 30 days.

Conclusion

HMRG continues to perform strongly against the 4-month review standard despite increasing case complexity and workload. The review process has matured, with learning shared more effectively and wider engagement from stakeholders, including GPs, DGHs and external services, supporting improved review quality.

Across the Trust, mortality analysis and governance continue to demonstrate transparency and a clear commitment to improvement. This is illustrated by the prompt identification of coding and submission issues affecting HED data and the coordinated response across relevant teams to address them. As a result, processes have been introduced with greater clinical oversight, that hopefully will address the issues identified. As highlighted in this report, there was clear learning demonstrated by changes in clinical practice such as the nutritional monitoring on PICU improving bone health. Further more HMRG is increasingly shaped by the organisation's new

safety-culture approach, promoting psychological safety, open reflection, and stronger multidisciplinary learning. This shift supports more transparent discussions, deeper system learning, and continued improvements in the quality and impact of mortality reviews

Digital processes have been introduced to streamline administration and improve the timeliness of documentation.

Family feedback on child death reviews remains high in volume and requires careful, sensitive handling. This quarter, the Trust received positive feedback from a number of families relating to their bereavement care which shows that we are listening and trying to accommodate their wishes where possible.
Neonatal transfers continue to be monitored through ongoing audit. No significant concerns have been identified in learning disability, neonatal or general paediatric deaths. Continued neonatal audit and comprehensive mortality review provide strong assurance of a proactive approach to mortality governance in the new safety culture that has been created.

References

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

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

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

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 24th June 2026**
Report of:	**SQAC Chair**
Paper Prepared by:	SQAC Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the Safety Quality Assurance Committee meeting held on 24th June, along with the approved minutes from the 20th May 2026 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	

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

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

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

1. **Introduction**

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

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

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

A list of items presented to the meeting is provided in Appendix 1.

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

None

4. **Positive highlights of note/areas of significant discussion**

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

- Divisional Quality update, with good discussion held.
- Liverpool Neonatal Partnership Quality Assurance update with good discussion held.
- Committee welcomed the update/plan regarding clinical letters
- Committee welcomed the Diagnostics notification update, noting that there is further ongoing work required.
- Committee welcomed the Situation, Background, Assessment, Recommendations, Decision (SBARD) for maintaining oversight of Patient Safety through the transition from Divisions to Systems, particularly via InPhase
- Committee welcomed the Oncology outliers update report, noting that further work is required, the committee requested a further update at the December 2026 meeting.
- Committee welcomed Sefton SEND Inspection report, with good discussion held.
- Committee welcomed the Cheshire & Merseyside Mental Health Transformation Plan, with good discussion held.
- Committee welcomed the Mortality Quarter 4 report

5. **Issues for other committees**

None

6. **Recommendations**

The Board is asked to **note** the contents of the report

Appendix 1 – Agenda items received, discussed / approved at the meeting

- Minutes of the meeting held on 20.05.26 were approved as a correct record
- Divisional Quality Assurance updates from each of the Divisions were received and noted
- Liverpool Neonatal Partnership Quality Assurance update was received and noted
- Patient Safety Programme Board update was received and noted
- Infection Prevention Control Annual Report was received and noted
- Clinical Letter Production and Issuing update was received and noted
- Diagnostics notification update was received and noted
- Situation, Background, Assessment, Recommendations, Decision (SBARD) was received and noted for maintaining oversight of Patient Safety through the transition from Divisions to Systems, particularly via InPhase, with good discussion held on the current position.
- Oncology Outliers Report was received and noted with good discussion held
- Sefton SEND Inspection report and outcome was received and noted
- Southport Learning Review was received and noted
- Clinical Effectiveness & Outcome Group Chairs highlight report was received and noted
- Board Assurance Framework was received and noted
- Board Assurance Framework – Deep dive of Risk 1.1 was received and noted
- Trust Mortality Report Quarter 4 Report was received and noted
- Improve My Life Chances update (December 2025-June 2026 inclusive) was received and noted.
- Cheshire & Merseyside Mental Health Transformation Plan was received and noted
- Discharge Planning Policy, was received, noted and Ratified
- Debriefing Guidance document was received, noted and Ratified
- Environmental Risk Assessment and Management Guideline, Self-Harm and Suicide/Ligature Prevention was received and noted. SQAC agreed that amendments are required to be made to the guideline which would be addressed offline, Guideline would be reissued to SQAC to be Ratified at a future meeting once amendments had been made.
- RM49 – Hospital Cleaning Policy was received, Noted and Ratified

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 20th May 2026
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Alfie Bass	Chief Medical Officer	AB
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	Aba
	Kerry Byrne	Non-Executive Director	KB
	Gerald Meehan	Non-Executive Director	GM
	Laura Rad	Head of Nursing – Clinical Research	LR
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	JP
	Rachael Pennington	Associate Chief Nurse – Surgical Division	RP
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Jill Preece	Governance Manager	JPr
	Jenny Devine	Governor	JD
	Veronica Greenwood	Director of Allied Health Professionals (AHPs)	VG
	Jackie Rooney	Associate Director of Nursing & Governance	JR
26-27-35	Kelly Black	Deputy Head of Neonatal Nursing, LNP	KBL
26-27-38	Paul Sanderson	Chief Pharmacist	PS
26-27-40	Sarah Craigie	Patient Safety Investigation Lead	SC
26-27-49	Ian Gilbertson	Deputy Chief Digital & Information Officer	IG
26-27-51	Melissa Ashe	Policy Lead/Advisor to the Chief Executive	MA
26-27-55	Lindsey Neil	Clinical Lead for Children & Young People Gender Service North	LN
Apologies:	Lisa Cooper	Divisional Director, Community & Mental Health Division	LC
	Ava Killbride	Governor	AK

26/27/30 **Welcome and Apologies**
The Chair welcomed everyone to the meeting and apologies were NOTED.

26/27/31 **Declarations of Interest** - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

26/27/32 **Minutes of the Previous Meeting**
The Committee members were content to **APPROVE** the minutes of the meeting held on 22nd April 2026.

26/27/33 **Matters Arising/Review of Action log**
SQAC **NOTED** that BMV compliance remains below expected levels, with challenges in consistent adoption across clinical areas. It was confirmed that an organisation-wide review is underway to understand barriers, including system, workflow and technical issues

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

26/27/34 **Divisional Updates**
Division of Medicine
CW presented the Medicine Division update and drew attention to a few key points from the report including:-
Highlights:-

- Neurology service recovery: Risk rating had reduced to 4 following sustained improvement.
- RTT performance had improved to 94%, with longest waits reduced from >39 weeks to 28 weeks.
- There is a significant reduction in overdue follow-ups (from 133 to 10 for >2 years).
- There is a marked improvement in completed patient pathways.

- Recruitment of ACP and junior clinical fellow
- Positive progress had been made regarding grid trainee recruitment (pending confirmation).
- A successful multidisciplinary away day had been held, improving engagement and team cohesion.
- All previously paused services had now been reopened, with strengthened relationships with District General Hospitals, with improving shared care pathways.
- Development of SLA and clear referral criteria is underway.

Challenges:-

- Challenges were **NOTED** with regards to Patient triage process, although this is actively being addressed.
- There had been a slight decline in policy compliance which remains >90%, attributed to workload pressures and timing of policy reviews.

KB queried whether improvements are sustainable long-term, and whether they are dependent on individual consultants and workforce stability. In response CW advised that improvements are based on fundamental service reset, including team behaviours and relationships, job planning and operational processes and acknowledged residual risk if workforce instability occurs.
AB provided further assurance and advised that the changes are as a result of significant long term work, and not short term gains and represent a system-wide transformation, and not solely operational recovery and includes new models of care delivery across the region; reduced pressure on consultants; cultural and behavioural change within the team.
SQAC **NOTED** this as a potential exemplar model for other fragile services.

FB queried whether learning from backlog recovery could support sustained improvement to meet targets.
Aba referred to the future approach including real-time letter completion and sign-off in clinic, reduced reliance on transcription which is recognised as a cultural shift in clinical practice.
FB raised concern regarding declining compliance trends. In response CW confirmed that this issue is recognised within the Division and is being monitored, with improvement expected in the coming months. CW confirmed that the challenges were linked to workload and clustering of policy reviews.

Division of Surgery

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

Highlights:-

- Successful pilot of day case beds on Ward 3A, improving patient flow and capacity. Positive feedback had been received from both clinicians and patients, leading to extension of the pilot.
- Introduction of “pre-op cinema club” to prepare children for surgery had been well received. This initiative is particularly beneficial for children with additional needs, helping reduce anxiety and improve engagement. Programme is planned to expand further
- Sustained 100% Sepsis pathway compliance
- EPRR compliance is improving, including training and documentation.

Challenges:-

- Ongoing organisational changes which are affecting staff morale and are impacting productivity and workflow efficiency.
- Increased volume and complexity of complaints, placing pressure on team capacity. With continued focus on improving compliance with response timelines.
- While clinical performance remains strong, there is ongoing work required to improve training compliance, particularly in relation to sepsis education.

FB highlighted that there are no risks scored >15 in Surgery, in contrast to other divisions and sought clarity whether this accurately reflects the true risk position, or whether there may be inconsistency in risk scoring across divisions and queried whether there is any potential under-representation of operational and cultural risk, and a need for consistency in risk appetite and scoring methodology across the organisation. In response RP outlined the Division of Surgery approach and advised that risks undergo initial triage through governance meetings prior to inclusion on the risk register. With emphasis on early mitigation, reducing risks to moderate levels where possible; with regular fortnightly review and monthly updates held. RP confirmed that the Division of Surgery philosophy is to avoid tolerating high risks, where mitigation can reasonably reduce them and acknowledged the need to further consider operational risks, particularly in the context of organisational change.

FB **NOTED** the Division of Surgery approach which may represent good practice, particularly in proactive risk mitigation and stated that this may be an opportunity for cross-divisional learning, while ensuring risks are not inadvertently under-scored.
NA proposed that a review of risk scoring and consistency would be undertaken through the Risk Management Forum.
GM referred to the increasing volume and complexity of complaints across the organisation and the impact on staff capacity and the ability to manage and respond effectively. In response RP stated that the use of AI-generated complaints referencing legal frameworks is increasing complexity and creating uncertainty for staff responding to complaints and suggested the need for training and support for staff, particularly around legal context; refocusing responses on clinical care issues rather than legal framing.
FB emphasised the importance of early resolution and direct communication, even where complaints are formally submitted.

Clinical Research Division
LR presented the Clinical Research Division update drew attention to a few key points from the report including:-
Highlights:-
- A successful Quality Round had been held in April 2026, providing an opportunity to reflect on achievements over the previous 12 months, with positive initial feedback.

Challenges:-
- Division are experiencing ongoing difficulty in meeting the 150-day study set-up target, with continued performance pressures and impact on staff.
- Reduction in GCP (Good Clinical Practice) compliance, linked to introduction of new training requirements.
- Workforce pressures requiring prioritisation of activity, including deferral of low-risk sponsor audits to support delivery of core targets.
- Mitigations in place - Staff who had not completed GCP training had been identified and contacted, with low immediate risk confirmed. Sponsor audits risk assessed and rescheduled, allowing focus on priority areas.

FB stated that the 150-day study set-up target remains an ongoing and recurring challenge for the division and that improvement is anticipated but will require sustained focus and monitoring.

Community and Mental Health Division
JP presented the Community & Mental Health Divisional update and drew attention to a few key points from the report including:-
Highlights:-
- The SPOT (Speech, Physio and Occupational Therapy) service received a National Council for Disabled Children SEND Award. SPOT provides a single point of access community clinic.
- A second transition study day had been held with increased external partner engagement, with 74 attendees and positive feedback received on improving transition to adult services.
- Division had a significant reduction in sickness absence, following ongoing divisional focus.

Challenges:-
- Division have had an increase in the number of risks, resulting in ongoing fortnightly divisional risk review meetings and focus on ensuring quality and appropriateness of risks and their management.
- JP advised on an emerging Genomics risk which is a new risk identified relating to transition to whole genome sequencing with potential impact on clinic capacity and demand. JP confirmed that further detail would be included within the divisional update to SQAC at the June SQAC meeting.

FB highlighted the significant improvement in sickness absence and queried whether this improvement is sustainable given the current pressures. In response JP acknowledged that current system pressures remain high and indicated potential for variation in the coming months. JP confirmed that there is continued active monitoring and ongoing divisional focus on maintaining improvement.
Resolved: SQAC received and **NOTED** the Divisional Assurance Reports.

26/27/35 **Liverpool Neonatal Partnership Monthly update**

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

Highlights:-

- Introduction of a targeted psychosocial screening tool for families with babies admitted ≥3 days, this has enabled early identification and triage of psychosocial needs, improving access to support services. It has demonstrated a significant increase in service uptake following screening, with positive feedback highlighting strong family trust in clinical teams, with a plan to roll out across the partnership, supported by additional trainee resource.
- Development of a partnership-wide culture programme, including psychological safety; civility and behaviours; team effectiveness and leadership development. Programme to be delivered Initially to senior leadership teams and then rolled out across clinical leaders and wider workforce.
- There is strong collaborative working across organisations, with support from organisational development teams and external partners.

Challenges:-

- Implementation of the joint governance framework remains complex and requires multi-organisational agreement and Board-level sign-off across both sites. Supported by external advisors (MIAA) and structured milestone approach.
- Organisational change/structural uncertainty with ongoing uncertainty regarding operational support arrangements and future reporting structures across both organisations.
- Key Risk regarding the Neonatal Transfers (Long-standing BAF Risk), with continued requirement for ITU-level transfers between Alder Hey and the Women's site for surgical patients. The risk will only be fully resolved with opening of the new neonatal unit. Interim mitigations include 24/7 medical cover at Alder Hey neonatal unit (consultant and advanced practitioners), Increased ability to retain higher acuity patients on site, reducing transfers. With ongoing monitoring of transport incidents with no reported moderate harm incidents. SQAC acknowledged that transfers are likely negative for families, particularly where multiple procedures are required, however no specific concerns had been raised through PALS, complaints or within feedback data.

Clarity was requested regarding the level of assurance regarding the transfer risk.
ES advised that further work is required to strengthen assurance narrative within the Board Assurance Framework and provide additional detail on interim mitigations, with emphasis placed on maintaining high visibility of this risk at Board level and ensuring continued focus on preventing recurrence of historical incidents.
Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership Monthly update.

---- Safe ----

26/27/36 **Patient Safety Update**

JR presented the Patient Safety update and drew attention to a few key points within the report:-
Highlights:-
SQAC **NOTED** the continued strong performance across key safety metrics, alongside targeted areas requiring improvement, particularly in clinical engagement and compliance.
Highlights:-

- There had been zero cases of C. difficile, and MRSA reported in the reporting period.
- There had been a 5% reduction in low and above harm incidents per 1,000 bed days and there had been a 5% increase in reporting of no-harm incidents per 1,000 bed days against 24/25 data.
- Improvement in timeliness of PALS resolution within 5 working days.
- Patient Safety Partner Programme had transitioned to business as usual. With national recognition received, with opportunity to showcase best practice and contribute to development of impact KPIs.
- Sustained >99% compliance with Level 1 patient safety training.
- Staff are progressing through advanced (Level 4) patient safety training.
- Development of Safety culture programme (pilot commencing); Deteriorating patient educational programme and establishment of a deteriorating patient learning forum.

Challenges:-

- There had been a slight increase in low and above harm incidents per 1,000 bed days in-month which required monitoring to identify any further upward trends.
- There was insufficient clinical attendance at safety reviews impacting compliance with internal KPIs, timeliness of PSII and AAR processes.
- NatSIPPs Compliance – there is ongoing lack of engagement outside theatre environments, limiting full implementation.
- Blood Transfusion Consent compliance: Audit identified non-compliance with e-consent requirements. Established as a formal improvement programme with regular monitoring.
- Delay in transition to LFPSE version 6 due to national system issues (now resolved).
- Theatre External Review: Delay due to withdrawal of subject matter expert. A new external review has been commissioned with a three-month completion timeframe which is expected by end of July.

KB welcomed the Blood Transfusion Consent compliance audit as a strong example of clinical audit practice and sought clarity whether the audit was triggered by an incident or routine assurance and referred to scope exclusion of emergency cases and whether consent should still be maximised where possible. In response JR advised that the audit reflects recurrent variability in compliance, now requiring a more structured improvement approach. JR confirmed that she would provide feedback to the Transfusion Committee regarding emergency scope.
NA clarified that compliance standards relate to non-urgent transfusion scenarios, in line with regulations.

GM referred to the theatre external review and sought assurance that no further delays would occur and sought clarity regarding the interim risk position and whether any additional concerns had arisen. In response JR provided assurance that the review is due to progress as planned, with a new independent expert and advised that no additional concerns had been identified. JR also advised that no further never events had been reported since the last incident.
Resolved: SQAC received and **NOTED** the Patient Safety update

26/27/37 Patient Safety Annual Report

JR presented the Patient Safety Annual Report (April 2025 – March 2026) and **NOTED** the strong evidence of delivery against both national and organisational patient safety priorities, with clear progression of key workstreams into business as usual.

Highlights:-

- Delivery of Patient Safety Programme: - multiple workstreams had been successfully delivered, including: Martha's Rule; Patient Safety Partners; Safety Culture Programme; Deteriorating Patient initiatives and Medicines safety and sampling improvements.
- Key programmes (e.g. Martha's Rule and Patient Safety Partners) had transitioned from programme phase into routine practice.
- Organisational Learning and Engagement with strong evidence of Trust-wide engagement in patient safety priorities; integration of learning from incidents into practice and ongoing consultation and quality walkarounds with staff and patient safety partners.
- Key Priorities for 2026–2027 include recognition and escalation of deteriorating patients; reduction in delays or loss to follow-up; Medicines safety (including timely administration of critical medications); improved consent and documentation standards; mitigation of IT- related patient safety risks and continued embedding of a just, restorative and learning culture.

Ongoing focus required on delivering against identified priorities for 2026–2027 and ensuring sustained cultural and behavioural change across the organisation.
The Patient Safety Plan is under development and will be informed by staff engagement; patient safety partner input and qualitative and quantitative data.

FB welcomed the report and highlighted the clear evidence of embedded processes and continuous improvement cycles; the strong demonstration that the organisation reviews priorities; delivers against them and refreshes and evolves priorities appropriately. SQAC **NOTED** this as a positive indicator of organisational maturity in patient safety.
Positive feedback was given on the routine nature of safety processes; evidence that workstreams are becoming fully integrated into operational practice, rather than remaining programme based.

Resolved: SQAC received assurance that the Trust is delivering against both national and internal patient safety strategies. Patient safety systems are well established, embedded, and continuously improving.
Resolved: SQAC received, **NOTED** and Approved the Patient Safety Annual Report and confirmed assurance regarding delivery of the patient safety strategy

26/27/38 **Drugs & Therapeutics Quarterly and Annual Report**

PS presented the Drugs & Therapeutics Quarterly and Annual Report. SQAC **NOTED** the continued effective oversight of medicines governance, including management of risks, medicines shortages, and controlled drugs compliance.

Highlights:-

- Several risks had been closed, reflecting improved control and mitigation.
- There is continued active monitoring of medicines-related risks within the governance framework.
- There is improved compliance in controlled drug (CD) audits across most clinical areas. Overall position indicates strengthened governance and assurance arrangements.
- Medicines Shortage Management**:** Report included detailed case examples (e.g. contrast media and amiodarone shortages), demonstrating the complexity of supply chain issues and the significant operational efforts required to maintain safe patient care.

Challenges:-

- A new risk has been added relating to pharmacy workforce capacity, driven by vacancies; sickness absence and increased service demand.
- Challenges were **NOTED** regarding the ongoing medicines supply pressures and the continued national and local medicines shortages, requiring active management; clinical and operational workarounds and increased workload for pharmacy teams.

FB sought clarity whether controlled drugs reporting should be escalated to Board level. In response PS confirmed that assurance can be appropriately provided through SQAC oversight, supported by quarterly and annual reporting to SQAC.
FB requested whether SQAC were assured on controlled drugs governance and management. SQAC confirmed assurance, supported by audit compliance and governance arrangements.
FB advised that assurance on controlled drugs should be escalated to the Board via the SQAC Chair's highlight report, ensuring visibility at Board level.
Resolved: SQAC **NOTED** the effective systems and processes which are in place for medicines governance, including controlled drugs and that audit and oversight arrangements are robust and improving.
SQAC **NOTED** the continued pressure on pharmacy capacity and the ongoing medicines supply challenges requiring sustained oversight.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Quarterly and Annual Report

26/27/39 **EPRR Quarterly update and Annual Assurance Report**

NA presented the EPRR Quarterly update and Annual Assurance Report and **NOTED** continued progress in strengthening incident response arrangements and organisational resilience, alongside ongoing challenges in action delivery and business continuity planning.

Highlights:-

- Strong progress has been made in incident response processes, with effective systems in place to capture, share and embed learning following incidents.
- Positive assurance that structured processes exist to review and act on lessons learned.
- Clear focus on achieving substantial assurance against core EPRR standards by September 2026, subject to finalisation of national requirements.

Challenges:-

- A number of actions from previous incidents remain open, including those arising from the Measles incident and the System downtime and cyber incidents
- Ongoing challenges are **NOTED** in completion and testing of business continuity plans; achieving consistent compliance across the organisation.
- External dependencies - delay in receiving national guidance and assurance frameworks, impacting progress towards formal assurance submission.

FB queried whether outstanding actions from the measles incident were being sufficiently progressed. NA confirmed that actions are being actively progressed, with leadership oversight in place.

KB expressed concern regarding the long-standing outstanding actions (e.g. cyber incidents >18 months old); the repeated deferral and extension of actions and requested detailed assurance and visibility within future reports. NA acknowledged the concern and committed to providing further detail and follow-up in future reports.
KB highlighted the lack of progress in BCP development and implementation and queried whether there are sufficient resources and capacity in place and highlighted the need for clear timelines and stronger monitoring arrangements. NA acknowledged challenges and committed to strengthening oversight; providing further assurance in future reporting and engaging offline to progress actions.
Resolved: SQAC received and **NOTED** the EPRR Quarterly update and Annual Assurance Report and welcomed enhanced assurance and progress reporting on outstanding actions in future reports.

26/27/40 HDU PSII Never Event (Medication administered by the wrong route)

SC presented the HDU PSII Never Event (Medication administered by the wrong route)
The investigation was **NOTED** to be comprehensive, systems-focused and aligned with a just culture approach, with no attribution of individual blame.
SC provided an Incident Summary which detailed that an IV phosphate prescription was made however, an oral formulation was mistakenly administered intravenously.
The error was not identified at the time of administration and was only recognised retrospectively approximately two weeks later during preparation for another patient.
Key contributory factors included look-alike medication packaging and storage proximity; high acuity environment and workforce pressures; complex prescribing and documentation processes; human factors, including cognitive load and confirmation bias.
A comprehensive action plan is in place, including Standardisation of prescribing and naming conventions; Improved storage and segregation of high-risk medications; Review of BMV compliance and system functionality**;** Enhanced training on medication safety and human factors.
SQAC commended the quality of the investigation**,** noting a strong systems-based and just culture approach.
Discussion took place regarding the look-alike medications as a significant risk factor; and the importance of appropriate skill mix and supervision in high-acuity settings and the recognition that the incident reflects multiple system failures rather than individual error.
KB queried whether reliance on NHSP staff in high-risk areas could be reduced.
NA advised that NHSP usage is not inherently unsafe, and that the incident reflects a combination of multiple system pressures and emphasis should be on skill mix and supervision, rather than eliminating NHSP use.
FB highlighted the Importance of appropriate seniority and supervision, particularly in HDU settings. NA advised on ongoing work to clarify role expectations and competency levels, particularly for Band 5 and 6 nurses.
SQAC emphasised the importance of learning dissemination across the organisation and ensuring actions translate into sustained practice change.
Resolved: SQAC received, **NOTED** and commended the quality of the HDU PSII Never Event (Medication administered by the wrong route) investigation and confirmed assurance that appropriate learning and actions are in place.

26/27/41 Compliments, Complaints & PALS report Quarter 4 and Year End 2025/26

NA presented the Compliments, Complaints & PALS report Quarter 4 and Year End 2025/26 report
SQAC **NOTED** a continued increase in formal complaints over the reporting period, alongside early signs of improvement in monthly trends. The report demonstrated ongoing work to strengthen organisational learning and responsiveness.

Highlights:-

- Improvement in compliance trends**:** while overall volumes remain high, a downward trend in formal complaints month-on-month is beginning to emerge.
- The Medicine Division was NOTED to receive the highest number of complaints and demonstrate the highest compliance with response standards, indicating effective processes that may be replicated elsewhere.
- Learning from complaints: Inclusion of examples of lessons learned provided assurance that the organisation is embedding learning from complaints into practice.
- A reduction in PALS contacts was **NOTED**.

Challenges:-

- Despite recent improvements, complaint levels remain consistently high, reflecting increased demand and greater complexity of cases, with some complaints involving detailed legal or rights-based arguments; Increased time and expertise required to respond.
- Capacity and resource pressure with ongoing pressure on teams to manage volume and maintain compliance with response timelines.

GM referred to the increasing volume and complexity of complaints across the organisation. and the impact on staff capacity and the overall organisational workload and resilience.
It was agreed that this issue required further exploration at Trust level, rather than solely within divisional reporting.
NA highlighted the opportunity to improve conversion of formal complaints into informal resolution (PALS) where appropriate and advised on a planned development of new governance processes and system changes to support this approach.
FB supported greater emphasis on early engagement and resolution, even where concerns are initially raised as formal complaints.
FB welcomed the revised report format, noting it is easier to navigate and more effective in presenting key information.
Resolved: SQAC **NOTED** the complaint volumes and complexity remain a significant and ongoing pressure with further work required to improve early resolution pathways & manage organisational impact and capacity.
Resolved: SQAC received and **NOTED** the Compliments, Complaints & PALS report Quarter 4 and Year End 2025/26 and requested continued focus on reducing complaint volumes and improving early resolution approaches.

26/27/42 **Patient Experience and Family Feedback Report Quarter 4 2025/26**

NA presented the Patient Experience and Family Feedback Report Quarter 4 2025/26
SQAC **NOTED** the continued strong performance across patient experience measures, with evidence of improving quality of environments and national recognition of patient-centred care initiatives.
Highlights:-

- PLACE (Patient-Led Assessments of the Care Environment): Sustained strong performance across all indicators, with improvements NOTED compared to the previous year.
- The Trust had become the first NHS organisation to fulfil all of “Sophie’s Wishes**”**, reflecting high-quality patient-centred care and strong contribution from play, catering and facilities teams.

Resolved: SQAC received and **NOTED** the Patient Experience and Family Feedback Report Quarter 4 2025/26, and **NOTED** the assurance on current performance & requested continued development of deeper patient experience insight in future reporting

26/27/43 **Quarter 4 Children & Young People Engagement Leads Report**

JP presented the Quarter 4 Children & Young People Engagement Leads Report. SQAC **NOTED** a high level of engagement activity across the Trust, with clear alignment to organisational priorities and the Trust’s 2030 vision. The report demonstrated the significant contribution of young people to service development and improvement.
Highlights:-

- The Young People’s Forum (YPF) and wider engagement leads delivered a broad range of activities across the quarter, supporting both local and national initiatives.
- C&YP Forum had contributed to Allied Health Professional (AHP) Day, leading to development of communication skills training for AHP students.
- Engagement work highlighted improvements in Pre-operative pathways for neurodiverse children, ensuring care is more responsive to individual needs.
- Collaboration with partners, including Royal Liverpool services, to improve Psychological support and transition pathways for young people moving into adult care.
- Continued development of local and national networks, including collaboration with Sheffield Children’s Hospital.
- Engagement activity supports delivery of the Trust’s strategic ambitions, including work linked to the “#IWill” social action programme, with funding applications submitted to support future development.

Challenges:-

- The Young People's Forum did not undertake recruitment activity during the quarter due to organisational recruitment restrictions.
- The Potential impact on sustainability and diversity of representation

SQAC acknowledged that the report reflects a wide breadth of activity and strong engagement from young people. FB referred to the positive recognition of the enthusiasm and commitment of young people and The Trust's ability to both benefit from and give back to young people through engagement opportunities.
Resolved: SQAC received and **NOTED** Quarter 4 Children & Young People Engagement Leads Report

26/27/44 **Patient Experience Annual Report**

NA presented the Patient Experience Annual Report and expressed his thanks to VG for compiling the report.
SQAC **NOTED** the revised concise format, which effectively captures the breadth of patient experience activity. SQAC **NOTED** that patient experience work is well embedded with evidence of continuous improvement and engagement across the organisation.
Discussion highlighted the need to strengthen insight into core patient experience measures, including patient information materials and the digital patient journey to understand how patients perceive and use information provided.
NA confirmed that these areas will be progressed through future work plans and engagement activity.

Resolved: SQAC received, **NOTED** and Approved the Patient Experience Annual Report and received assurance on current performance and progress.
SQAC supported the direction of travel, particularly improvements in reporting clarity and requested strengthened insight into the impact of patient information and the digital experience to enhance future assurance**.**

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26/27/45 **AR Learning Review Action plan and Southport Inquiry Phase 1 – Actions on recommendations**

NA presented the AR Learning Review Action Plan and Southport Inquiry Phase 1 – Actions on Recommendations and **NOTED** significant progress in delivery of actions, with the majority now complete and remaining actions on track.
The report also highlighted ongoing work to embed learning more broadly across the Trust
Highlights:-

- 36 of 39 actions had been completed, with further progress since the previous reporting period.
- Remaining actions are on trajectory against agreed timelines.
- Integration of Inquiry Recommendation: Inclusion of public inquiry elements within reporting, ensuring alignment with wider national learning.
- Progress is NOTED on key recommendations (including Recommendation 53), with collaborative working across organisations.
- Forward Focus**:** Planned **"**stand back" review session to consider learning more broadly across the organisation and Identify opportunities to apply improvements beyond the initial scope.

Challenges:-

- Embedding learning across the organisation - whilst actions are largely complete, focus is now shifting to sustained embedding of learning; ensuring consistency of application across services
- Clarity of Roles in Multi-Agency Working: Ongoing need to strengthen clarity of lead agency responsibility and documentation and communication in complex, multi-agency cases.

GM queried whether staff feel able to safely escalate concerns in multi-agency environments and queried whether there is sufficient clarity on which organisation holds lead responsibility in complex cases. Discussion highlighted that current processes may be implicit rather than explicit, creating potential ambiguity.
NA and JP confirmed that work is underway to strengthen clarity through training, policy and safeguarding processes and improve documentation and visibility of lead agency roles.

It was acknowledged that National guidance is evolving (Phase 2 of the Inquiry), however local action should not be delayed.
GM emphasised the importance of not waiting for national guidance to address key issues and encouraged the organisation to actively ask and document lead responsibility in real-time cases.
FB supported this position, noting the importance of raising and documenting the question, even where formal frameworks are still evolving.
A minor issue was **NOTED** regarding a typographical error within the report ("contemptuous" vs "contemporaneous"), with request for correction prior to further circulation.
Resolved: SQAC received assurance that significant progress had been made in delivering the AR Learning Review Action Plan and that the remaining actions are on trajectory and are actively managed.
SQAC acknowledged the need for proactive local action alongside national developments and NOTED the importance of clear, explicit processes to support staff in complex safeguarding environments
Resolved: SQAC received and **NOTED** the AR Learning Review Action Plan and Southport Inquiry Phase 1 – Actions on recommendations report

26/27/46 Clinical Effectiveness and Outcomes Board Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report which highlighted the continued strengthening of clinical effectiveness governance, with evidence of improved compliance, enhanced oversight mechanisms, and system development.
The report reflected a maturing governance framework, with increasing use of digital tools to support assurance and performance monitoring.

Highlights:-

- The Trust had achieved 100% compliance with Central Alert System (CAS) responses within required timeframes, supported by development of a monitoring dashboard.
- Annual Clinical Audit Report approved, with continued improvement in Divisional audit oversight; and completion and monitoring of audit programmes.
- Significant progress had been made against the MIAA action plan, with one remaining action, which is on trajectory for completion.
- Introduction of a dedicated NICE app within InPhase, which is improving Tracking, ownership benchmarking and compliance monitoring.
- Data and Reporting Improvements: Move towards A3 reporting format for NICE and confidential inquiries, supporting Improved clarity, greater accountability.
- Document Management System (DMS): development of a proof of concept to migrate DMS into InPhase, aiming to Improve system functionality; Enable better reporting and oversight.
- Future digital enhancements include exploration of enhanced document access solutions, including potential use of AI-supported tools to improve usability and accessibility (subject to funding and system alignment).

Challenges:-

- Limitations of current Systems - the existing DMS is described as not fit for purpose, requiring: manual workarounds; limited system-level reporting capability.
- Financial and resource limitations are impacting the ability to implement enhanced digital solutions and adoption of a more advanced systems (e.g. AI-enabled document management).

AB querier whether migration to InPhase would improve document governance, including alerts for review dates and compliance tracking. In response JR confirmed that the new system would provide notification functionality**;** enable improved compliance monitoring and reporting; and h**i**ghlighted the need for continued responsibility of document authors and reduction in unnecessary documentation.
AB highlighted an opportunity to explore AI-enabled document systems to Improve accessibility, support clinical decision-making in real time. Following discussion it was NOTED that alignment required with wider organisational work and funding availability with ongoing exploration through innovation and system-wide collaboration.
NA emphasised the need to reduce duplication; move towards nationally standardised guidance where possible; focus organisational effort on locally specific policies and procedures where required.
SQAC acknowledged the importance of balancing system improvement with resource constraints with continued focus on streamlining governance processes.

SQAC supported the continued development of digital and system-based solutions to enhance oversight.

Resolved: SQAC received and **NOTED** the Clinical Effectiveness & Outcomes Board Chairs Highlight report **NOTED**

26/27/47 **Clinical Effectiveness and Outcomes Board Annual Report**

JR presented the Clinical Effectiveness & Outcomes Board Annual Report (April 2025 – March 2026) and NOTED continued development and maturity of clinical effectiveness governance, with strong performance in national audit participation, NICE compliance, and system oversight.

Highlights:-

- The Trust participated in 19 national audits, achieving 100% data submission compliance.
- Confidential Inquiries and programmes: The Trust participated in 4 national confidential inquiries 1 national service improvement programme (MBBRACE) and 1 national surveillance programme (UKHSA). All submissions were completed within required timeframes.
- Clinical Audit development: continued delivery of clinical audit education programme, including: Multiple masterclasses with high engagement; evidence of increased audit activity following training.
- Of the 188 NICE publications received: 49 were relevant to the Trust; 14 required baseline assessment. The majority were completed within required timeframes, with extensions appropriately managed.
- Introduction of NICE app in InPhase is strengthening oversight and accountability.
- Development of Clinical audit module within InPhase
- There are plans for a clinical effectiveness dashboard with improved tracking and reporting systems.

Challenges:-

- Timeliness of NICE assessments: Some NICE baseline assessments required extensions beyond the standard timeframe, as a result of capacity and process challenges.
- System alignment**:** Need to align divisional and system-level processes, particularly in the context of organisational restructuring.
- Ongoing system development**:** continued reliance on implementation of digital tools (InPhase) and development of reporting dashboards to fully realise governance benefits.

Priorities for 2026–2027 include, continued learning from national benchmarking and outcome data; full implementation of clinical audit module in InPhase; alignment of governance processes to new system operating model; development of clinical effectiveness dashboard; enhanced triangulation with patient safety and patient experience data and Completion of remaining MIAA audit actions.

Resolved: SQAC received, **NOTED** and Approved the Clinical Effectiveness & Outcomes Board Annual Report and confirmed assurance regarding the delivery of the Clinical Effectiveness Strategy

26/27/48 **Board Assurance Framework**

ES presented the Board Assurance Framework and drew attention to a few key points within the report:-

SQAC **NOTED** that the BAF risks remain well understood and consistent with previous reporting, with a good level of assurance.

ES advised that risks within the BAF remain largely unchanged, with key issues already well rehearsed across governance forums. Particular focus continues on Mental health and neurodiversity-related risks, including waiting times and medication issues.

ES advised that a good level of assurance had been received through SQAC and other committees in relation to key risks and mitigations.

ES referred to a key risk relating to Liverpool Neonatal Partnership (LNP) - The neonatal transfer risk which requires clearer cross-referencing within the BAF, particularly across relevant risk categories. Although the risk is well understood and mitigated operationally it was NOTED that: greater visibility is required due to potential safety impact of delays and its relevance across multiple areas of the framework.

ES proposed the strengthening cross-referencing of key risks within the BAF to ensure: clear visibility of interdependencies and improved understanding of impact across domains.

SQAC supported enhancing the presentation and linkage of risks within the framework.
SQAC revisited earlier discussion regarding the absence of high-scoring risks in Surgery.
ES supported a review of risk scoring and calibration through the Risk Management Forum.
It was NOTED that some risks (e.g. capital equipment and infrastructure risks) may sit outside divisional registers, and still have direct operational impact, requiring consideration within assurance discussions. Emphasis placed on continuing to test the robustness of risk mitigations ensuring that risks are not only recorded but are actively challenged and validated through governance processes.
SQAC emphasised the importance of ensuring the BAF provides a clear, coherent narrative of risk and visibility of interdependencies and system-level impacts
Resolved: SQAC received and **NOTED** the Board Assurance Framework and supported further work to improve risk cross-referencing and visibility and review risk scoring consistency through Risk Management Forum.

26/27/49 Mortality coding update report

IG presented the Mortality coding update report following previously identified discrepancies between internal mortality understanding and external benchmarking data. The update outlined the findings of a detailed review and actions taken to improve accuracy, timeliness and governance of coding processes.
Key Findings - Historical Data Issue (2024/25): - A small number of cases missed submission deadlines, resulting in invalid coding entries and distortion of benchmarking data. Although cases were later corrected, the dataset had already been locked nationally, preventing retrospective amendment.
A comprehensive case review had been undertaken jointly with clinical and coding leads to review 2025/26 data. The review identified that the majority of coding was accurate, with some discrepancies due to poor clinical documentation, leading to inaccurate coding interpretation and further missed deadlines within allowable correction windows. Approximately 15 cases were identified and corrected, with resubmission completed. It is anticipated that 2025/26 data will provide a more accurate reflection of mortality position.

Actions and Improvements include the establishment of monthly mortality coding review meetings, involving coding leads, Clinical oversight (mortality lead) and introduction of processes to ensure: timely submission of coding data; improved documentation quality and ongoing validation of coding accuracy. With a recognition that improvements in data quality may not be immediately visible, due to a lag in national reporting systems.
KB raised concern regarding whether failure to complete coding processes was a conscious prioritisation decision due to capacity pressures, or whether this related to an unrecognised gap.
IG confirmed that the issue was not formally escalated at the time and was only identified through retrospective review.
Concern highlighted regarding the lack of visibility of operational risks when tasks are deprioritised due to pressure.
KB emphasised the need for robust escalation processes where tasks are not being completed due to capacity constraints.
FB reinforced the importance of ensuring that decisions to stop or deprioritise activity are visible and understood at the appropriate level and that risks associated with such decisions are explicitly recognised and managed.
ES confirmed that there is ongoing work within wider governance discussions to capture and manage risks arising from organisational pressures and system changes.
Resolved: SQAC received and **NOTED** the Mortality coding update report and confirmed assurance on corrective actions and future processes.

26/27/50 2025/26 Quality Account

NA presented the 2025/26 Quality Account which provides a comprehensive and accurate reflection of the organisational quality performance.
SQAC **NOTED** the reduced length and improved format of the Quality Account, while maintaining required content.
External feedback from the ICB was highly positive, with no additional areas for development identified.
Resolved: SQAC received, **NOTED** and Ratified the Quality Account, subject to minor updates, and supported progression to Board for final approval.

26/27/51 Clinical Strategy: 2026-2030

MA presented the Clinical Strategy: 2026-2030 which detailed the Trust's direction and priorities over the next five years. The strategy reflected extensive clinical engagement and consensus, building on previously developed clinical blueprints and aligning with the organisation's broader ambitions and transformation agenda. The Strategy had been developed through clinical consensus and engagement**,** ensuring alignment with frontline priorities and provides a coherent framework for future service development, aligned to Organisational ambitions and system-wide partnerships and collaboration.

The strategy sets out the Organisational ambitions and priorities and a framework to empower clinical leadership and system working. With focus on Engagement and Communication, Strategy to be supported by Internal and external communications plans and Ongoing engagement with stakeholders and partners.

Challenges:-

- Need to further develop clear metrics and KPIs to track delivery and impact and define monitoring and reporting mechanisms.
- Delivery of the strategy is partly dependent on external system partners, with ongoing changes in the wider system environment and potential impact on prioritisation and implementation.

FB welcomed the strategy as a clear and well-structured document and NOTED it builds effectively on prior Board discussions and ongoing organisational dialogue.

KB highlighted the presence of multiple specific ambitions within the strategy and queried how these will be measured, monitored and reported and whether systems are in place to track progress against objectives. In response MA acknowledged that delivery frameworks and metrics would need to be further developed and advised that the confirmed approach will rely on clinical system leaders to define priorities and measures and be shaped by evolving system context and partnerships.

GM suggested development of alternative formats of the strategy for children and young people and wider audiences and emphasised importance of making the strategy Accessible and easy to understand. MA welcomed this feedback and confirmed that it will be incorporated into communications planning and engagement work.

SQAC emphasised the importance of translating strategy into deliverable, measurable outcomes and clear accountability and oversight mechanisms.

Resolved: SQAC received, **NOTED and Approved** the Clinical Strategy: 2026-2030 and supported progression to Communication and engagement phase and development of delivery and monitoring frameworks.

26/27/52 Clinical Audit Annual Report 2025/26

JR presented the Clinical Audit Annual Report 2025/26

SQAC **NOTED** the continued development and strengthening of clinical audit processes, with improved alignment to organisational priorities and enhanced engagement across clinical teams.

Highlights:-

- Introduction of a revised audit registration process, providing clearer distinction between Clinical audit; service evaluation and alignment with the Trust's 2030 vision and strategic priorities.
- Audit Engagement and Education: continued delivery of clinical audit masterclasses, with: high demand and strong attendance. Evidence of increased audit and service evaluation activity following participation.
- Audit Monitoring and Reporting**:** Implementation of a compliance calculator, enabling: Improved tracking of audit progress against standards and greater visibility of performance at team level.
- Progress in development of the clinical audit module within InPhase, with positive user feedback and ongoing migration of audit data into the system.
- There is enhanced support for staff undertaking academic or external study, ensuring: appropriate audit or service evaluation registration and alignment with governance requirements.

Challenges:-

- System alignment**:** need to ensure alignment between divisional audit processes and wider system-based model, particularly in light of organisational change.

- Ongoing system implementation**:** continued reliance on successful implementation of: InPhase audit module and Associated reporting and oversight mechanisms.

FB welcomed the audit education programme and queried how feedback is captured from participants, particularly in relation to whether training translates into practical audit activity and improvement. In response JR confirmed that feedback is gathered both at the time of training and through ongoing engagement and support sessions. JR advised that teams are supported to develop audits in real-time and apply learning directly to service improvement initiatives.
FB NOTED the clear alignment between audit activity and organisational priorities.
Resolved: SQAC received, **NOTED** and Approved the Clinical Audit Annual Report 2025/26

26/27/53 **Trust wide Clinical Audit Plan for 2026/2027**

JR presented the Trust wide Clinical Audit Plan for 2026/2027 which had been developed in line with national requirements, organisational priorities, and quality governance frameworks.
The plan was described as an iterative and dynamic programme, designed to respond to emerging priorities, including those arising from external reviews and public inquiries.

- National and Mandatory Audits**:** Inclusion of 18 nationally mandated audits, ensuring compliance with external requirements.
- Local Priority Audits: Inclusion of 17 Trust priority audits, aligned to: organisational risks, quality account priorities and service improvement needs.
- The Trust Wide Clinical Audit plan is aligned to the Quality schedule requirements; Annual Quality Account priorities and broader clinical effectiveness and governance processes.
  With recognition that the plan will evolve throughout the year and incorporate additional audits arising from: Public inquiries (e.g. Southport) and emerging risks or priorities.

Challenges:-

- Some divisional priority audits remain pending approval
- System Transition**:** Requirement to align audit activity with the transition from divisional to system-based structures, reflecting organisational change.

SQAC acknowledged that the plan represents a structured and comprehensive approach to audit delivery, with appropriate flexibility.
Resolved: SQAC received, **NOTED** and Approved the Trust wide Clinical Audit Plan for 2026/2027 and confirmed assurance on its alignment and structure.
SQAC Acknowledged that the plan will be kept under review and updated as required

26/27/54 **National Confidential Enquiries Report: Quarter 4 2025/26 Summary position report and Annual Report**

JR presented the National Confidential Enquiries Report: Quarter 4 2025/26 Summary position report and Annual Report, noting the high levels of compliance with national reporting requirements and robust organisational engagement with external assurance programmes.
The report provided assurance that the Trust is actively participating in national learning systems and embedding findings into practice.

Highlights:-

- The Trust participated in 4 national confidential inquiries, with full details outlined within the report.
- Timely Data Submission: High levels of compliance with submission requirements, including:
  95% (18/19 cases) submitted within the two-day target for the national programme (MBRACCE).
  100% submission of reportable infection cases to national surveillance systems.
- Engagement with National Programmes: there is active participation in National service improvement programmes and National surveillance programmes.
- Actions arising from published NCEPOD reports have been identified, tracked and progressed through governance structures.

Challenges:-

- Isolated reporting gap: 1 case was not submitted within the two-day timeframe due to: A national system transition issue (change to new reporting system). Issue has since been resolved at national level.

Resolved: SQAC received and **NOTED** the National Confidential Enquiries Report: Quarter 4 2025/26 Summary position report and Annual Report and confirmed assurance regarding participation and compliance with national confidential enquiries and associated programmes

26/27/55 Children & Young People Gender Service (North) Quarter 4 Report (01 May 2026 – 31st March 2026)

LN presented the Children & Young People Gender Service (North) Quarter 4 Report (01 May 2026 – 31st March 2026)

SQAC **NOTED** the continued stabilisation and delivery of the service, with positive patient feedback and sustained activity levels.

The report highlighted the service as now operating in a more established and consistent model, while acknowledging ongoing risks associated with the clinical pathway and research framework.

Highlights:-

- The service is now operating as a sustained and established mode, following initial implementation phases.
- There is continued positive feedback from children, young people and families

Challenges:-

- Ongoing risks associated with the medical pathway, reflecting the complexity of clinical decision-making and the evolving national context.
- Research Framework: Risks relating to research arrangements, including: Development and integration of evidence-based practice and Alignment with national expectations.

FB acknowledged that the service appears to have reached a more stable and sustainable operational position, with consistent delivery.

KB requested enhanced reporting in future updates, including trend data and graphical representation (e.g. activity over time) and greater use of comparative and proportional data to provide deeper insight. Additional requests included: More detailed analysis of: Patient demographics, including sex distribution and Neurodiversity prevalence (e.g. autism) in comparison to wider population.

KB queried why patients are being seen from outside the North region. In response LN advised that the service is currently operating as part of a national model, with patients allocated from a national waiting list and that Families may choose to Travel to access earlier appointments

Future include Transition to a regional model once additional hubs are operational.

LN agreed to work with relevant teams (e.g. BI) to: Enhance data presentation and reporting quality in future updates.

FB suggested development of automated reporting (e.g. dashboards**)** to support ongoing monitoring.

SQAC acknowledged the importance of robust, data-driven reporting to support governance and strategic oversight and welcomed enhanced reporting and data analysis in future updates to support improved oversight.

Resolved: SQAC received and **NOTED** the Children & Young People Gender Service (North) Quarter 4 Report (01 May 2026 – 31st March 2026)

26/27/56 Assessment against SQAC Terms of Reference – May 2026

NA presented the Assessment against SQAC Terms or Reference – May 2026

NA advised that the review demonstrates strong alignment overall, with only limited areas requiring further development

Key Findings:-

- The assessment confirmed high levels of alignment between: SQAC Terms of Reference, SQAC agenda and activity and indicated that SQAC is appropriately covering its remit across safety, quality and assurance domains.
- The exercise was NOTED as a positive governance tool, providing clear visibility of coverage and an opportunity to identify areas for strengthening.
- A small number of areas were identified where coverage could be strengthened and additional focus may be required in future work plans.
- Some duplication within the Terms of Reference mapping was identified, likely reflecting: overlap across different sections of the framework.
- Identified gaps will be incorporated into forward work planning and addressed through refinement of Committee agendas and reporting.

FB raised a query regarding whether NICE-related work and assurance is fully reflected within the appropriate sections of the framework. It was suggested that NICE activity may warrant greater prominence within the mapping, given its importance to assurance processes.

Resolved: SQAC received assurance that SQAC is operating in line with its Terms of Reference and that governance processes are aligned and effective in delivering oversight of safety, quality and assurance.
Resolved: SQAC received and **NOTED** the Assessment against SQAC Terms of Reference – May 2026

---- Well Led ----

26/27/57 **C5 Child Death and bereavement policy**
Resolved: SQAC received, **NOTED** and **RATFIED** C5 Child Death and bereavement policy

26/27/58 **Countermeasures plan**
Resolved: SQAC received, **NOTED** and **RATIFIED** the Countermeasures Plan

26/27/59 **Incident Co-ordination Centre Standard Operating Procedure**
Resolved: SQAC received, **NOTED** and **RATIFIED** the Incident Co-ordination Centre Standard Operating Procedure

26/27/60 **Mass Casualty Major Incident Plan**
Resolved: SQAC received and Approved the Mass Casualty Major Incident Plan.

---- Any Other Business ----

26/27/61 **Any Other Business**
None received

---- Board Assurance ----

26/27/62 The key assurances and highlights report was presented to the Board meeting held on 7TH May 2026.

MEETING OF THE GROWTH AND OPPORTUNTIES COMMITTEE

Confirmed Minutes of the meeting held on **Thursday 30 April 2026 at 2.00pm. Teams**

Present:	Mr. M. Jennings	Non-Executive Director (Chair)	(MJ)
	Mr J. Kelly	Non-Executive Director	(JK)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mr. A. Bateman	Deputy CEO/ Chief Operating Officer	(AB)
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Ms. V. Greenwood	Director of Allied Health Professionals	(VG)
	Dr. K. Birch	Director of the Alder Hey Academy	(KB)
	Mr. D. Hawcutt	Director Alder Hey, Research Division	(DH)
Part	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
In Attendance:	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Ms. M. Ashe	Policy Advisor to the CEO	(MA)
	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Mrs. S. Leo	Head of Operations - Research, Innovation, Alder Hey Futures	(SL)
	Ms. L. Rad	Acting Associate Chief Nurse- Research, Innovation and Alder Hey Futures	(LR)
	Mrs. A. Prendergast	Assoc Director of Strategy and Partnerships	(AP)
	Ms. N. Palin	Director of Transformation	(NP)
	Ms. N Deakin	Change Programme Manager	(ND)
	Mrs. U. Das	Divisional Director - Medicine	(UD)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Ms. J Preece	Governance Manager	(JP)
Item 26/27/004	Dr. C Grime	Chief Clinical Information Officer/ Consultant in Paediatric Respiratory Medicine, Sleep and Long-Term Ventilation	(CG)
Observing:	Ms. C Brown	Governor	(CB)
	Ms. W Blumenow	Governor	(WB)
	Mr. S. Khan	Governor	(SK)
Apologies:	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Ms. F. Ashcroft	Chief Executive (AH Charity)	(FA)
	Mr. S. Leonard	Head of Marketing & Communications (AH Charity)	(SLe)
	Mr. R. Guerrero	Director of Global Health	(RG)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Ms. L. Cooper	Divisional Director - Community/MH	(LC)
	Ms. C Lee	Associate COO	(CL)
	Mr. A. McColl	Associate Director of Finance	(AMc)
	Mr. A. Bass	Chief Medical Officer	(Aba)

26/27/001	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
26/27/002	**Declarations of Interest** MJ is Chief Solutions and Services Officer at Strasys Ltd, who have some involvement from time to time across the Cheshire and Merseyside healthcare system in an advisory capacity.
26/27/003	**Minutes and Action Log of the GO Committee Meeting on 26 February 2026** The minutes of the last meetings held on 26 February 2026 were approved but noted the correction of SL's title. The action log was reviewed and updated.
26/27/004	**AI Learning from Toronto** The Committee received a detailed update on AI learning from the Toronto (SickKids) visit, noting that AI is embedded within routine clinical care, particularly in the Emergency Department, where it is used to predict patient acuity, likelihood of admission and flow through the system in real time. It was highlighted that this approach enables improved operational oversight, earlier decision-making and enhanced patient experience through digital tools that provide waiting time information and tailored clinical guidance to families. SickKids' model is underpinned by strong governance, dedicated clinician time for innovation, and a culture where AI development is clinician-led and integrated rather than an "add-on". The Committee noted the significant role of foundation funding in enabling rapid innovation, as well as the potential for commercial return through partial ownership of successful products. Members recognised that while some elements of the North American model may not directly translate to the NHS context, there are clear opportunities for Alder Hey, particularly in patient flow, regional system integration and virtual oversight of care across the paediatric network. It was agreed that a hybrid approach to AI (combining internal development with external solutions) is most appropriate, supported by robust data foundations, clear governance and safety guardrails, strengthened research output, and a focus on embedding AI within clinical pathways as a core capability. The Committee endorsed further development of this work, including collaboration with SickKids, and supported progression to Board for strategic consideration.
26/27/005	**Innovation Conference Feedback** The Committee received an update on the Innovation Conference, held to mark the 10-year anniversary of the Innovation Hub and the first conference since COVID. Although initially planned as a modest re-start, the event exceeded expectations and demonstrated Alder Hey's ability to deliver high-quality, large-scale events, including workshops, networking sessions and a multi-day programme.

	The conference attracted a strong mix of national and international speakers, including global partners and senior civic representatives, and was delivered in collaboration with external partners such as IDEO and the Charity. It successfully positioned Alder Hey as a credible convener in paediatric innovation and strengthened existing partnerships. Operationally, the event showed that the Innovation Hub can host complex engagement activities and foster meaningful collaboration. It was also financially sustainable, with costs offset through sponsorship and commercial activity. The Committee noted the significant opportunity to build on this momentum through future events, including developing themed, high-profile conferences, strengthening links to city-region initiatives, and enhancing Alder Hey's role in global partnerships and innovation networks. Members formally congratulated the team on a highly successful event.
26/27/006	**Health Equity Activities in Research** The Committee received an update on Health Equity Activities in Research, noting that this is a key strategic priority aligned with both national policy and the development of the Liverpool Institute of Child Health and Wellbeing. Members recognised that health inequalities are increasingly central to national research funding, presenting a significant opportunity for Alder Hey to take a leading role in this area. It was reported that an internal funding call had generated seven applications, with two projects funded and further proposals being supported through mentoring to strengthen future bids. The funded projects focus on addressing practical inequalities in care, and the Committee noted this as a positive step in building research capability and supporting a more inclusive research culture across the Trust. The Committee also noted that whilst there is strong data linking deprivation to health outcomes, this intelligence is not yet systematically embedded into organisational decision-making or reporting. There was agreement that further work is needed to strengthen the use of data and develop a more consistent approach to health equity reporting. Looking ahead, members highlighted the opportunity to align local work with national funding priorities, including a forthcoming NIHR call focused on paediatric respiratory health inequalities. The Committee supported continued development of regional collaborations and partnerships to maximise funding potential and impact, recognising this as a high-value area for future growth and leadership.
26/27/007	**<u>Research and Innovation Financial Sustainability</u>** The Committee received an update on Research and Innovation (R&I) financial sustainability, noting the current position for 2026/27 includes a £425k Trust contribution alongside additional cost pressures. The proposed approach defines sustainability as covering direct and indirect costs of externally funded activity, with core corporate overheads continuing to be supported by the Trust.

	Members reviewed a set of guiding principles to support this transition, including greater financial flexibility, retention of surplus for reinvestment, removal of CIP requirements, and improved support for releasing clinical time. It was noted that, while progress could reduce the overall funding gap, a remaining shortfall would require further action, including potential review of management structures. The Committee approved the approach outlined in the paper and asked the Research and Innovation teams to adhere to these principles for 26/27 onwards. The Committee emphasised the need to ensure both Research and Innovation activity remain aligned to Trust priorities while maintaining flexibility to respond to external funding opportunities. It was also recognised that this work will need to evolve alongside wider system changes, including the "Bring Me the Future" programme.
26/27/008	**Leading the Way for the Children's System: CYP System Collaboration** The Committee received an update on the CYP system collaboration programme, noting that a structured two-year programme approach is being established to support system-wide transformation across Cheshire and Merseyside. This reflects the scale and complexity of the work, including the need for robust governance and formal processes where service change may be required. It was highlighted that, alongside longer-term design, early progress is being taken forward with partner organisations, including work with early adopter sites to test opportunities without prejudicing future decisions. The Committee noted the importance of balancing immediate delivery with development of a consistent system-wide model of care. Members also noted the need to establish a shared understanding across partners on the level of ambition and collaboration required, to avoid fragmented approaches across the system. Work is underway to strengthen programme management, analytics and engagement, and to develop an early view of the emerging business case and associated costs.
26/27/009	**GO Metrics** The Committee received the first iteration of the GO metrics dashboard, designed to provide a visual overview of progress across initiatives aligned to the agreed missions and to highlight areas requiring support. As this represents the first month of reporting, it was noted that measures and data collection processes are still being established, with most initiatives currently assessed as on track, alongside two areas flagged as red relating to Global and Private Patients where mitigating actions are underway. The Committee welcomed the clarity of the dashboard and its value as an assurance tool but noted the need for further refinement. This included aligning metrics with Board reporting (IPR), ensuring the level of ambition is sufficiently stretching, and rationalising measures to focus on those of greatest impact. It was agreed that a further iteration would be completed ahead of the June meeting to establish a consistent and aligned set of metrics going forward. **Action:** **GO Metrics to come back to the next meeting.**

26/27/010	**Programme Update – Highlight Reports** **Futures, Research, Innovation, Education and Digital** The Committee received programme updates by exception across Futures, Research, Innovation, Education and Digital. Within the Futures portfolio, it was noted that progress continues despite some pressures, including delays to the Secure Data Environment programme, with work underway to reprofile funding timelines in agreement with external partners. Positive financial performance was highlighted, with the programme delivering a small year-end surplus following strong performance in research income and commercial activity, supported in part by the AVT programme. [In relation to Digital, the Committee noted a significant milestone with the successful go-live of Alder Connect, marking the Trust's first live patient portal and a major step forward in digital engagement and service transformation. Updates across Research, Innovation and Education highlighted continued progress in activity and partnerships, including growth in observership programmes and international engagement, alongside ongoing innovation and research income generation. Members also noted the need to review how assurance reporting is structured going forward, particularly in light of the "Bring Me the Future" system changes, to ensure alignment across programmes and avoid duplication. Overall, the Committee noted positive progress across the programme areas, alongside the need to adapt reporting, governance and delivery approaches to reflect emerging organisational and system developments **Private Patients** The Committee received an update on the Private Patients programme, noting positive early demand, particularly within imaging, with activity generating income and indicating strong underlying market potential. It was agreed that a pause is required to replan delivery to ensure a sustainable and scalable model, including progressing discussions with the Charity regarding potential commercial partnership arrangements and appropriate delivery models. The Committee noted that short-term progress may be impacted by organisational changes, with a focus over the next 4–6 weeks on establishing leadership, governance and a clear delivery approach to support future growth. **Global Health** The Committee received an update on Global Health activity, noting continued progress in strengthening international partnerships, including a recent visit from Children's Hospital One in Vietnam and plans to establish a new Memorandum of Understanding with a children's cancer centre in Peru. It was acknowledged that progress across some partnerships has been slower than anticipated and that there is a need to increase pace and strengthen delivery. The Committee also noted challenges relating to capacity, capability, and a gap in global communications and branding, with further work required to improve visibility and align with the wider Trust brand strategy. **Resolved:** The committee noted the updates provided.

26/27/011	**GO Committee Annual Report 25/26** The Committee received the Growth and Opportunities (GO) Committee Annual Report for 2025/26, noting that the report covers the period from the Committee's establishment in October through to March and therefore represents a partial year. Members were invited to review the report and provide feedback outside of the meeting. It was noted that the report reflects the Committee's progress against its remit, including key developments across innovation, partnerships, research, and system working, and will inform wider organisational reporting and governance. The Committee did not raise any immediate issues and agreed that feedback would be provided following further review, supporting finalisation of the report.
26/27/012	**Intellectual Property Policy** The Committee received an update on the Intellectual Property (IP) Policy, noting that the policy is overdue for review and has now been updated by the Innovation team. Executive lead responsibility has been assigned, with the updated policy intended to ensure clearer governance and support the organisation's innovation activity. Members discussed the appropriate governance route for approval, with agreement that the policy should first be reviewed at Executive level before being submitted to the most relevant Committee, recognising the need to consider both financial and workforce implications. It was also noted that the policy should support appropriate incentivisation to encourage clinician and staff engagement in innovation
26/27/013	**Any Other Business** **Marmot Accreditation** The Committee noted that Alder Hey and the Charity have successfully achieved Marmot accreditation as part of Liverpool's Fairer, Healthier City initiative. This was recognised as a significant achievement, reflecting the organisation's commitment to addressing health inequalities and supporting wider strategic ambitions in this area. Members formally acknowledged the contribution of colleagues in securing the accreditation and highlighted its value as a recognised "kite mark" that strengthens the Trust's position in future bids, partnerships and research activity. The Committee also emphasised the importance of actively leveraging this accreditation across programmes, particularly in relation to health equity and innovation work.
26/27/014	**Review of the Meeting** The Chair reflected that the meeting had covered a strong range of strategic priorities, with particularly valuable discussion on AI learning from Toronto, where the Committee endorsed a hybrid approach to development and the need to progress this to Board for further consideration. The Innovation Conference

	was noted as a significant success, reinforcing Alder Hey's position as a leading convener in paediatric innovation, and the health equity work in research was recognised as a high-impact area requiring stronger alignment and more systematic use of data. The Committee also acknowledged progress on Research and Innovation financial sustainability, with broad agreement on the proposed principles, subject to further refinement in line with organisational changes. Updates on the CYP system collaboration programme highlighted the need to balance long-term system design with early delivery, alongside early visibility of the emerging business case. The new GO metrics dashboard was welcomed as a useful assurance tool, with further iteration required to align with Board reporting and ensure appropriate focus and ambition. Finally, the Chair noted ongoing progress across programme areas, including Private Patients and Global Health, alongside key achievements such as the launch of Alder Connect and Marmot accreditation. It was agreed that focus now should be on maintaining momentum, strengthening alignment across programmes, and progressing key areas—particularly AI strategy and system transformation—to Board for further development and decision-making.
	Date and Time of Next Meeting: 25 June 2026 at 1.00pm, Teams

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement 2025-26**
Report of:	**Medical Appraisals 2025-2026**
Paper Prepared by:	Dr Z Bassi, Helen Blackburn

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:	Payments to appraisers

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
#550	Appraiser Remuneration	6

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

1. Executive Summary

The Annual Submission to NHS England North West: Framework *for Quality Assurance and Improvement* is a national requirement designed to ensure that Trusts have robust systems in place to record all medical appraisals.

This report is to provide assurance that appropriate processes and systems are established 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%**.

2. Background and current state

The Trust is required to submit an annual update to the Higher-Level Responsible Officer (HLRO) to provide assurance that all medical staff holding a licence to practice undergo annual appraisal. These annual appraisals form part of a continuous five-year revalidation cycle, during which doctors are also expected to complete both colleague and patient feedback.

Following the completion of the appraisal cycle, the outcomes are formally reviewed by the Trust Responsible Officer Advisory Group. Based on this review, revalidation recommendations are then made and submitted to the GMC.

Last appraisal year we added **68** new Drs to the system, predominately clinical fellows who are given 1-year contracts. There are **74** appraisers in the trust, average number of appraisals is **5.3** annually for every appraiser.

The submission for 2025-26.

The Trust had 407 GMC registered Drs, consultants, SAS and Clinical Fellows.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	407
Total number of appraisals completed	351
Total number of appraisals approved missed	45
Total number of unapproved missed	11
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	60
Total number of late recommendations	0
Total number of positive recommendations	53
Total number of deferrals made	7
Total number of non-engagement referrals	0

3. Conclusion

The Appraisal Lead and Revalidation Team use approved systems and processes and have achieved a compliance rate of 97.3%. This represents a marginal decrease compared to the 2024/25 reporting period.

A small number of appraisers have stepped down from their roles due to the inability to include the responsibilities within their job plans or to receive remuneration in line with Trust policy. As a result, there are currently 46 appraisees who have not yet been allocated an appraiser. Hence this has been put on the risk register.
Replacement appraisers are being actively recruited to cover those who have retired or chosen not to continue in the role; however, a shortfall remains.

4. Recommendations & proposed next steps

- Allocate and ringfence funding to ensure appraisers are appropriately remunerated and that the role can be incorporated into job plans, in line with GMC requirements.
- Continue to support current appraisers through ongoing training, including the organisation of regular update sessions.
- Deliver appraisal training through the New Consultants Forum to support and familiarise new consultants with appraisal systems and processes.

5. Actions from last year:

- A new appraiser training event was organised to increase the pool of appraisers (Completed).
- A peer review with local Trusts was undertaken, as required once every five years (Completed).
- The Appraisal and Revalidation Policy was reviewed and updated (Completed).

BOARD OF DIRECTORS

Thursday, 2nd July 2026

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

Does this relate to a risk? Yes R No ☐

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

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

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

Introduction

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

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.

The cultural priorities centre on five interconnected areas:

- **Leadership behaviour under pressure** – ensuring leaders remain visible, compassionate, honest and consistent, particularly when decisions are difficult and uncertainty is high.
- **Psychological safety and trust** – creating environments where staff feel safe to speak up early and are confident in how concerns will be handled.
- **Fairness, justice and consistency** – reducing avoidable employee harm by improving how decisions, processes and people issues are managed across the organisation.
- **Thriving teams, inclusion and voice** – addressing uneven staff experience by strengthening team functioning, collective wellbeing, inclusion and meaningful staff voice that leads to action.
- **Learning, purpose and sustainability** – making learning visible, sustaining staff wellbeing and functioning, supporting staff through moral strain, and reinforcing a shared sense of purpose under pressure.

Underlying all priorities is the need to strengthen 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

Maintaining SALS as a high-access listening service continues to be a priority. Contact rates are now at 21000 since the establishment of the service in April 2020. In keeping with previous trends, the last 10 weeks has seen 180 new referrals and over 900 contacts, with April representing the busiest month with 87 new contacts. This is due to the initial impact of organisational change, major incident impact response, and suicide postvention support which SALS have partnered with the Samaritans Liverpool office to develop further.

The service continues to see a sustained high level of contacts from the Community and Surgery Divisions, reported on previously and linked to the impact of work-based incidents, Public Inquiry impact and leadership strain and burn out. A rise in contacts from the Medicine Division has been linked to the impact of organisational change on administrative and operational colleagues. Staff in these roles are seeking support whilst applying for internal jobs and managing the impact of organisational change and transition. This is also reflected in the rise in the percentage of 'Administrative and Clerical' colleagues and 'Nursing' staff who remain the top two most frequent contacts.

Additional themes across the organisation relate to the emotional and psychological consequences of voluntary redundancy. There has also been an increase in staff reporting neurodiversity or disabilities who are impacted by inconsistencies in the implementation of flexibility or reasonable adjustments. The service is also seeing a rising number of staff affected by disciplinary action.

Using insight to inform targeted interventions and leadership action is among the key strengths of the SALS approach. Targeted support is being offered in group sessions to operational and administrative staff, with thematic feedback being shared with relevant leaders in the organisation to improve change processes and approaches. The increase in leadership strain and risk of burnout is being addressed via increased individual and group support to leaders either leading on or impacted by organisational change. A bespoke Leadership Under Pressure session is being delivered to the executive team as part of an away day session and will be rolled out to the SLT in July and then to groups of leaders as the organisational leadership structure is fully established.

Equality, Diversity, and Inclusion

Alder Hey continues to show a clear and active commitment to progressing its equality, diversity and inclusion priorities, implementing a broad and meaningful programme of work that aligns with its strategic aims while creating a welcoming and inclusive environment for staff, as well as children, young people and their families.

Lord Mann Review

The Lord Mann Review is an independent review commissioned by NHS England and led by John Mann to examine racism, antisemitism, discrimination, and inclusion within the NHS. Published in June 2026, the review was carried out following concerns about the experiences of NHS staff and patients, including incidents of antisemitism, Islamophobia and wider racism. It explored how effectively NHS organisations respond to discrimination and what more can be done to create inclusive, safe, and respectful environments for everyone

The review called for:

- An anti-racist workplace culture across the NHS.
- Clear processes for reporting and investigating racism.
- Greater accountability for perpetrators of discriminatory behaviour.
- Updated and mandatory anti-racism training for staff and leaders.
- Creating environments where staff feel safe to speak up and challenge inappropriate behaviour.

A more detailed accompanying paper has been prepared for the Board, setting out Alder Hey's position and response to the review

Liverpool City Region Anti Racism Strategy

Liverpool City Region's new Anti-Racism Strategy was launched in June 2026. The strategy sets out a clear vision to dismantle systemic racism, strengthen trust and celebrate the contribution of members of Black, Asian and Minority Ethnic communities. Created with more than 200 local organisations and over 500 individuals, including community groups, public sector, grassroots activists, educators, businesses, and residents from every borough, the strategy marks a major step in the City Region's commitment to become a fairer, more inclusive and more equitable place for everyone. Alder Hey has been actively involved in the development of the Liverpool City Region Anti-Racism Strategy as a member of the Public Sector EDI Professionals Forum. The focus of the strategy is on effecting change, which is often about what people think, feel and experience in their lives. This involves changing the culture of organisations and of the Liverpool City Region to a more progressive, inclusive one where anti-racism and diversity is actively recognised and celebrated. Alder Hey is committed to playing an active role in the implementation of the Liverpool City Region Anti-Racism Strategy, working in partnership to support delivery, embed change, and contribute to improved outcomes for the communities we serve.

Active Bystander Training

Following the recent Active Bystander training, a comprehensive suite of learning materials and a detailed presentation have been developed to support the rollout of staff training. This programme will be delivered by a trained cohort of facilitators and will support implementation of the Lord Mann Review recommendations and the work untaken to support the NW BAME Assembly Anti-Racist Framework.

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% (94.35% as at 02.06.26) there

remains to be pockets of non-compliance linked to specific staff groups, teams, individuals and topics. Divisional reports are distributed across the Trust in the first week of each month. These are distributed to each SLT (Director, ACOO and Associate Chief Nurse) and the associated HR Business Partner by the end of week one. During week two divisional reports are distributed to divisional and departmental managers and leaders, totaling over 270 contacts. Subject Matter Experts (SMEs) are also updated with reports to enable them to be aware of the current position and instigate corrective action if compliance is not maintained, or there are areas of emerging or continuing concern.

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 will take place with partners to celebrate the success and development of our 25/26 interns.
- 15th June 2026 saw the commencement of a weeklong event activity with our partners Elevate EBP and Year 6 pupils at St Margaret Mary's Primary School. This programme showcases a range of careers available for young people (with a focus on health and care as well as wider sector), enhances pupil's knowledge of the Liverpool City Region, facilitates learning around promoting health, both physically and mentally, as well as developing a range of skills and abilities.
- Aspiring Medics will run in early July, supporting Year 12 students intending to apply to medical school in the Autumn
- Work has commenced to plan next academic years activity between Alder Hey, Widening Participation, Medical Needs Education
- Plans are underway to hold a national teen tech event for 65 students from Liverpool schools in October 2026. Hosted by Maggie Philbin (formerly of Tomorrow's World) this will focus on innovation and unusual NHS careers.

PDR Update

Discussions have taken place with Executive colleagues regarding the culture shift required to ensure PDR compliance is achieved. Key messages have been shared at Commenting leaders and connecting 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 HWWWITF programme of work, if felt applicable by the relevant team(s).

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.

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. Phase two is now ready to launch with a focus on an individual skill scan process and information regarding career pathways. Phase three – talent management has commenced and will become an area of increased focus.

Employee Relations & Wellbeing

Sickness Absence

The Trust's sickness absence rate for May 2026 stands at 6.07%. This is a slight increase compared to the previous month's figure of 5.83% (Apr). Sickness absence rates have been on an upward trajectory since April 2026, however, remains below the rates recorded in January (6.69%) and December (7.36%). The current sickness rate remains over 1% higher than the Trust's target of 4.5%. When examining the breakdown of absence, long-term absence decreased slightly to 3.84% in May (compared to 4.23% in April) against a target of 2.5%. Short-term absence increased in May to 2.23% (compared to 1.61% in April), and this stands above the target of 2%.

The Trust's dedicated HR sickness support team continue to provide tailored support to improve levels of absence across the Trust. Focus remains on prevention, working with SALS, Occupational Health and Trade Union colleagues, with support for stress risk assessments, reasonable adjustments, enhanced wellbeing support from Occupational Health, management training, and targeted support for areas with higher absence.

Management of Workforce Variance

The total Whole Time Equivalent (WTE) reported in May was 33.37 WTE below the budgeted plan. Measures in place to achieve the 2026/27 workforce plan Include:

- **Bank Staff Reductions:** Efforts will be made to reduce reliance on bank staff. A higher bank position was reported in May at 97.03 WTE (compared to 90.89 WTE in April). Those areas who have converted overtime spend to bank will be contributing to the increasing bank use. The main reason for using bank is attributed to short term sickness absence cover, followed by cover for vacancies.
- **Recruitment Pauses:** Recruitment pauses will continue to be implemented where appropriate, helping to control workforce numbers and manage costs.

- **Voluntary Redundancies:** The facilitation of voluntary redundancies will enable eligible colleagues to leave the Trust voluntarily, thereby contributing to the alignment of actual staffing with the planned workforce.
- **Organisational Change:** Ongoing organisational changes will support the management of workforce variance, ensuring that staffing levels are maintained in line with operational requirements and strategic objectives.

Collectively, these actions are aimed at closing the gap between actual and planned workforce numbers, supporting the Trust's operational and financial goals.

Between March 2026 and March 2027, analysis of the WTE (Whole Time Equivalent) movement indicates a projected overall reduction. The reduction is to be achieved through the Trust's consistently low vacancy rate, alongside continued robust controls on bank and agency expenditure, service re-design and innovation, specifically linked to the HWWITF programme, and enhancement of digital capabilities.

Voluntary Redundancy Scheme

The Trust 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 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, 2nd July 2026

Paper Title:	**Trust response to the Lord Mann Review**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	**Angela Ditchfield, Head of Equality, Diversity, and Inclusion**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Background Papers and/or supporting information:	**Checklist for policies / guidelines / SOPs:** Reviewed by subject matter expert Yes☑ No☐ Reflects best practice / national guidance / current practice Yes☑ No☐ Approved by Operational Committee Yes☑ No☐ Changes included in version history (and summarised below) Yes☑ No☐
Action/Decision Required:	To note ☐ To approve **R**
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Impact:	
Associated risk (s)	Include risk(s) reference, title of risk, and current risk score.

1. Introduction

This paper presents to the People Committee with a summary of the key findings and recommendations from the recent Lord Mann Review into racism and antisemitism within the NHS. It also outlines the required actions in response to the NHS England letter dated 4th June 2026 and seeks approval for the proposed organisational response.

2. Background

On 4 June 2026, NHS England issued guidance to NHS leaders following publication of the Lord Mann Review. The Lord Mann Review is an independent review commissioned by NHS England and led by John Mann to examine racism, antisemitism, discrimination and inclusion within the NHS. It explored how effectively NHS organisations respond to discrimination and what more can be done to create inclusive, safe and respectful environments for everyone. The review concludes that racism, including antisemitism and Islamophobia, remains present within NHS organisations and can negatively impact the experiences of staff, patients and communities. NHS England highlighted the responsibility of leaders to actively address structural discrimination and create environments where all individuals are treated with dignity, compassion and respect. The review's recommendations focus on strengthening organisational culture, leadership accountability and anti-racist practice across the NHS.

NHS England has accepted all the proposed recommendations and has written to NHS organisations requiring immediate action.

3. NHS England Requirements

NHS England have set out a series of actions that they have asked organisations to take:

- To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.
- Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups.
- Prepare to implement the forthcoming NHS Staff Standards.
- Adopt the new government definition of anti-Muslim hostility.
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available.
- Ensure Board agreement to undertake new anti-racism training when it becomes available.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are

appropriately engaged in further developments to address antisemitism and all forms of racism locally.

- Ensure Trust Board and relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress

4. Our current position

The Trust welcomes the publication of the Lord Mann Review and the recommendations set out by NHS England. We recognise the importance of creating an environment where all our staff, children, young people, their families and our communities feel safe, respected, valued and included. Alder Hey has a well-established commitment to equality, diversity, inclusion and belonging and has existing arrangements in place through:

- Equality Data monitoring
- Freedom to Speak Up arrangements
- Violence Prevention and Reduction processes
- Our Staff Networks
- Patient Experience and Engagement Framework
- Quality and Equality Impact Assessment processes
- EDI and anti-racism training
- Recent Bronze Status from NHS BAME Assembly Anti-Racist Framerwork

In addition, we continue to monitor workforce experience through the Workforce Race Equality Standard (WRES), staff survey results, workforce metrics and feedback from our staff networks, ensuring that areas of concern are identified and addressed.

Whilst these arrangements provide a strong foundation, the Lord Mann Review presents an opportunity to strengthen organisational capability, governance and assurance. The Trust Board will receive regular assurance on progress against the Lord Mann recommendations and associated NHS England requirements through existing governance arrangements, including the EDI Steering Group, People Committee and Trust Board reporting, as part of Alder Hey's ongoing commitment to equality, diversity, inclusion and belonging.

5. Risks

Failure to implement the recommendations may result in:

- Increased risk of discrimination and harassment.
- Negative staff experience and retention.
- Reputational damage.
- Reduced confidence amongst patients and communities.
- Regulatory concerns through NHS England oversight frameworks.
- Failure to meet statutory Equality Act obligations.

The proposed actions will support mitigation of these risks, and most actions can be delivered through existing workforce, organisational development and equality programmes.

6. Proposed Actions to Implement NHS England Recommendations

To ensure compliance with the recommendations from the Lord Mann Review and NHS England response, Alder Hey will implement the following actions:

1. Review our current position and develop an action plan based on the proposed recommendations
2. Ensure oversight of progress through the EDI Steering Group, People Committee and Trust Board
3. Consider adoption of the NHS Race and Health Observatory's Seven Anti-Racism Principles.
4. Confirm adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility.
5. Review staff experience data relating to discrimination, bullying, harassment and inclusion and develop targeted improvement actions where required.
6. Review existing Equality, Diversity and Inclusion training provision to ensure alignment with emerging NHS England anti-racism standards, and consider making anti-racism training mandatory
7. Implement any future NHS England anti-racism learning programmes and NHS Staff Standards as they are published.

Alder Hey is already undertaking significant work that aligns with the Lord Mann Review recommendations. The Trust's recent achievement of Bronze Status under the NHS BAME Assembly Anti-Racism Framework provides a strong foundation on which to build. Through strengthened governance, enhanced staff engagement, targeted education, robust data monitoring and ongoing partnership with staff and communities, the Trust will continue its journey towards becoming a truly anti-racist organisation and meeting the expectations set out by NHS England.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
June 2026

Alder Hey Children's NHS Foundation Trust

People Committee
Minutes of the last meeting held on 13th May 2026
Teams

Present:

Jo Revill	Non-Executive Director **(Chair)**	(JR)
Adam Bateman	Deputy Chief Executive & Chief Operating Officer	(AB)
Garth Dallas	Non-Executive Director	(GD)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Chloe Lee	Associate Chief Operating Officer – Surgery	(CL)
Jo Potier	Associate Director of Organisational Development	(JP)
Erica Saunders	Chief Corporate Affairs	(ES)
Melissa Swindell	Chief People Officer	(MS)
Sharon Owen	Deputy Chief People Officer	(SO)

In attendance:

Kathryn Allsopp	Associate Director of People	(KA)
Katherine Birch	Director of Academy	(KB)
Audrey Chindiya	Finance Manager	(AC)
Angela Ditchfield	EDI Lead	(AD)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Gill Foden	Head of L&D and Widening Partnership	(GF)
Rebecca Murphy	Head of Marketing & Communications	(RM)
Jill Preece	Governance Manager	(JP)
Nikita Pickard	Interim Associate Chief Operating Officer Medicine	(NP)
Natalie Palin	Director of Transformation and Change	(NP)
Jason Taylor	General Manager	(JT)
Kerry Turner	FTSU Guardian	(KT)
Julie Worthington	Staff Side Chair	(JW)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Nathan Askew	Chief Nursing Officer	(NA)
Fiona Beveridge	Non-Executive Director	(FB)
Alfie Bass	Chief Medical Officer	(AB)
Pauline Brown	Deputy Director of Nursing	(PB)
Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
Urmi Das	Director, Division of Medicine	(UD)
Sarah Leo	Associate Chief Operating Officer	(SL)

26/27/001 **Declarations of Interest**

No declarations were declared.

26/27/002 **Minutes of the previous meeting held on 26th March 2026.**

The minutes of the last meeting were approved as an accurate record.

26/27/003 **Matters Arising and Action Log**

Action log was updated accordingly.

26/27/004 **Terms of Reference**

- **Workplan**

The Committee reviewed proposed revisions to its governance documentation and forward work programme, including updates to the Terms of Reference (covering the committee's title and membership) alongside a refreshed annual workplan for 2026/27

aimed at strengthening assurance, improving focus, and supporting more timely scrutiny.

Proposed changes to the Terms of Reference (ToR) as follows:

- Refresh of ToR wording/terminology
- Proposed change of Committee title name
- Attendance / Representation – Freedom to Speak Up (FTSU)
- Wider governance documentation refresh linked to organisational transition
- Proposal to change meeting occurrence

Workplan:

A draft annual workplan was presented, designed to make monthly oversight more practical and efficient. Its key features were:

- Deep dives
- Workplan to remain dynamic
- Incorporating change impact / transformation lens
- FTSU reporting cadence and ToR clarity
- The draft model proposed a consistent core pack each month including (as standing agenda items):
  - scorecard / workforce metrics,
  - risks and Board Assurance Framework (BAF),
  - cost/productivity (including agency/temp spend), and
  - staff experience/culture and Freedom to Speak Up (FTSU)

The Committee acknowledged the need to clarify how frequently FTSU reporting comes formally and whether the FTSU Guardian should be explicitly named in the ToR attendee list. Follow-up discussion was agreed outside the meeting.

Action: The Terms of Reference and Workplan will be brought back to the Committee in June, incorporating the recommendations discussed at today's meeting.

Resolved: The Committee received the Terms of Reference recommendations.

26/27/005 **People Committee Annual Report**

The Committee welcomed the people committee annual report as an important way of demonstrating the scale of delivery, the number of actions progressed, and the impact of its discussions on organisational priorities.

The Committee acknowledged that activity levels over the reporting period had been considerably higher than in the previous year**,** reflecting both the demands of the current operating environment and the increasing maturity and scope of the Committee. Members agreed that the report captured well the Committee's contribution to progressing key workforce initiatives and highlighted areas where meaningful improvements had been achieved at pace.

The Chair emphasised that the report also demonstrated the Committee's role in supporting the wider organisation, particularly through facilitating constructive and high-quality discussions that have influenced decision-making and organisational direction and reiterated that the work of the Committee reflects a strong commitment to supporting staff and improving outcomes for the workforce.

Members agreed that the report provided a positive reflection of the organisation's focus on its people, whilst also acknowledging the ongoing scale of work required. There was also recognition of the substantial effort involved in preparing the report**,** with specific thanks recorded for Jill Preece, Governance Manager.

Resolved: The Committee noted the contents of the Annual Report.

26/27/006 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received an update on the Board Assurance Framework (BAF) and associated risk reframe, with the discussion focusing on the appropriateness of current risk descriptions, scoring and the robustness of mitigations in light of recent Board-level challenge.

It was noted that the previous meeting had included a detailed and comprehensive discussion on risk redefinition, and further work had since been undertaken however, the Board had specifically challenged whether current risk scores appropriately reflect the true level of organisational risk, particularly in the context of the scale of change and external pressures.

The Committee acknowledged that, whilst there is confidence in the breadth of mitigation activity in place across workforce, culture and EDI risks, there is also a need to ensure that reliance on mitigations does not inadvertently suppress risk scoring where underlying exposure remains significant. In particular, discussion focused on the sustainable workforce risk (2.1), organisational culture risk (2.2) and EDI/inclusion risk (2.3)**,** with members noting that external environmental pressures and internal transformation activity may not yet be fully reflected within current scores. There was a view that some risks, particularly EDI and inclusion with a broader patient and family lens, and culture, remain complex and evolving, with elements of "known unknowns" that require further analysis before any immediate adjustment to scoring is made.

The Committee therefore agreed that, whilst some members expressed a view that certain risks may be understated, it would be more appropriate to undertake targeted deep dive reviews to assess the robustness and impact of mitigations, and to consider a wider range of qualitative and quantitative evidence (including staff survey insights, experience data and operational intelligence) before formally revising risk ratings. It was highlighted that culture should not be assessed solely through a single metric such as staff survey results, and careful distinction should be made between short-term fluctuations in morale and longer-term cultural position, with a more rounded assessment required. Similarly, it was acknowledged that there is stronger

understanding of workforce-related EDI risks than wider organisational or patient-facing EDI risks, and that further evaluation is required to fully understand gaps and opportunities.

The Committee also identified the need to strengthen explicit links between workforce planning and the BAF, noting that systematic workforce planning is critical to supporting the sustainability of the workforce risk and should be more clearly articulated within controls and actions.

The Committee supported the approach of undertaking further analytical work and structured deep dives before making any changes to risk scores, recognising the complexity of the risks and the importance of ensuring that any adjustments are evidence-based and clearly articulated to the Board. It was agreed that outputs from this work would be brought back to the Committee to inform future consideration and then reported to the Board, providing assurance that the Committee is actively responding to Board feedback and strengthening its approach to risk evaluation.

Resolved: The Committee noted the contents of the Board Assurance Framework.

26/27/007 **Internal Communications Update**

The Committee received and considered the internal communications update, noting the continued focus of activity on supporting the organisation through the "How We Work in the Future" programme whilst maintaining progress across wider communication priorities.

It was reported that the majority of communications capacity has appropriately been directed towards the transformation programme, reflecting its scale and organisational significance, although progress has also been sustained in other areas of the communications strategy. Positive developments highlighted included the introduction and rollout of the structured communications calendar, which has been well received by staff, alongside recent organisational campaigns such as International Nurses Day communications.

The Committee further noted the launch of the Annual Staff Awards process, recognising the importance of celebration and recognition during a period of significant organisational pressure, although it was clarified that awards categories have been streamlined in response to both financial considerations and previous feedback regarding inclusivity and overall format.

In discussion, members explored the broader impact of these changes within the current organisational context, particularly the risk that reducing award categories, whilst operationally justified, may create a perception of reduced recognition at a time when staff morale is under pressure. It was acknowledged that this reflects a wider cultural sensitivity across the organisation, with increased scrutiny from staff on

recognition, communication and engagement activities during a period of change and perceived resource constraints. The Committee emphasised the importance of ensuring that recognition is not solely dependent on formal award processes, and that alternative, more frequent and locally-driven recognition mechanisms should continue to be strengthened, including informal recognition, ongoing initiatives such as "Stars of the Month", and targeted celebratory events such as long-service recognition activities.

The Committee also considered the effectiveness of internal communication channels, particularly in relation to the "Connecting Alder Hey" programme and wider engagement activity. Whilst current participation and reach data was encouraging, it was acknowledged that evaluation remains challenging due to limited feedback and response rates from staff, making it difficult to fully assess engagement levels or identify specific groups or areas of the organisation that may be less connected. It was noted that multiple feedback mechanisms are in place, including surveys, communication inboxes and informal channels, however further work is required to improve the consistency and quality of feedback in order to strengthen insight and inform future communications planning.

Members further highlighted the strong interdependency between communications, organisational change and culture, noting that internal communications activity is operating within a highly sensitive environment where staff perceptions are influenced not only by messaging but also by wider organisational pressures.

It was acknowledged that even established communication and recognition approaches may be perceived differently by staff in the current climate, with heightened sensitivity and expectation. The Committee therefore emphasised the importance of maintaining a high level of awareness of staff sentiment, ensuring clarity and consistency of messaging, and continuing to adapt communications approaches to reflect the evolving organisational context.

Resolved: The Committee noted the contents of the Internal Communications

26/27/008 **People Plan Update – Key People Issues**

The Committee received the People Plan update, presented as a comprehensive paper summarising current workforce activity, operational performance and key priorities, noting that this is a standard report aligned to the Board and intended to provide a consolidated view of people services across the organisation.

The update highlighted a period of significant organisational pressure and change, with particular emphasis on the impact of the "How We Work in the Future" programme on staff experience, morale and service delivery. It was reported that, whilst a degree of uncertainty and workforce stability challenges would be expected during such a period of transformation, there has been a notable increase in engagement with support

services, including occupational health and staff wellbeing support, reflecting both heightened demand and proactive interventions following recent incidents.

The Committee noted ongoing challenges in workforce metrics, including a continuing gap between planned and actual staffing levels, and received assurance that a range of measures are being implemented to address this, including cost improvement programme (CIP) activity, voluntary redundancy schemes and targeted workforce interventions.

The Committee further noted that the Board had provided constructive challenge on several aspects of the People Plan, particularly in relation to the interpretation and presentation of workforce data**,** including the need to differentiate between natural attrition and managed turnover, and to strengthen clarity and transparency in reporting. Attention was also drawn to performance management metrics, specifically the position regarding Personal Development Reviews (PDRs), with the Board expressing clear expectations that compliance should consistently meet target levels. It was acknowledged that variability in PDR completion rates is not acceptable and must be addressed as a priority, with actions already underway to improve compliance and reinforce accountability.

In relation to Equality, Diversity and Inclusion (EDI), the update confirmed continued engagement at both organisational and regional level, including active involvement in the Liverpool City Region anti-racism framework and ongoing delivery of initiatives such as the dual mentoring programme, which was highlighted as a positive example of impact and engagement. Members also noted the importance of continuing to embed EDI priorities within the wider workforce strategy and ensuring that progress is visible and sustained across the organisation.

The Committee acknowledged that the People Plan reflects a complex operating environment, characterised by significant organisational change, workforce pressures and the need to balance operational delivery with transformation. The discussion reinforced the importance of maintaining clear oversight of workforce risks, strengthening data transparency, and continuing to prioritise staff support and engagement during this period. The update was noted, with the Committee providing assurance that appropriate actions are in place and ongoing work will continue to address the key challenges identified, with further updates to be brought through future reporting cycles.

Resolved: The Committee noted the contents of the People Plan Update.

26/27/009 **Transforming People Services**

The Committee received a detailed update on the Transforming People Services agenda, which outlined both the national direction of travel set by NHS England and the Trust's local response through organisational change within people services.

It was noted that the national programme represents a significant, multi-year transformation focused on the development of a digital-first HR operating model, including standardisation of people policies, implementation of a new workforce system to replace ESR, and the redesign of HR services to prioritise strategic, value-adding activity over transactional processes.

The Committee was advised that this is a seven-year programme, with regional rollout phased over time, and that the Trust is proactively positioning itself to align with this future model by implementing local structural changes in advance.

In that context, the Committee considered the Trust's proposed target operating model for people services, which centres on the establishment of multiple centres of excellence (including workplace culture, EDI, employee relations and policy, education and talent, and workplace safety), alongside a revised business partnering model. This model will see a shift away from divisional HR teams providing largely transactional and casework support, towards a structure where strategic business partners are embedded at system level, focusing on workforce planning, organisational development and long-term service support, with operational activity delivered through specialist centres. The intention of the redesign is to ensure that HR resource is deployed more effectively, enabling greater focus on complex workforce issues, leadership support, and strategic priorities. The Committee noted that the proposed changes are currently subject to formal consultation and that implementation is anticipated from July, with a structured transition period to support staff movement into the new model.

An update was provided on staff engagement, indicating a mixed but broadly constructive response, with some areas of the workforce expressing enthusiasm for aspects of the new model, particularly where it strengthens capability (workforce analytics and integrated systems), whilst other areas, particularly those impacted by role reductions or changes to transactional services, are experiencing understandable uncertainty.

The Committee acknowledged that this reflects the scale and complexity of the change and emphasised the importance of maintaining clear communication, engagement and support throughout the transition.

The discussion also considered the alignment of this transformation with the emerging national 10-year workforce plan, which places strong emphasis on being a best employer, strengthening culture and inclusion, improving leadership capability, and developing a digitally enabled workforce. It was noted that while culture is not explicitly embedded within the national people services transformation model, it remains a critical component of the wider workforce strategy and is intrinsically linked to how these changes are implemented locally. The Committee recognised that successful delivery would depend not only on structural change but also on how effectively the organisation supports staff through transition and embeds new ways of working.

The Committee acknowledged the strategic importance and scale of the Transforming People Services programme**,** recognising that it represents a fundamental shift in how people services are delivered both nationally and locally. Members noted that the Trust's proactive approach to early alignment places it in a strong position to adapt to future national requirements but also recognised the significant organisational impact and the need for continued oversight. The Committee therefore noted the update, providing assurance that appropriate governance, engagement and transition planning are in place, whilst emphasising the importance of closely monitoring staff experience, service impact and delivery risks as implementation progresses.

Resolved: The Committee noted the contents of the report.

26/27/010 **Trust wide Metrics**

The Committee received the trust-wide workforce metrics report, which provides a consolidated overview of key people performance indicators across the organisation, and considered the position in the context of both ongoing operational pressures and wider organisational change.

Sickness: Slight month-on-month increase, rising from 5.59% in March to 5.83% in April. Long-term sickness is decreasing, but short-term absence remains the main challenge.

It was noted that the report continues to offer a comprehensive view of core indicators, including workforce compliance metrics, absence levels, workforce activity and employee relations data however, discussion focused less on the data detail itself and more on areas requiring enhanced oversight, assurance and improvement. In particular, the Committee reflected on previously highlighted concerns regarding Personal Development Review (PDR) compliance, acknowledging that although progress is being made, there remains inconsistent performance across the organisation, which is not aligned with Board expectations. It was reiterated that PDR completion should consistently meet target levels and that variation is not acceptable, given its importance in supporting performance, development and staff engagement.

The discussion also explored employee relations metrics, with a specific focus on the timeliness of appeal hearings and the impact of delays on staff experience. Members highlighted that extended timeframes between appeal submission and resolution can lead to prolonged uncertainty and distress for staff, and that this presents both a workforce wellbeing issue and a potential organisational risk. Whilst it was acknowledged that there are practical constraints, including the availability of senior panel members, case complexity and the requirement for independent decision-makers, the Committee agreed that greater visibility, challenge and potential redesign of processes may be required. There was a collective view that improvements should be pursued through a more coordinated and potentially innovative approach,

including exploring alternative ways of scheduling or resourcing panels, and ensuring robust monitoring and escalation where delays occur.

It was further noted that ongoing work around "avoidable employee harm" provides a relevant framework for addressing these concerns and ensuring that staff are appropriately supported throughout such processes.

The Committee considered the broader implications of the metrics within the context of organisational change and service pressures, recognising that many of the indicators reflect a system under sustained demand. It was acknowledged that some of the trends observed, including workforce compliance variability and operational pressures within people processes, are influenced by wider contextual factors such as transformation activity, staffing constraints and competing priorities. Nevertheless, the Committee emphasised the importance of maintaining strong grip and accountability across these metrics, ensuring that key people processes are delivered consistently and effectively despite these challenges.

Resolved: The Committee received and noted the Metric report.

- **Divisional Metrics**

Surgery Division

The Committee received the Surgery Division metrics report (April 2026) data.

- **Mandatory Training Compliance:** Maintained above the 90% Trust target. All areas continue to be closely monitored and regularly reviewed through divisional governance.
- **PDR Compliance:** Band 7 and above performance reported at 90%. Considered a positive position, particularly given wider organisational challenges. This position demonstrates strong engagement from senior staff and effective leadership accountability at higher bands. Band 6 and below reported 76% to date. Divisional deep dive into hotspot areas supported by HRBPs and introduction of weekly monitoring /check ins across areas.
- **Agency Usage and Spend:** Maintained at 0% since June 2025. Identified as a significant achievement, reflecting effective workforce planning, improved staffing stability, reduced reliance on temporary workforce. Positively contributes to financial performance, workforce continuity and quality.
- **Sickness Absence**: Reported above trust target. Hot spot areas identified and plans of targeted interventions and monitoring though divisional processes.
- **Temporary Staffing / Bank Spend**: Increased usage linked to high patient acuity and one-to-one care requirements, particularly in specific ward areas across level 3 & 4.

- **Workforce and Service Redesign**: Continued oversight of ongoing organisational and service redesign.
- **Voluntary Redundancy (VR) Scheme:** Division actively engaged in reviewing applications and assessing feasibility of supporting requests with decisions to be finalised in the near term.

Resolved: The Committee noted the contents of the Metrics Report.

Clinical Research Division

The Committee received The Clinical Research Division metrics report (April 2025) data.

- **Workforce Diversity (BAME Representation)**: BAME representation remains stable at around 20% across the Division, indicating a consistent workforce profile and continued alignment with EDI priorities. The divisional lead provided assurance that diversity metrics remain steady, with no significant change reported.
- **Sickness Absence**: Overall sickness absence was around 4% in March, below the Trust target and therefore a positive position. Long-term sickness reduced by a further 2%, showing continued improvement.
- **Return-to-Work (RTW) Compliance**: Improved to approx. 82%, showing steady month-on-month progress. Continued focus is needed to achieve full compliance.
- **Overpayments**: Reduced to zero, providing positive assurance.
- **PDR Compliance:** Band 7 and above achieved 94%, exceeding target and showing strong appraisal engagement at senior level.
- **Overall PDR Compliance**: Overall compliance was 88%, slightly below target. The gap sits mainly outside the Band 7+ group and remains a small but important area for improvement to ensure consistency across all staff groups.
- **Workforce Planning**: Ongoing work remains aligned to the "How We Work in the Future" programme. The Division's research workforce is largely externally funded, limiting flexibility for workforce reduction or redesign and creating a structural constraint unique to the Division.
- **Voluntary Redundancy (VR) Scheme**: VR has limited applicability in the Division due to its reliance on externally funded posts, leaving little scope to use the scheme and reducing flexibility for workforce cost savings.
- **Staff Survey "Big Conversation"** Staff survey results were received, and divisional engagement sessions are now being planned.

Resolved: The Committee noted the contents of the Metrics Report.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (April 2026) data.

- **Sickness Absence**: Sustained improvement, with around five consecutive months of reduction. Current levels are reported at 4% below previous levels, indicating a positive trajectory and improved workforce stability.
- **Staff Survey Engagement**: The Division reported high staff survey response rates, with strong engagement from clinical and managerial leaders through structured "Big Conversation" sessions and leadership-led team discussions. The focus remains on sustaining engagement and sharing learning across the organisation.
- **Staff Turnover**: Turnover remains a significant concern, compounded by existing vacancies. This is increasing service pressure and making workforce stability harder to maintain. The Division continues to monitor the position and implement targeted workforce interventions.
- **Vacancy Pressures**: Ongoing workforce gaps in key areas are linked to turnover and organisational change. The Division is working to manage these gaps and align staffing to emerging structures.
- **Sickness Hotspot Areas**: Overall sickness has improved, but some areas remain challenging and require targeted intervention, ongoing monitoring and support.
- **Staff Survey "Big Conversations"** Active programme of team-level discussions on staff survey results, supported by senior leaders and facilitated sessions with the Head of Organisational Development. The focus is on sustaining engagement, addressing themes from feedback, and linking discussions to organisational change.
- **Workforce Stability and Retention:** Turnover and vacancies present a significant ongoing risk. Action plans in place to manage accordingly.

Resolved: The Committee noted the contents of the metric report

Medicine

The Committee received the Medicine Division metrics report (April 2025) data.

- **PDR Compliance:** Band 7 and above exceeded 90% compliance by year-end, following a 16% improvement in the final quarter. This was recognised as a significant achievement given previous challenge, driven by:
  - focused leadership,
  - targeted divisional effort,
  - strong clinical engagement.
- Priority now is to sustain performance and ensure compliance within the current appraisal window.
- **Return-to-Work (RTW) Compliance:** Improved from 59% in January to 75% in March, driven by the adoption of a multidisciplinary RTW model and learning from Surgery Division best practice. This approach will continue to be embedded to support further improvement.
- **Agency Spend Reduction**: Agency usage reduced notably in March. Key progress included eliminating agency use in Radiology, making strong recruitment

progress in Microbiology to replace long-standing high-cost agency roles, and planning full elimination of agency spend across the Division by September.

- **Sickness Absence**: The overall trend is improving but remains above the Trust target. Hotspot areas include specific wards with high acuity and workforce pressure, contributing to increased temporary staffing and ongoing operational strain. Continued targeted intervention is needed in these high-risk areas.
- **Temporary Staffing / Acuity Pressures**: Continued use of temporary staff linked to high patient acuity and increased one-to-one care requirements.
- **Overpayments**: Overpayment value increased in March, but around 50% relates to a single case. The issue is not widespread by volume, though high-value cases significantly affect the overall position. Recovery remains challenging in some cases and continues to be managed through workforce controls and monitoring of change processes.
- **Workforce Planning**: A key divisional priority, focused on aligning the workforce to future service models and responding to financial and system pressures. Progress is challenged by the complexity of workforce planning, tight timescales, and some teams' difficulty engaging at pace.
- **Staff Survey "Big Conversations"** Survey results have been received and discussions have started, though progress is behind schedule. Actions are underway to link feedback to change management, leadership conversations and workforce engagement, with a focus on making the survey a meaningful tool rather than an added burden.

Resolved: The Committee noted the contents of the Metric Report.

26/27/011 **Sickness Update**

The Committee received a detailed update on sickness absence, noting both progresses made and the remaining challenges in improving overall performance across the Trust.

It was reported that there has been a continued positive trajectory in the management of long-term sickness absence**,** with evidence of consistent reduction over recent months, reflecting the impact of strengthened processes, improved case management, and effective partnership working with occupational health services.

The Committee also noted the expansion of supportive interventions, including access to physiotherapy and increased utilisation of occupational health not only for absence but also for preventative advice and workplace adjustments, demonstrating a shift towards a more proactive and supportive approach to workforce wellbeing. Additionally, the completion of the majority of previously identified actions from an earlier improvement programme was acknowledged, with attention now turning to the next phase of work focused on prevention and targeted intervention. However, it was highlighted that despite improvements in long-term absence, short-term sickness absence remains a persistent and more complex challenge**,** with recent data indicating

a slight increase, contributing to an overall rise in the Trust's sickness rate between March and April.

The Committee acknowledged that short-term absence is inherently more difficult to manage due to the wide range of underlying causes and limited ability to intervene early. In response, the team outlined a series of actions aimed at strengthening understanding and control in this area, including the identification of a small number of services that account for a disproportionate level of absence, enabling more targeted support and intervention. There are also plans to pilot earlier intervention triggers, particularly for individuals with repeated absences linked to mental health, to support timely wellbeing conversations and preventative action.

The Committee further noted ongoing work to improve process efficiency and compliance**,** particularly in relation to return-to-work discussions, where performance remains below expected levels. Whilst improvements have been seen in some areas, achieving consistent compliance continues to be a challenge, and members emphasised the importance of strengthening this process given its role in supporting staff, identifying underlying issues, and preventing recurrence. It was acknowledged that despite efforts to simplify processes and improve forms, further work is needed to embed consistent practice across all areas, and additional ideas and feedback were welcomed to support improvement.

The Committee also discussed the potential for system-based solutions and automation to support more efficient management of short-term absence processes, recognising that technological solutions may provide opportunities to reduce administrative burden and improve consistency.

In considering the wider context, the Committee acknowledged that sickness absence levels are influenced by a range of organisational and external factors, including service pressures, workforce challenges and the impact of ongoing transformation activity. There was recognition that interpreting absence data requires consideration of these broader pressures, and that sickness should not be viewed solely as an isolated HR metric but as an indicator of wider workforce wellbeing and system demand. The Committee therefore emphasised the importance of maintaining a balanced approach that combines robust performance management with a strong focus on staff support, prevention and wellbeing**.**

Resolved: The Committee noted the contents of the Sickness update.

26/27/012 **Raising Concerns FTSU Update**

The Committee received a verbal update from the Freedom to Speak Up (FTSU) Guardian, noting that a full Annual Report will be presented at the next meeting, and considered current themes, activity and developments within the FTSU function.

It was reported that whilst the overall volume of contacts remains broadly stable, there has been a notable shift in the nature and complexity of cases, with concerns increasingly relating to behaviours and working relationships rather than policy or process issues. This shift was highlighted as significant and reflective of the wider organisational context, particularly in relation to staff morale and the impact of ongoing change, with cases requiring more time and detailed engagement to resolve.

The Committee also noted progress in strengthening the FTSU infrastructure, including the introduction of additional mandatory training modules ("Listen Up" and "Follow Up") alongside the existing "Speak Up" module, with work underway to ensure appropriate targeting of these modules to managers and senior leaders. Compliance levels were reported to have recovered following a temporary dip, returning to expected standards. In addition, members were advised of the imminent implementation of a new digital reporting mechanism via the InPhase system, which will provide staff with an additional, secure channel to raise concerns, including the ability to report anonymously. This development was welcomed as a positive step in improving accessibility and confidence in speaking up arrangements.

Further updates were provided on the planned refresh of the FTSU Champions network, drawing on learning from other organisations to strengthen local engagement and visibility, with the intention of aligning this work to emerging organisational structures as part of the wider transformation programme.

The Committee noted that this presents an opportunity to embed speaking up arrangements more effectively within new systems and teams. The Executive Lead for FTSU endorsed the progress made, highlighting the importance of this work in supporting organisational culture and reinforcing safe and effective reporting mechanisms.

The Committee was also advised of forthcoming national changes, specifically the closure of the National Guardian's Office in June and the transition of responsibilities to NHS England. It was noted that there remains limited clarity regarding future arrangements, particularly in relation to reporting requirements and governance, and that further updates will be provided once more information becomes available.

The Committee acknowledged the evolving nature of FTSU activity, particularly the shift towards more complex behavioural concerns, and recognised the importance of maintaining strong, accessible and trusted speaking up mechanisms during a period of organisational change. The update was noted, with the Committee seeking continued visibility of themes, progress against planned developments, and the impact of national changes through the forthcoming Annual Report

Resolved: The Committee noted the progress of the verbal FTSU update.

26/27/013 **How We Work in the Future**

The Committee received an update on the "How We Work in the Future" programme, noting that the organisation is currently in the delivery phase of a large-scale transformation programme, with Phase One focused on establishing new organisational structures and system configurations.

It was reported that significant progress has been made to date, including the completion of key consultation phases relating to system design and organisational groupings, with a further phase of consultation underway and due to conclude imminently. The programme remains on track to deliver core structural changes and leadership arrangements by September, which will provide the necessary stability to progress into Phase Two, where the focus will shift to service-level design and the practical implementation of new ways of working.

The Committee acknowledged the scale and intensity of activity delivered over recent months, noting that the breadth of engagement and consultation undertaken demonstrates a thoughtful and structured approach to change management, with a clear emphasis on bringing staff with the organisation through the transition.

In discussion, members highlighted that whilst the programme is progressing well against its planned timeline, the impact on staff experience is significant, with varied responses across the organisation. It was recognised that some teams and individuals are responding positively and engaging with the opportunities presented by the new model, whilst others are experiencing uncertainty, distress and concern, particularly where roles, structures or future positions remain unclear.

The Committee emphasised the importance of maintaining clear communication, providing timely clarity wherever possible, and ensuring that appropriate support mechanisms are in place to help staff navigate the transition. It was acknowledged that the emotional and cultural impact of change at this scale should not be underestimated and requires ongoing leadership attention.

The Committee also noted strong feedback from consultation activity, particularly support for the move towards pathway-based system working, which was identified as a consistent theme across responses. This was seen as a positive indicator of alignment between the proposed model and staff views on future service delivery. However, it was recognised that further work is required to ensure that all teams understand how the changes will affect them, particularly as the programme moves into more detailed service-level design in Phase Two. Members highlighted the need to ensure that no groups feel overlooked during the transition, and that there is clear communication about timelines and expectations for all areas, including those that may not undergo significant structural change.

The Committee further reflected on the interdependency between the transformation programme and organisational culture**,** noting that the current period of change is placing pressure on morale and engagement, and that there will be a critical need to refocus on cultural development and team cohesion once structural changes are embedded. It was emphasised that the success of the programme will not be determined solely by the delivery of new structures, but by the organisation's ability to support staff, rebuild confidence and embed positive, sustainable ways of working. The transition to Phase Two was therefore identified as a key opportunity to move beyond structural change and focus on service effectiveness, empowerment and patient-centred delivery.

Resolved: The Committee noted the contents of the report.

26/27/114 **Voluntary Redundancy Update**

The Committee received an update on the Voluntary Redundancy (VR) scheme**,** noting that the process had now formally closed and was progressing through the assessment and decision-making phase.

It was reported that a total of 224 applications had been received, of which an initial tranche had been reviewed, resulting in a combination of approved and declined applications, with a significant number still undergoing evaluation.

The Committee was advised that the review process is being undertaken through structured panels, with additional panel sessions scheduled to ensure that all remaining applications are considered in a timely manner. It was further noted that applications are being reviewed both individually and, where appropriate, in cohorts of similar roles (for example administrative, facilities and management groupings), enabling a more consistent and strategic assessment of risk and organisational impact in line with future workforce requirements.

The Committee noted that early approvals have already delivered approximately £1.5 million in savings**,** with an expectation that further savings will be realised as the remaining applications are processed. The approach to decision-making was described as risk-based, balancing financial requirements with service sustainability, workforce capacity and the need to maintain safe and effective service delivery.

Members acknowledged the scale and intensity of the work required to operate the panels and manage the process, recognising that this represents a significant organisational effort within an already pressured environment.

In discussion, the Committee highlighted the importance of clear and timely communication with staff**,** particularly for those who submitted applications early in the process and may be experiencing uncertainty while awaiting outcomes. It was emphasised that managing expectations and maintaining transparency around

timelines and decision-making processes is critical to mitigating anxiety and supporting staff wellbeing during this period.

The Committee also recognised that the cohort-based panel approach provides a more equitable and strategic method of assessment, ensuring alignment with the organisation's future operating model rather than making decisions in isolation.

The Committee was further advised that subsequent stages of the process will include consistency panels and appeals mechanisms, ensuring that decisions are applied fairly and that staff have appropriate routes to challenge outcomes where necessary. It was acknowledged that the position remains dynamic, with outcomes continuing to evolve as panels progress, and that a more complete and final position will be reported to a future meeting.

The Committee noted that the Voluntary Redundancy scheme is progressing in line with expectations, with early financial benefits realised and robust governance arrangements in place. However, members emphasised the need for continued oversight, particularly in relation to staff experience, communication and the operational impact of decisions, recognising that the scheme is taking place within a broader context of organisational change and workforce pressure. The update was therefore noted, with further detailed reporting to follow once the full process has concluded.

Resolved: The committee received and noted the contents of the report.

26/27/115 **Equality, Diversity & Inclusion Update**

The Committee received the Equality, Diversity and Inclusion (EDI) update, noting continued progress against key strategic priorities and alignment with both organisational and regional agendas.

It was reported that the Trust remains actively engaged in the Liverpool City Region (LCR) anti-racism framework, with representation ensuring that the voices of children and young people are appropriately reflected within the development of the regional strategy, which is due to be formally launched in June. The Committee welcomed this external collaboration, recognising its importance in strengthening the Trust's approach to tackling inequalities and embedding inclusive practice beyond organisational boundaries.

The update also provided assurance on progress against the NHS EDI improvement frameworks and six high impact actions, with it noted that the organisation is making good progress across multiple domains, supported by a range of established and emerging initiatives. These include the continued rollout of active bystander training, the mutual mentoring programme, and leadership development initiatives such as

Grow to Lead**,** alongside ongoing work to improve reasonable adjustments processes and support for managers**.**

The Committee recognised that much of the progress achieved over the past 12 months has been instrumental in supporting delivery against these national requirements and demonstrates a coordinated and structured approach to advancing the EDI agenda.

Members acknowledged the breadth and depth of activity underway and the extent to which EDI considerations are increasingly embedded within wider workforce and organisational development work.

It was noted that these initiatives not only support compliance with national frameworks but also contribute to a broader cultural shift, reinforcing the organisation's commitment to inclusion and equity.

The Committee further recognised the importance of sustaining momentum, ensuring that progress is measurable, and that the impact of initiatives is clearly understood and communicated across the organisation.

The Committee welcomed the update and commended the progress made, particularly in relation to regional collaboration and alignment with national priorities. The report was noted as providing assurance that the Trust is continuing to advance its EDI objectives in a structured and meaningful way, with ongoing work required to maintain focus, embed improvements and demonstrate impact over time.

Resolved: The committee received and noted the contents of the report.

26/27/116 **Oliver McGowen Decision Documentation**

The Committee received an update on the Oliver McGowan training and decision documentation**,** noting the current position in relation to compliance with the newly issued national Code of Practice and the specific challenges faced by children's organisations in meeting the requirements.

It was reported that, whilst the Trust is fully compliant with Tier 1 (awareness-level training), it is currently unable to achieve full compliance with the higher-tier elements of the framework, particularly in relation to the delivery model and applicability to paediatric settings.

The Committee was advised that this is not unique to the organisation, with similar challenges identified across children's trusts nationally, primarily due to the framework being designed with a stronger focus on adult services and not adequately reflecting the needs or voices of children and young people. Feedback gathered locally, including engagement with staff and the Youth Forum, has consistently highlighted that the

perspectives and experiences of children are not sufficiently represented within the current national approach, which limits its relevance and effectiveness within a paediatric context.

In response, the organisation is actively engaging with NHS England through monthly monitoring and reporting processes, ensuring that the current position is transparent and that the specific challenges faced are clearly articulated. It was noted that national colleagues are considering these issues, including exploring alternative approaches more suited to specialist settings such as ambulance services and children's organisations. Locally, the Trust is also progressing discussions with partner organisations, including Sheffield, to explore the development of a bespoke or adapted training provision that aligns with the principles of the Oliver McGowan framework whilst being appropriately tailored to children's services. This approach would aim to ensure that the intent of the training—improving understanding of learning disability and autism and enhancing patient experience—is delivered in a way that is meaningful and applicable within the Trust's context, even if not strictly aligned to the national model in its current form.

The Committee acknowledged that this represents a complex compliance issue, requiring a balance between adhering to national expectations and ensuring that training remains relevant, practical and impactful for staff and patients.

Members were assured that the organisation is maintaining a pragmatic and proactive approach, focusing on delivering the core learning objectives whilst continuing to work with national bodies to influence and shape a more appropriate framework for children's services.

Resolved: The Committee noted the update, recognising the limitations of the current national model, and supported the continued development of a locally appropriate solution, alongside ongoing engagement with NHS England to achieve a sustainable and compliant position over time.

26/27/117 **Policies for ratification**:

- **Consultant and SAS Doctors Leave Policy**

The Committee received the Consultant and SAS Doctors Leave Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Consultant and SAS Doctors Leave Policy

- **Pay Progression Policy**

The Committee received the Pay Progression Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Pay Progression Policy

- **Maternity, Paternity, Adoption, Shared Parental & Neonatal Care Leave Policy**

The Committee received the Maternity, Paternity, Adoption, Shared Parental & Neonatal Care Leave Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Maternity, Paternity, Adoption, Shared Parental & Neonatal Care Leave Policy

- **Travel and Expenses Policy**

The Committee received the Travel and Expenses Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Travel and Expenses Policy

26/27/118 **Staff Partnership Forum Committee (SPF) Minutes**

The Committee received the approved minutes of the SPF meeting held on (January 2025)

26/27/119 **Any Other Business**

There were no items of AOB

26/27/12 **Review of Meeting – Chair's Report to Board**

- **Terms of Reference/Workplan:**
  The Committee reviewed updates to the Terms of Reference and workplan, supporting a move to monthly meetings to strengthen oversight and timeliness of assurance. Members also supported the proposed change of name to the People and Culture Committee, reflecting the growing importance of culture alongside workforce metrics. The revised workplan, with standing assurance items and thematic deep dives, was endorsed as a more effective way to manage the volume and complexity of business.
- **People Committee Annual Report**
  The Committee endorsed its Annual Report as an accurate reflection of a year of increased activity and assurance delivery. Members recognised the scale of work undertaken and confirmed it as a strong basis for Board assurance.
- **Board Assurance Framework – monitoring of strategic workforce risks**

The Committee reviewed the Board Assurance Framework and risk reframe following Board challenge on current risk scoring. Members agreed that, despite mitigations, ratings may not fully reflect exposure in workforce sustainability, culture and EDI, and that further deep-dive analysis is needed before any scores are revised.

- **Internal Communications Update**

  Communications activity remains focused on supporting organisational transformation, with good progress in structured communications and campaigns. Members emphasised the need to strengthen staff engagement, feedback and recognition during a period of change.

- **Strategy People Update – Key People Issues**

  The Committee noted a challenging workforce environment, including pressures on staffing, morale and performance metrics. Key issues included PDR compliance, workforce gaps and the impact of change programmes. The Committee also noted Board challenge regarding data clarity and expectations for improvement, particularly in relation to performance management.

- **Transforming People Services**

  The Committee received an update on the national and local transformation of people services, including the move to a digital-first, centre-of-excellence model. The Trust's proactive alignment with this approach was welcomed, alongside recognition of the impact on staff and the need for ongoing engagement and support through the transition.

- **Trust/Divisional Metrics Update**

  The Committee reviewed Trust-wide and divisional metrics, noting a mixed but improving picture. Positive trends included lower agency use, better return-to-work compliance and improvement in some divisions, but concerns remain over:

  - variable PDR compliance,
  - delays in employee relations processes,
  - sickness in some areas.

  The Committee stressed the need for more consistent performance and clearer reporting.

- **Sickness Update**

  Noted continued improvement in long-term sickness absence, reflecting strengthened management processes. However, short-term sickness remains a key challenge, contributing to a slight increase in overall absence levels. Targeted interventions and preventative approaches are being implemented, with continued oversight required.

- **How We Work in The Future**

  Programme Delivery: The transformation programme remains on track to deliver structural changes by September.

  Staff Impact: Members acknowledged the significant effect on staff experience and emphasised the need for clear communication and support throughout the transition.

- **Voluntary Redundancy Update**

  A total of 224 applications received and a structured panel process in place to assess outcomes. Early financial benefits have been realised; however, the Committee highlighted the importance of clear communication and careful management of staff experience and service impact as the process progresses.

- **Equality, Diversity & Inclusion Update**

  Strategic Alignment: The Committee received assurance on progress against EDI priorities, including alignment with national frameworks and active participation in the

Liverpool City Region anti-racism strategy. Members noted that initiatives such as mentoring, leadership development and wider inclusion work continue to support sustained progress.

- **Oliver McGowen Decision Documentation**

  The Committee noted that full compliance with the Oliver McGowen framework is not currently possible due to its limited applicability to paediatric settings. Work is ongoing with NHS England and partner organisations to develop a locally appropriate solution that meets learning objectives and reflects the needs of children and young people.

- **Policies for Ratification**
  - Consultant and SAS Doctors Leave Policy – ***APPROVED***
  - Pay Progression Policy - ***APPROVED***
  - Maternity, Paternity, Adoption, Shared Parental & Neonatal Care Leave Policy – ***APPROVED***
  - Travel and Expenses Policy – ***APPROVED***

Date and Time of Next meeting.
Monday 29th June 2pm – 4:30pm – Teams

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**Chair's Report from ARC meeting, 18th June 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 16th April 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 review of the Trust's Annual Report and Accounts and EY's report on their audit

- External Audit Year and Report on the Trust's Accounts (ISA 260)
- Trust's Annual Report and Accounts
- Letters of Representation (to be signed by the ARC Chair and CFO following Board)
- Understanding how the Audit & Risk Committee gains assurance from management (on the risks to the financial statements) signed by ARC Chair
- Clinical Audit Annual Report 25/6
- Clinical Audit Annual Plan 26/7
- Third Party Assurance Report ELFs (for provision of payroll services to the Trust)
- Final Head of Internal Audit Opinion **(Received)**
- Clinical & Non-Clinical Claims Report 25/6 (discussion deferred to June meeting)
- ARC Annual Report
- Annual Report for each Assurance Committee
- Gifts & Hospitality Register

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

The Committee noted the new requirement in the External Audit Letter of Representation relating to notifying External Audit of any use of AI which might impact on the preparation of the financial statements. It was recognised that, as AI is increasingly adopted within the Trust there is a need to ensure that the Finance Team are aware of any that might impact the accounts. ARC agreed to look into this in 26/7.

4. Positive highlights of note / areas of significant discussion

The Committee was pleased to note that the production of the Annual Report & Accounts and the external audit process had run smoothly this year. Whilst recognising there remained a small number of items to be completed before the Accounts are signed, EY were indicating an unqualified opinion; assuming completion of these items without significant issues ARC endorsed the Accounts for approval by Board.

5. Issues for other committees

None

6. Recommendations

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

Appendix 1 – 2025/26 Internal Audit Plan

Audit	Assurance	May be of interest to…
Assurance Framework Opinion	Met Requirements	Board
Conflicts of Interest	Substantial	Board
Governance of the Gender Development Service	Substantial	Board & SQAC
Key Financial Controls:		FTPC
General Ledger	Substantial	
Accounts Receivable	High	
Accounts Payable	Moderate	
Treasury Management	High	
Budgetary Control	Substantial	
Asset Management Processes	Substantial	FTPC
Financial Measures (Grip & Control)	Substantial	FTPC
Governance of Workforce Reduction Programme		People Committee
Clinical Audit	Moderate	SQAC
Theatre Management	Limited	SQAC
Data Security & Protection Toolkit	High risk	FTPC
Remote Access	Moderate	FTPC
Balance Sheet Controls Processes	Moderate	FTPC
Governance of Financial Improvement Programme		FTPC

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

Audit	Assurance	May be of interest to…
Cyber Assessment Framework Part 2	Limited	FTPC
Clinical Governance	Substantial	SQAC

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

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

Appendix 2 – 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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 16th April 2026**
Lecture Theatre 1, Institute in the Park

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. K. McArdle	Anti-Fraud Specialist, MIAA	(KMA)
	Miss. J. Preece	Governance Manager	(JP)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRo)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Observing:	Mr. G. Bagnall	Staff Governor	(GB)
Item 26/27/06	Mr. A. Green	Chief Technology Officer	(AG)
Item 26/27/16	Ms. C. Watson	MIAA	(CW)
Items 26/27/22, 23 & 24	Mrs. K Warriner	Chief Transformation and Digital Officer	(KW)
Item 26/27/25	Ms. N Palin	Director of Transformation and Change	(NP)
Item 26/27/26	Mr. J. Grinnell	Chief Executive	(JG)
Apologies:	Mr. A Bateman	Chief Operating Officer & Deputy Chief Executive	(AB)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)

26/27/01 Introductions and Apologies

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

26/27/02 Declarations of Interest

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

26/27/03 Minutes from the Meeting held on 12th February 2026
Resolved:

The minutes of the meeting held on 12th February 2026 were **approved**, subject to Governor Geoff Bagnall being recorded as an apology.

26/27/04 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action 23/24/97.1: *Innovation risks and Risk Appetite/Tolerances for Innovation and Advocacy* – A Risk Oversight Meeting was held with Sarah Leo and Laura Rad. A robust process is in place for both Innovation and Research, although this is more established in Research than in Innovation. Further work is underway with the team, and the risk has been correctly scored. Training has been offered to the Innovation Team. Sarah and Laura are now overseeing Innovation governance to ensure it is properly understood and accurately reflected in the risk register. It was felt that feedback from the Community and Mental Health pilot was helpful and should be applied to the other areas. **ACTION CLOSED**

Action 25/26/26.1: *Interim Testing Update (Submit a one page summary in April 2026 when providing an update on the outcome of Interim Testing to enable the Committee to review the briefing in advance of the meeting)* – This action has been addressed. **ACTION CLOSED**

Action 25/26/31.1: *Annual Assurance Reports for DQ, Cyber Security, DP and FoIA (include a section at the end of each report which draws out the specific assurances that can be provided (which are currently detailed throughout the reports)* – The Chair advised that the reports are more detailed this year. **ACTION CLOSED**

Action 25/26/61.1: *Roll out of Risk Appetite* – This action was closed, as it related to the rollout process, which had been paused and is now due to recommence. **ACTION CLOSED**

Action 25/26/123.1: *Update on Risk Appetite and Tolerance Rollout (Consolidate all estate-related risks for discuss at April's RMF)* – This action has been addressed. **ACTION CLOSED**

Action 25/26/125.1: *Withdrawal of funding for the Little Hearts at Home programme (Liaise with the relevant person regarding the compilation of a business case for the Little Hearts at Home Programme)* – Following discussion with a member of the Innovation Team, the risk narrative was updated. A business case is being prepared to address the risk but has not yet been submitted. The action was therefore proposed for closure. GM noted that the funding remained at risk and sought assurance that the service would not be interrupted. RL advised that a business case has been prepared and would progress through the usual route. It was also noted that external funding will always carry a renewal risk, and that proactive planning is needed to manage this. **ACTION CLOSED**

Action 25/26/125.2: *Risk 513 (Biomedical Engineering – Renewal of Medical Equipment 22/23) – Update the narrative for this risk to reflect that funding has been allocated for the renewal of all medical equipment associated with this risk, thereby reducing the overall risk related to the Trust's equipment replacement plan* – It was confirmed that this risk has been addressed. **ACTION CLOSED**

Action 25/26/128.1: *Draft Internal Audit Plan for 2026/27 (Liaise with Daniel Scheffer regarding funding options for the commissioned work on the governance of the LNP to be undertaken by MIAA and consult with RL to explore whether it could be financed through the LNP's revenue budget)* – This matter is to be submitted to the LNP Board in May. If agreement cannot be reached, the action will be referred back to ARC and re-opened. **ACTION CLOSED**

Action 25/26/129.1: *Internal Audit Progress Report (Share the audit on the Trust's Balance Sheet Controls with J Kelly, with a follow-up discussion should any further actions arise)* –

This item is to be presented to the Finance, Transformation and Performance Committee (FTPC) in April, by exception. **ACTION CLOSED**

Action 25/26/135.1: *Accounting Policies (PFI (Life Cycle Costs) - Discussion to take place with E&Y re the potential disclosures the Trust might be required to make)* – E&Y confirmed that no detailed disclosure is required. They will clarify any national expectations with the national team, after which the wording of the Accounting Policies will be finalised. **ACTION CLOSED**

Action 25/26/138.2: *Outcome of Annual Effectiveness Reviews (Liaise with Jackie Rooney for an update on Clinical Audit reporting, which is to be submitted to both SQAC and ARC)* – It was reported that an A3 Plan will be developed over the next few weeks to determine what is needed to provide assurance. The approach will then be agreed. A further update will be provided in September 2026. **ACTION TO REMAIN OPEN**

Actions deferred to July:
25/26/138.1: *Effectiveness Reviews (IA benchmarking to be repeated at the end of the year).*

26/27/05 Update on the Risk Management Process within Corporate Services

JR and ES presented the annual update on risk management processes within the Corporate Services Teams demonstrating a well-established and maturing risk management framework. Risk management processes are embedded through the monthly Corporate Services Collaborative and Trust-wide Risk Review Meetings, enabling focused scrutiny of High and Moderate risks and adoption of a 'hot spots' approach. The current risk profile demonstrates a predominance of Moderate risks with a smaller number of High-scoring risks, reflecting ongoing operational, workforce and digital pressures. Notable improvements during 2026 include strengthened risk oversight, refreshed risk registers, active Risk Appetite discussions and full compliance with review cycles. Continued focus is required to align risk management to organisational changes and to further embed Risk Appetite across Services.

The Committee noted that elements of the report overlapped with the Risk Management Forum update for Corporate Services. Work has therefore begun to consider how Corporate Services risk reporting will transition into a Professional Services model. It was recognised that there will not be a direct one-to-one alignment with the current arrangements, and that Estates and Facilities will move into a different System.

The importance of preserving the progress achieved under the current arrangements and maintaining a clear governance identity for these functions was emphasised. The Chair supported this approach, noting that bringing the relevant areas together had created a structure comparable to Divisional governance. The Committee also noted that, although the future model is still being developed, it will be important to retain the ability to consolidate risk information across Systems.

Concern was raised about team capacity and the risk of duplicate or delayed reporting during the transition. It was agreed that, once the new structure has been confirmed, the implications for reporting should be reviewed and an appropriate transition point identified, potentially between Q1 and Q2.

The Chair indicated that she usually observes one Corporate Services Collaborative meeting each year and will attend one or more this year to see the transition in real time.

Resolved:
The Audit and Risk Committee **(**ARC) noted the update on the Risk Management Process within Corporate Services.

26/27/06 Update on Cyber Risks

AG delivered a presentation following a request to extend deadlines to recommendations arising from the internal audit of Cyber from June to July 2026. Assurance was provided that progress against the audit actions was ongoing with no blocked actions, although a proportion of actions remain in progress and will continue to be monitored through established governance routes.

The Committee noted that there are robust assurance arrangements, with audit actions overseen through a structured governance framework including weekly, monthly, six-weekly and quarterly forums, enabling regular monitoring of progress, escalation of risks and executive oversight. Audit actions are tracked through a centralised process, with progress reported via Highlight Reports and Action Trackers.

AG described a "defence in depth" approach to cyber security, encompassing multiple layers including prevention, monitoring and response, data, endpoint, network and perimeter security controls to provide comprehensive protection across the organisation

The Committee also noted ongoing cyber forward planning, including development of a centralised SharePoint-based approach to managing cyber risks and registers, supporting improved visibility and coordination of cyber security activity.

The Committee welcomed the development of the cyber portal as a useful means of bringing relevant information together and asked how the Trust benchmarks its cyber arrangements across the NHS. AG advised that a number of centrally shared metrics are available and that benchmarking is used to identify indicators of good practice, with areas for improvement considered as part of ongoing development rather than solely as negative findings. In response to questions about balancing day-to-day operational demands with longer-term cyber priorities, AG explained that the team uses automated security alerting, nationally provided intelligence feeds and a regularly reviewed Action Tracker to prioritise activity, supported by input from Informatics colleagues.

The Committee discussed the implications of an increasingly community-based approach and the associated cyber risks. AG advised that the core principles of cyber security remain the same regardless of location, including staff education, training and appropriate technical guardrails. However, it was noted that greater system and partnership working increases reliance on third parties and supply chains, which may represent the most significant area of vulnerability. The Committee emphasised the importance of ensuring that suppliers and partners are held to equivalent standards of cyber assurance.

The Committee noted that third-party supplier arrangements differ from formal partnerships and that the legal and assurance requirements may therefore need to be strengthened. The Committee discussed whether a more consistent national approach to supplier cyber standards may emerge over time but agreed that local action is still required. RL confirmed that additional cyber assurance requirements could be incorporated into new supplier arrangements, including through contractual requirements and procurement processes. EK agreed to take this forward through the new supplier process and tender evaluation arrangements, linking in with HPL. The Committee noted that this is a common issue across

the sector and that stronger requirements would place the Trust in a better position should any future breach occur.

26/27/06.1 **Action:** Add cyber assurance requirements into new supplier arrangements, including contracts and procurement processes. **EK**

Resolved:
ARC approved the request to extend the deadline for completion of audit recommendations and noted the cyber update.

26/27/07 Update on Risk Appetite and Tolerance Rollout

ES reminded the Committee that the Board had previously agreed to pause the rollout of Risk Appetite and Tolerance implementation while the Medium-Term Plan was being developed and approved.

This work was revisited in Q4 2025/26, when Committee Chairs and relevant Executive Leads met to consider Risk Appetite in the context of the 10 Year Plan, the Medium-Term Plan and the challenging financial environment facing the NHS.

The Committee reflected positively on the recent discussion and noted the importance of balancing financial considerations with safety and quality. It was also recognised that the Trust may need to review its Appetite for certain external risks. Following Board consideration of the updated Statement, the rollout will resume starting with the Medical Division and Digital Services.

Resolved:
ARC noted the update on Risk Appetite and Tolerance rollout.

26/27/08 Board Assurance Framework (BAF) Report

ES presented the BAF report for February 2026. The Committee noted that there were no specific issues to highlight. It was confirmed that the annual review had met MIAA requirements and that the BAF is actively used. The Committee also noted that the BAF had become more dynamic over the past 18 months and provided clear evidence of Non-Executive Director use. Further changes will be reflected in the next version following the review undertaken as we move into a new financial year.

Resolved:
ARC received the Board Assurance Framework report for February 2026.

26/27/09 Risk Management Forum (RMF) Update; including Chair's Highlight Report and Corporate Risk Register

ES reported that the RMF held on 9th April 2026 had been a positive and well-supported meeting. ARC received an update on the work undertaken to strengthen oversight of Estates risks, and all Divisions were represented for a detailed review of the full risk profile. RMF also considered the transition from Divisional arrangements into the new System model, including the importance of aligning this with InPhase and the Terms of Reference. It was noted that progress was well advanced, with a transition plan being developed, and the Committee emphasised the importance of maintaining momentum and ensuring effective alignment between risk, clinical quality and assurance reporting.

ARC sought assurance that the transition to the new Systems would be supported by a clear sequence of gateway stages, with defined checks to confirm readiness before progressing to the next phase. ES confirmed that this approach was being developed with support from the Transformation Team and agreed to feed this back to colleagues.

The Committee discussed a newly added workforce-related risk, noting that it had re-emerged following the end of a fixed-term arrangement. It was reported that options were being explored with system partners, including a possible candidate at ICB level, but that the risk would remain high scoring until a sustainable solution was in place.

The Committee also discussed a safeguarding risk (relating to Named Doctor), including the likelihood of further external scrutiny. The Committee were advised that a plan was in place, with support from system partners and oversight of the Liverpool contract through Sefton Place. It was noted that this remained one of the Trust's top three risks, but assurance was provided that interim cover was in place through an existing staff member.

The Committee found the Corporate Risk Register update helpful, particularly the distinction between risks driven by external dependencies and those within the Trust's direct control. The analysis was considered clear and proportionate, and the Committee were reassured that external risks were being managed as effectively as possible. It was also noted that risks with more limited action plans were clearly explained, including progress against the Pharmacy risk.

It was noted that the number of risks, particularly High risks, had increased in line with the current operating environment, although further work on Estates infrastructure may reduce this position in due course.

Resolved:
ARC noted the RMF update, the CRR for the reporting period 1.12.25 to 31.12.25; and the approved minutes from the RMF held on the 09.04.26.

26/27/10 Risk Management Annual Report, 2025/26

The Committee received the Risk Management Annual Report for 2025/26 and noted that robust arrangements remain in place to support the identification, assessment, management and escalation of risk across the Trust. The RMF continues to provide effective oversight through regular review of the BAF, Corporate and Trust Risk Registers, supported by targeted deep dives into key risk areas.

Governance performance remained strong, with most meetings quorate and continued scrutiny of long-standing risks highlighting ongoing pressures relating to capacity, demand, resourcing and workforce. Risk management arrangements were further strengthened through improvements to InPhase, updated policy and strategy, enhanced reporting, revised training and strengthened oversight forums.

During the year, RMF undertook nine targeted deep dives to strengthen scrutiny and assurance across strategic, operational and emerging risks, including capital funding, cyber security, financial risk, infrastructure and environmental risks, CAMHS, the Division of Medicine, adoption records and server assurance.

Long-standing high and moderate risks will remain a focus for 2026/27.

The Chair thanked the RMF for its work.

Resolved:
ARC noted the Risk Management Annual Report for 2025/26 and was assured that risk management arrangements remain fit for purpose and provide effective organisational oversight.

26/27/11 Trust Risk Register (TRR) Report

ARC received the TRR Report noting that there were 212 risks recorded on the Trust Risk Register, with the majority classified as Moderate (approximately 72%), indicating a stable but pressured risk profile. Improvements were observed in the number of risks overdue review and an increase in risks closed, alongside a reduction in long-standing High-Moderate risks; however, a deterioration was noted in the number of risks with increased risk scores, highlighting the need for continued challenge to ensure mitigations are effective.

The Committee also noted areas of concern relating to risks without agreed action plans (7.1%) and overdue actions (10.99%), primarily within the Community and Mental Health Division, with actions in place to address these issues.

JR drew attention to the extraordinary RMF meeting held in response to financial pressures across the NHS and the Trust, focusing on the impact of savings decisions and the Financial Improvement Programme on service delivery, quality and risk. As a result, monitoring the impact of financial decisions on High-scoring risks will be a key focus for 2026/27.

Overall, the report demonstrated continued strengthening of risk management processes, although further improvement is required in ensuring timely action completion and effective mitigation of risks across all Divisions and Services.

Resolved:
ARC received and noted the Trust Risk Register Report.

26/27/12 Horizon Scanning

The Committee reflected on the implications of increased system working, particularly where risks and accountability may be shared across organisational boundaries. It was recognised that further consideration would be needed to clarify how our risk management processes should develop in response.

Discussion was held on the potential impact of system and partnership working on cyber risk, noting that collaborative working between organisations can create vulnerabilities and that supply chains may represent the weakest point of control. It was emphasised that risks should be considered proactively rather than only in response to incidents. ES advised that discussions had commenced with legal partners and that a draft proposal was being developed to define how risk management expectations would operate in practice, including the need for partner organisations to adopt a reciprocal approach.

The Committee also noted the importance of understanding how risk intersects with organisational culture, including the value of triangulating intelligence from across the Trust, such as survey findings, and considering how this might extend to partner organisations. In discussing the AFT context, it was recognised that system working brings opportunities for shared learning and good practice as well as new risks that will require ongoing oversight.

Resolved:
There was nothing to raise under this item.

26/26/13 Draft Head of Internal Audit Annual Opinion 2025/26

The Committee received the Draft Head of Internal Audit Annual Opinion (HoIAO) 2025/26 noting a Substantial Assurance Opinion, indicating that the Trust has a generally sound system of internal control with controls largely applied consistently. This Opinion is underpinned by delivery of a risk-based internal audit programme, with no critical recommendations raised and all recommendations accepted by management, alongside evidence of continued progress in implementation.

The Committee noted that audit activity highlighted key themes, particularly the need to further strengthen aspects of the digital and cyber control environment, and that one Limited Assurance Opinion was received in relation to Theatre Management Systems. Overall, it was recognised that the Trust continues to operate within a challenging external environment, and that Internal Audit provides a positive and reliable source of assurance to support the Annual Governance Statement, with ongoing focus required on embedding improvements and maintaining control effectiveness.

Resolved:
ARC received and noted the HoIAO for 2025/26.

26/27/14 Draft Internal Audit Plan for 2026/27

The Committee received the draft Internal Audit Plan for 2026/27, which had been developed using a risk-based approach aligned to the Trust's Strategic Objectives and the BAF.

ARC noted that the Plan had been informed by a comprehensive risk assessment, drawing on organisational intelligence, previous audit coverage and assurance mapping. It will remain sufficiently flexible to respond to emerging risks, with regular in-year review and a formal review at six months.

The Plan also includes follow-up of previous audit actions, together with provision for contingency and added-value activity, supported by clear KPIs for delivery and quality. Overall, the Committee was assured that the Plan is appropriately focused on the Trust's principal risks and provides a sound basis for assurance in 2026/27. On this basis, the Committee approved the Plan.

Resolved:
ARC approved the Internal Audit Plan for 2026/27.

26/27/15 Internal Audit Charter

The Committee received the Internal Audit Charter 2026/27 and noted that it sets out the purpose, authority and responsibilities of Internal Audit in line with the Global Internal Audit Standards for the UK Public Sector, confirming its role in providing independent assurance on governance, risk management and control.

The Committee also noted that Internal Audit operates with full independence, including unrestricted access to records, staff and senior management, and reports directly to the Audit and Risk Committee.

The Charter confirmed that internal audit is risk-based, aligned to the Trust's objectives and BAF, and includes arrangements for planning, reporting, follow-up and the Head of Internal Audit Annual Opinion informs the Annual Governance Statement.

Resolved:
ARC approved the Internal Audit Charter 2026/27.

26/27/16 Internal Audit Progress Report

The Internal Audit Progress Report was presented to provide an update on delivery of the 2025/26 Internal Audit Plan. ARC noted that four reviews had been finalised during the period and that one assurance rating would be amended to Moderate in the final report. The Theatre Management Systems audit had been delayed but was expected to be finalised shortly following feedback to the service. Two further audits were also reported as delayed but progressing.

The Remote Access audit examined four virtual private networks and identified a high-risk issue relating to resilience, with a single point of failure in current arrangements. It was reported that a second solution was being developed and would be tested as part of the follow-up process. While the IT Team had engaged positively, the Committee agreed that this area would require continued monitoring.

In discussion, concern was expressed that issues such as patching and vulnerability management represent fundamental cyber controls and should not ordinarily require identification by, and escalation through, Internal Audit. The Committee emphasised that these checks should be routine, well embedded and visible through the Trust's wider digital governance arrangements, including reporting to FTPC. It was acknowledged that team capacity and structure may be contributing factors, but the Committee stressed the importance of strengthening assurance over day-to-day control compliance.

The Committee also discussed how the Trust compares with wider expectations and noted that controls of this nature form part of essential digital assurance, including requirements linked to the Data Security and Protection Toolkit and other core technology risks. It was agreed that the associated action plan should be considered through the Cyber Reporting Group (which reports into FTPC).

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

26/27/17 Internal Audit Follow Up Report

The Committee received the Internal Audit Follow Up Report and noted progress in the implementation of internal audit recommendations, with 8 of 13 actions due in the reporting period confirmed as implemented and one superseded, demonstrating continued improvement in addressing internal audit findings.

The Committee also noted that four actions remain partially implemented, primarily relating to EDI and Cyber Assessment Framework requirements, with agreed extensions to May and July 2026. Overall, progress across the broader action set was positive, with a significant number of recommendations either completed or not yet due; however, continued focus is required to

ensure timely delivery of outstanding actions and to evidence completion, particularly in areas of digital, cyber and EDI.

Resolved:
ARC received and noted the content of the Internal Audit Follow Up Report.

26/27/18 Anti-Fraud Services Draft Plan 2026/27

The Committee received the draft Anti-Fraud Service Plan for 2026/27 and noted that it aligns with national requirements, including the Government Functional Counter Fraud Standard (GovS 013) and NHS Counter Fraud Authority strategy. The Plan is informed by a dynamic fraud risk assessment based on organisational intelligence, national threats and previous anti-fraud activity, covering fraud relating to workforce, suppliers, patients and third parties, including cyber risk.

Delivery will focus on four core areas: assure, understand and prevent, and respond. This includes maintaining compliance with GovS 013, strengthening fraud risk assessment, undertaking proactive work, delivering training and awareness, supporting policy fraud-proofing, and managing referrals and investigations, including sanctions and recovery where appropriate.

The Plan will remain flexible to respond to emerging risks, supported by regular reporting and stakeholder engagement. Overall, the Committee was assured that it provides a clear and comprehensive approach to managing fraud risk across the Trust.

Resolved:
ARC approved the Anti-Fraud Service Draft Plan 2026/27.

26/27/19 Anti-Fraud Annual Report for 2025/26

The Committee received the Anti-Fraud Annual Report 2025/26 and noted that the Trust maintains a risk-based and proactive counter fraud approach, supported by strong engagement from the Chief Financial Officer and regular reporting to the Committee. The annual self-assessment against the Government Functional Standard (GovS 013) achieved an overall 'Green' rating, demonstrating good compliance, with one Amber-rated component relating to fraud risk assessment, reflecting the need to refresh the assessment in 2026/27 in line with new requirements, including the Failure to Prevent Fraud Offence.

The Committee noted a broad programme of activity during the year focused on prevention, awareness and detection, including delivery of training and communications, proactive fraud exercises, and updates to policies to reflect emerging risks. High levels of staff engagement were demonstrated through awareness activities and strong compliance with mandatory fraud training. Anti-fraud work has been embedded across governance arrangements, including regular monitoring of the Work plan and reporting of outcomes, investigations and national initiatives such as the National Fraud Initiative.

The report highlighted low levels of fraud activity within the Trust, with a small number of referrals received and progressed to investigation, and no referrals carried forward at year end. Ongoing investigations relate primarily to workforce-related fraud types such as working whilst off sick and timesheet fraud. The Committee also noted the continued use of the national case management system to record and monitor activity, and that no financial losses or recoveries were reported.

The Chair noted that the report provided a helpful summary of the year's work and commented positively on the value of the webinar programme. It was also recognised that the Counter Fraud Service continued to deliver both proactive and reactive work effectively, with findings implemented promptly. Overall, the Committee was assured that effective counter fraud arrangements remain in place, while noting the continued need to refresh the fraud risk assessment and embed arrangements to address emerging legislative and fraud risks.

Resolved:
ARC received the Anti-Fraud Annual Report 2025/26.

26/27/20 External Audit Planning Report and Fees for 2025/26

The Committee received the Audit Planning Report for the year ended the 31.3.26 and noted that the External Auditor has set out a risk-based audit approach aligned to key financial statement risks and Committee expectations, with no changes in overall risk profile from the prior year. Significant audit risks include management override, revenue and expenditure recognition, capitalisation and cut-off of expenditure, and property, plant and equipment valuation, reflecting areas of judgement and potential misstatement.

The Committee noted that value for money arrangements will be assessed across financial sustainability, governance and efficiency, and that no significant weaknesses have been identified to date, although ongoing risks relating to PFI operational challenges will continue to be monitored through the audit.

Materiality has been set at £9.1m (2% of Operating Expenditure), with an established timetable for completion of the audit through to June 2026, and a structured programme of testing and reporting. Overall, the Committee was assured that a comprehensive plan is in place to support delivery of the external audit opinion and value for money conclusion.

The Chair asked whether there were any potential challenges to highlight. HR advised that discussions had taken place with the Finance Team since February and that the main area being kept under review related to the PFI position, pending any further clarification from NHS England.

RL confirmed that there were no deviations from the approach set out in the paper and that it remained consistent with previous discussions. It was also noted that relevant areas would be retested and that regular meetings were in place with E&Y to monitor progress and escalate any issues as necessary.

The Committee noted that the external audit fee for 2025/26 is £177,750, compared to £182,000 in the prior year, reflecting the removal of prior-year additional fees related to audit scope changes and national audit sampling requirements. It was noted that the agreed fee is based on standard audit assumptions, with any variation subject to agreement if additional work is required.

Resolved:
ARC received the External Audit Planning Report and noted the fees for 2025/26.

26/27/21 Statement of Going Concern for the 2025/26 Accounts.

The Committee received the going concern assessment noting compliance with DHSC guidance in preparing its 2025/26 financial statements on a going concern basis, supported by a strong financial position, consistent delivery against Control Totals and a proven track record of financial performance.

The Committee noted that the Trust maintains strong liquidity, with cash balances of £35.9m at 31 March 2026, alongside approved financial plans and anticipated funding flows which demonstrate continued financial sustainability over the medium term. Scenario modelling over an 18-month period confirms that adequate cash resources are maintained under both base and downside assumptions, supporting the Directors' assessment.

Overall, the Committee was assured that the Trust has sufficient resources to continue in operational existence for the foreseeable future and supported the recommendation that the 2025/26 Annual Accounts be prepared on a going concern basis.

Resolved:
ARC received the report outlining the basis for the Going Concern judgement.

26/27/22 Annual Assurance Report and Forward Plan – Data Quality
For noting:
Refer to agenda item 26/27/24 for update.

26/27/23 Annual Assurance Report and Forward Plan – Data Protection Act Compliance
For noting:
Refer to agenda item 26/27/24 for update.

26/27/24 Annual Assurance Report and Forward Plan – Freedom of Information Act Compliance

KW presented a suite of assurance reports and forward plans for Data Quality, Data Protection and Freedom of Information, which the Chair described as clear and helpful.

In relation to Data Quality, the Committee noted that performance against standards remains good and that significant work had been undertaken during the year, including preparation for the move to a new data platform. Areas requiring continued attention included clinical coding and the recording of ethnicity. It was noted that a plan is in place to address coding through the How We Will Work in The Future (HWWWITF), and that further work is underway to improve ethnicity recording, including the use of clearer terminology where patients choose not to disclose this information.

For Data Protection, the Committee noted the significant work undertaken in response to changes to the Data Security and Protection Toolkit standards during the year. Although the revised requirements had presented challenges, this had also supported learning and close engagement with NHS England. An Improvement Plan had been submitted and a compliant position achieved in November. The Committee welcomed the strong culture of openness and transparency in this area, including participation in voluntary audits by the ICO on cyber and children's data governance. Ongoing challenges relating to workforce capacity and HWWITF were noted, alongside plans for further changes during 2026/27. The Committee also noted a reduction in incidents within the Community and Mental Health Division and that the new portal was due to go live shortly.

In relation to Freedom of Information Act compliance, the Committee noted compliance of 95% and the actions in place to support continued improvement, including proactive training and engagement with Divisions and Services.

In discussion, the Chair suggested that the reports would benefit from showing trend information over a longer period. The Committee also discussed the presentation of ethnicity data and agreed that the terminology should better distinguish between information that had not been recorded and instances where patients had chosen not to disclose. Questions were raised about incidents in the Community and Mental Health Division, and assurance was provided that actions were in place to improve information sharing. The committee also noted the recent Remote Access internal audit findings agreed that these would be followed up with relevant colleagues. It was confirmed that further work would be taken forward under new leadership, with strengthened team arrangements now in place.

26/27/24.1 **Action:** Trend information over recent years should be included in future Data Quality, Data Protection and Freedom of Information Act Compliance Reports. **KW**

Action: Improve ethnicity terminology so it clearly distinguishes between not recorded and patient chose not to disclose. **KW**

Resolved:
ARC received and approved the assurance reports and forward plans for Data Quality, Data Protection and Freedom of Information Act Compliance.

26/27/25 **Annual Assurance Report 2025/26 and Forward Plan 2026/27 – Project Assurance**

NP presented the Annual Assurance Report and Forward Plan for Project Assurance and noted that good progress had been made during the year. The Committee heard that a strong collaborative model had supported delivery and improvement, despite a challenging year, and that learning from 2025/26 would inform the approach for the year ahead. It was acknowledged that quality-focused programmes had not progressed as far as originally intended, but that the overall programme remained well developed and aligned to organisational objectives.

The Committee noted that governance arrangements for transformation and strategic programmes had continued to strengthen, including clear governance structures through the Transformation Board, formal programme mandates, and greater focus on financial benefits realisation. The forward plan for 2026/27 includes further enhancements to milestones and gateway processes to strengthen risk identification and assurance.

In discussion, the Chair noted that the main report is submitted to FTPC, with additional reporting to the Transformation Board and bimonthly reporting to Trust Board. ARC welcomed the increased emphasis on benefits realisation but commented that programme management arrangements, particularly for non-building projects, would benefit from continued scrutiny to strengthen assurance over delivery against time and milestones.

Resolved:
ARC approved the Project Assurance Annual Report and Forward Plan.

26/27/26 Annual Governance Statement

Chief Executive, John Grinnell presented the 2025/26 Annual Governance Statement.

In introducing the Statement, it was noted that the annual review provided an opportunity to reflect on three key questions: whether the Trust understands its principal risks, whether appropriate arrangements are in place to manage them, and what sources of assurance are used to test those arrangements during the year.

The Statement described a robust set of governance arrangements that have continued to mature over time, including the BAF, the RMF and the Trust's Assurance Committee structure. ARC noted the Board's active use of these arrangements, including deep dives, work on Risk Appetite and strengthened oversight through the Financial Improvement Programme. Additional assurance was also referenced, including a Substantial Internal Audit Opinion, compliance with CQC registration requirements, a Segment 1 position within the NHS Oversight Framework and a Provider Capability Assessment that gave a positive assessment of governance and leadership arrangements. Overall, the Statement was regarded as positive and balanced, reflecting the pressures facing the organisation while demonstrating that effective governance arrangements remain in place and that no significant governance concerns had been identified.

In discussion, the Chair noted that the review of effectiveness section should more clearly reflect the contribution of Clinical Audit and requested that an additional paragraph be included in the main document to address this. It was also suggested that reference should be made to the role of the Counter Fraud Champion and that additional headings be used to improve signposting and flow. Subject to these amendments, the Committee was content to endorse the Annual Governance Statement.

26/27/26.1 **Action:** Add an additional paragraph in the main document to reflect the contribution of Clinical Audit in the Review of Effectiveness section. Add reference to the Counter Fraud Champion role. Use additional headings to improve signposting and flow. **JP**

Resolved:
ARC endorsed the Annual Governance Statement for inclusion in the Annual Report and Accounts 2025/26.

26/27/27 Tenders and Waivers Activity Report for Q3 and Q4

The Committee received the Tenders and Waivers Activity Report for quarters 3 and 4 and noted that 43 procurement waivers, with a total value of £5.55m, had been approved. These included both tender and quotation waivers, most of which related to single-supplier requirements or compatibility with existing systems and services. The highest volumes were recorded in Estates, Perfusion, Digital, Facilities and Theatres.

It was also noted that 47 waiver exemptions, totalling £3.12m, had been recorded, mainly in relation to leases, funding arrangements and transfers within the NHS and wider public sector. The Committee acknowledged that Procurement involvement had prevented a small number of waivers and that most requests were supported. However, a limited number proceeded without Procurement support because of urgency and operational need, including workforce and equipment pressures.

The Chair raised concern about retrospective waiver approvals and made clear that this was not acceptable. Assurance was provided that waivers were not being misused and that, where

Procurement support had not been provided, the reasons had been clearly documented, including any risks to service continuity. It was agreed that Procurement should flag potential waiver issues earlier so that concerns can be addressed promptly with the relevant lead, reducing the need for retrospective approval.

Resolved:
ARC noted the Tenders and Waivers Activity Report for Q3 and Q4.

26/27/28 Any Other Business

There was none to discuss.

26/27/29 Meeting Review

ARC noted that the agenda had been substantial but supported by helpful, well-presented reports that had enabled a constructive discussion. The Chair advised that the update to Board will highlight the Committee's discussion on basic IT controls, together with the wider implications of increasing system working for ARC. Overall, the meeting was considered productive and provided strong levels of assurance, supported by clear forward plans.

Date and Time of the Next Meeting: Thursday, 17th June, 2:00pm-5:00pm, LT1, Institute in the Park.

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Wednesday 3rd June 2026 at 3pm**
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)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance:			
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mr. G. Wadeson	Associate Director of Finance	(GW)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Mrs J Holloran	Deputy Development & Estates Director	(JH)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Ms A Prendergast	Associate Director of Strategy and Partnership	(AP)
	Ms N Palin	Transformation Director	(NP)
	Mrs. J Tsao	Executive Assistant (Minutes)	(JT)
Agenda item:			
Apologies:	Mr A McColl	Deputy Director of Finance	(AMc)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)

26/27/19	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
26/27/20	**Minutes of the Last Meeting** The minutes of the last meeting held on 27th April 2026 were approved.
26/27/21	**Matter Arising and Action Log** FTPC went through and discussed outstanding actions: **Pharmacy Outsourcing** EK updated that the Pharmacy outsourcing process has now been completed and the award has been made to Clatterbridge subsidiary as the preferred provider. As part of the process a standstill period will be adopted in which any queries can be raised by other bidders. **FTPC Agenda layout** The Chair noted the new layout of the agenda which is centred around the agreed top priority areas.
26/27/22	**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.
26/27/23	**Month 1 Financial Report** A deficit position of £900k was reported in month 1 in line with plan. Divisions are approximately £1.1m behind plan, mainly due to unallocated cost pressure

	funding. A cost pressure check and challenge panel is scheduled for 8th June as the latest request for funding exceeded the amount held in reserves. MJ questioned the realism of current budgets, suggesting a quick review and potential internal management plan to reflect actual performance and avoid tracking divergence throughout the year. Costs for Industrial Action in month 1 were reported as c£300k with no national funding expected. Whilst no further Industrial Action has been confirmed further dates are likely. DJW referred to the new structural change and asked how the old divisional budget format would change. EK said that whilst the financial budgets have been mapped out to the current structure there is a potential risks of services inheriting cost pressures and risks they are currently not the lead but a handover process is planned. **Resolved:** FTPC noted the current position in relation to the M1 Finance report.
26/27/24	**IPR report M1** AB highlighted the new format for the IPR report and noted the following risks: Neurodiversity patients with clinical indication to start medication for ADHD has currently been paused due to the medication not being available. The risk is on the Board Assurance Framework and continues to be highlighted to the ICB. AB noted next steps if the position doesn't change is to request support from Trust Board. Whilst an improvement plan was developed for overdue follow ups this continues to be a challenge particularly for Audiology and Dentistry. A paper is due to be presented to Execs on improving delivery of Audiology services. Areas that have improved include response times for clinical letters with the use of AVT.
26/27/25	**Board Assurance Framework** ES highlighted a number of risks to be updated including the campus risks in relation to doors. FTPC discussed the link with communications, branding and strategy noting the split reporting system between Growth Opportunities and People Committee. KW noted work in place to separate the risks within cyber, digital transformation and AI. **Resolved:** FTPC received and noted risks to be updated within the BAF.
26/27/26	**Liverpool Neonatal Partnership** CL gave a presentation highlighting: • The launch of the refreshed exec LMP board with Liverpool University Hospital Group, positive joint work with Nottingham Neonatal Unit on the mind ray system, and ongoing support for system integration. • Confirmed full funding for the 25-26 programme, receipt of Ockenden funding, and reconciliation of RN staffing, showing a slight under-establishment for the new unit. Ongoing reviews address supernumerary staff and COP transfers.

	• Workforce gap in AHPs especially pharmacy support and noted both sites are undergoing organisational change with ongoing management and commissioner discussions. **Resolved:** FTPC noted progress in relation to the Neonatal Partnership.
26/27/27	**Cyber NED Chairs report** MJ provided background noting members of the quarterly Cyber Reporting Group including himself, Ian Gilbertson, Kate Warriner and Andy Green, Chief Technical Officer. MJ highlighted challenges with medical device patching and third-party dependencies, increased cyber threats, and plans for AI governance, including training, policy development, and learning from external best practices. The Cyber group will report quarterly to FTPC and annual to Audit and Risk Committee. KJ outlined ongoing AI 101 training, drafting of an AI policy, and integration of clinical safety and DPIA processes for AI projects, with plans to learn from SickKids' approach to AI governance and ethics. **Resolved:** FTPC noted progress of the Cyber Reporting Group.
26/27/28	**Financial Improvement Update** RL referred to papers that had been circulated and gave a presentation. RL highlighted a 3% gap as of today, green has gone to 44% noting the positive improvement. RL provided details on the CIP saving forecast and proposed plans and opportunities for the expected gaps as well as noting risks particularly in month 5 and 6. RL referred to the paper and changes to CIP reporting in relation to the strategic themes, transformation programme, as well as the new systems. In terms of workforce, 221 redundancy applications have been received. Whilst the majority have been reviewed those that have been appealed will go through a separate review process to confirm the decisions were accurate. All the severance costs that have been approved are within the funding envelope that was built into the plan. RL went through a slide on what is still to be delivered. £14m currently in red and amber, £4m relates to non-pay schemes and £8.4m relates to pay. In relation to risk appetite on redundancies DJW asked for further details. AB provided details on the risks currently, noting caution going forward in regards to advertising for redundancies where there is room for approvals rather than advertising to all. Going forward FTPC discussed continued discussions with clinical leads to ensure priority remains on supporting services whilst reducing costs. **Resolved:** FTPC noted progress to date and future plans in relation to the Financial Improvement update.
26/27/29	**Transformation Programme**

	Urgent Care update NP provided a number of highlights from the paper including adding a transformation scorecard to be included in the Integrated Performance Report paper. NP noted concerns in relation to phase 2 plans not being completed asking for FTPC for support with this. The main challenge is translating opportunity into benefit and doing that in a way that is consistent and meets our ambitions around Vision 2030 and creating conditions for effective clinical leadership. AB responded noting areas that could be further developed included: AVT (Ambient Voice Technology) and Rev Care. KW added ways of tracking the programme further to provide more detail in other areas as well as finances and benefits. **Resolved:** FTPC noted progress against the Transformation Programme as well as next steps.
26/27/30	**Campus update** JH provided a detailed update noting ongoing delays in campus build completion, with December as the current target. Active negotiations with PFI providers, standstill agreement issues, and escalation to NHS and Cabinet Office. **Resolved:** FTPC noted progress to date in relation to Campus.
26/27/31	**PFI** **Resolved:** FTPC received and noted the PFI report
26/27/32	**Any Other Business** No further business was discussed.
26/27/33	**Review of the Meeting** The Chair thanked FTPC for their contribution.
	Date and Time of Next Meeting: Tuesday 30th June 2026, at 3pm via Teams

FTPC Priority Areas – June Update

Strategic Priority	Purpose	Current	Movement	Executive Commentary
Trust Financial Performance	Deliver the plan, strengthen grip and control, and improve forecasting and recovery.	Red	↓	Divisional performance behind plan YTD. Challenges with delivery of income and activity plans.
Operational Performance	Provide oversight of access, productivity delivery of standards, aligned to the NHS Oversight Framework.	Amber	→	Q4 oversight framework released and remain segment 1 but with some deterioration metrics
CIP & Transformation	Deliver recurrent CIP and a prioritised transformation portfolio with clear benefits realisation	Red	→	Delivery risk remains elevated with gap on fully developed programme
Capital & Campus Programme	Maintain robust capital governance, safety-led prioritisation and delivery	Amber	→	On plan but risk on campus programme due to NICU delays to be resolved in Q2
Growth & Investment	Monitor progress and developments on opportunities.	Green	→	Work continues on case for change and discussions progressing with ICB

On Track Monitor Off Track

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**Board of Directors – Annual Fit and Proper Persons Checks**
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	NHS England FPPT Framework
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
BAF 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

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

Alder Hey Children's
NHS Foundation Trust

Fit and Proper Persons Test – Assurance Report

1. Executive Summary

The purpose of this report is to provide assurance that annual checks have been undertaken for each Board Director to confirm their continuing compliance with the 'Fit and Proper Persons' requirements.

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test' (FPPT).

2. Current State

The new NHS England FPPT Framework was published in 2023 (updated April 2025) and has been adopted fully in the Trust's FPPT Policy, with enhanced DBS checks being completed for all Board of Directors every 3 years, as part of this process.

The results of these checks are shown in the table below and the Board of Directors can be assured that no areas of concern have been identified.

Self-attestation
In May 2026, the Board of Directors completed the Fit and Proper Persons Test Self Declaration Form and confirmed their compliance with each of the following statements:

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- (where applicable) have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (e.g. directors disqualification order)
- have not been convicted of a criminal offence
- am not an un-discharged bankrupt nor have I been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors that have not been discharged
- do not appear on any 'barred' list
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- hold any registration with a relevant professional body necessary to carry out my role, I have

the entitlement to use any professional titles associated with this registration. If I no longer meet the requirement to hold the registration, I will inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name	Title	Self-attestation signed	Chair sign-off
Jo Williams	Chair	15/05/26	24/06/26 by SID
John Grinnell	Chief Executive	21/05/26	23/06/26
Nathan Askew	Chief Nursing, AHP and Experience Officer	15/05/26	23/06/26
Alfie Bass	Chief Medical Officer	15/05/26	23/06/26
Adam Bateman	Chief Operating Officer/Deputy Chief Executive	21/05/26	23/06/26
Fiona Beveridge	Non-Executive Director	21/05/26	23/06/26
Kerry Byrne	Non-Executive Director	15/05/26	23/06/26
Lisa Cooper	Director of Community & Mental Health Division	15/05/26	23/06/26
Garth Dallas	Non-Executive Director	20/05/26	23/06/26
Urmi Das	Director of Medicine Division	15/05/26	23/06/26
Mark Jennings	Non-Executive Director	22/05/26	23/06/26
Dani Jones	Chief Strategy & Partnerships Officer	15/05/26	23/06/26
John Kelly	Non-Executive Director	15/05/26	23/06/26
Rachel Lea	Chief Finance Officer	21/05/26	23/06/26
Gerald Meehan	Non-Executive Director	15/05/26	23/06/26
Bola Owolabi	Non-Executive Director	22/05/26	23/06/26
Benedetta Pettorini	Director of Surgery Division	*on LTS	
Jo Revill	Non-Executive Director	20/05/26	23/06/26
Erica Saunders	Chief Corporate Affairs Officer	15/05/26	23/06/26
Melissa Swindell	Chief People Officer	08/06/26	23/06/26
Kate Warriner	Chief Transformation and Digital Officer	17/05/26	23/06/26

** annual checks to be undertaken upon return*

Social Media, Disqualified Directors and Professional Registration

In addition, and in accordance with the Guidance, organisations are required to undertake the following additional checks annually for each Board Member:

- Social Media Check
- Disqualified Directors & Removed Trustees Check
- Individual Insolvency Register
- UK Civil Litigation
- Professional Registration

The Trust engaged the services of Gatenby Sanderson and Neotas - specialists in undertaking these checks to provide external assurance to the Board. The Trust received the outcome of these checks on 18th June 2026 confirming no adverse findings and professional registrations all up to date where applicable. Individual Directors' records have been updated on ESR.

Board Member Reference

The new Guidance also looks at preventing unsuitable staff from being redeployed or re-employed in NHS, ICBs, and independent healthcare and adult social care sectors. Board Member References therefore need to be completed when a Board Member leaves the organisation

irrespective of whether a reference has been requested by a future employer. These have been completed as required for 2025/26 and kept locally on file.

3. Conclusion

The Chair reviewed the signed declarations (SID for the Chair) and determined that all Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test. The Trust's annual submission was submitted to NHS England on 24th June 2026 in accordance with the updated guidance.

4. Recommendation

The Board is asked to note the content of this paper and record that the Fit and Proper Persons Test has been conducted for 2026, and all Board members satisfy the requirements.

Board Members are also asked to acknowledge their ongoing duty to inform the Chair should circumstances change, and you can no longer comply with the Fit and Proper Person Test, as described above.

Erica Saunders
Chief Corporate Affairs Officer

BOARD OF DIRECTORS

Thursday, 2nd July 2026

Paper Title:	**Board Assurance Framework Report (May 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 May 2026	As detailed in the report

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

Board Assurance Framework 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 Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x1
1.2 AB	Children and young people not having have timely and safe access to elective, urgent and follow up care	FTPC / SQAC	**5x3**	3x3
1.3 RL	Building and infrastructure defects that could affect quality and provision of services	FTPC	4x4	2x3
1.4 LC	Increased waiting times for Specialist Mental Health community services.	FTPC / SQAC	**3x5**	3x3
STRATEGIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People and Culture Committee	**4x4**	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People and Culture Committee	3x4	2x3
2.3 MS	Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust	People and Culture Committee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Alder Hey Campus	FTPC	3x2	2x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	FTPC	**4x4**	4x2
3.4 RL	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	FTPC	**4x5**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Growth and Opportunities	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	FTPC	**4x4**	2x4

4. Summary of updates to end of May 2026:

- ***Inability to deliver safe and high-quality services (NA).***
  This risk has been reviewed. The current impact of the delay in opening the new NICU on the AH site has been captured as a gap in control. This risk is 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. All other controls continue to reflect the organisation's risks, with monitoring in place through the relevant routes.

- ***Children and young people not having timely and safe access to elective, urgent and follow up care (AB).***
  The Targets for 2026/27 have been refreshed, and performance will be monitored against the access targets set out in the Medium-Term Framework.
  May performance against 2026/27 targets:
  - Acute (95% by September'26) - ED performance achieved 83.9%, against the new national paediatric target of 95%
  - RTT (70.1% by March 2027) - 70.1% in month
  - Pts >52 weeks (0 by March 2026) - Currently 196 with the majority under dentistry. This is a proposed metric by C&M Provider Collaborative.
  - DM01 (97%) - Performance slightly reduced in April to 93.4%

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Risks remains largely as was last month due to progress in signing standstill deal by P Co. It is hoped that the matters will be resolved this week and it will be signed thus unlocking the breakthrough for works to commence.

  Immediate requirement for formal responses and time-bound plans from Project Co.
  Maintain enhanced monitoring and interim mitigations.
  Progress legal position on defects.
  Prepare for potential step-in should critical issues remain unresolved although this remains a last resort as the standstill is the key to unlock.
  Potential standstill deal in discussion.

- ***Increased waiting times for Specialist Mental Health community services. (LC).***
  BAF risk reviewed. Risk remains the same and controls in place. Cheshire & Merseyside Mental Health Transformation Plan 2026-27 shared with Trust for review and will be presented to SQAC in June 2026.

- ***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 discussed at Trust Board.
  Impact and plans to mitigate associated risk are reviewed regularly with oversight at People Committee. The VR scheme has now closed and the full impact of this will be understood in the next couple of weeks

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed and all actions reviewed and updated to reflect progress in thriving culture programme of work. No change to risk rating.

- ***Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust (MS).***
  All workforce actions have been reviewed and remain on track.

- ***Failure to fully realise the Trust's Vision for the Alder Hey Campus (RL).***
  Risk reviewed, gap in control and monitoring action added to reflect delay in opening of NICU.

- ***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, including HWWWITF, has transitioned from programme mobilisation into delivery and is a key enabler of Vision 2030, the Medium-Term Plan and the Trust's Financial Improvement Programme (FIP). There is a risk that the programme does not deliver the scale and pace of workforce, productivity, service and financial benefits required to support the Trust's strategic and financial objectives. Whilst significant progress has been made in establishing governance, leadership arrangements and the organisational foundations for change through HWWWITF Phase 1, many of the Trust's largest opportunities for improvement and recurrent benefit realisation now sit within HWWWITF Phase 2 clinical and pathway redesign programmes, several of which remain at an early stage of development. The risk is compounded by the scale and complexity of the transformation agenda, competing operational priorities, finite organisational capacity and capability, and the need to deliver substantial change whilst maintaining performance, quality and patient experience. Failure to maintain focus, prioritise delivery and realise benefits in a timely manner could impact achievement of both Vision 2030 ambitions and the Trust's financial sustainability requirements.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  Risk reviewed and score remains at 20.

  CIP delivery remains a key focus with target to achieve no more than 25% risk by the end of Q1 with the latest position at 45% fully achieved. Weekly submission on CIP remains in place.

  Achievement of I&E plan in months 1 and 2, however further assurance required on delivery of activity and income following challenges and the impact of industrial action.

  Forecast will commence from M3 identifying any key risks to delivery early and close tracking of any areas of concern.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk, control and actions have been reviewed and updated. We continue to work with partners and colleagues across the system, in times of ambiguity, to design the optimal structures and models for CYP. Work with the CMPC is gaining momentum and CYP are a priority area.

  Our awarded AFT status will enhance our transformation freedoms, and enable our CYP system working to evolve further.

- ***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.

- ***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. There will be a detailed review of this Risk in June to assess whether the Cyber element should be separated from strategy delivery.

  Ageing infrastructure is progressing, delays with one date centre programme meaning completion is now July. Network tender is close to completion and telephony discovery will now commence.

  Organisational Change is now complete and recruitment to key roles can now commence. CIP is 90% complete awaiting final staffing changes as per org change.

  Digital Transformation programme progressing well. Benefits review of 2025/26 is now complete and key projects Portal, 2.2 and Lyrebird progressing to next stages.

5. Corporate risks (15+) linked to BAF Risks (as at 8th June 2026)

There are currently 34 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
485	Potential for no laboratory haematology/transfusion service due to Increased workload pressures, inadequate staffing levels (training/sickness/vacancies)	5x4	Medicine	2.1	Jul 2021	Mar 2024
529	Named Doctor for Safeguarding Children	4x5	Community		Feb 26	Feb 26
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 2024
038	No neurophysiology consultant in post	5x4	Medicine	2.1	Jul 2023	Oct 2025
455	Breaching waiting time standards in the Eating Disorder Service (EDYS) service	3x5	Community	1.2	Oct 2025	Jan 2026

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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
409	Inability to provide safe staffing levels	4x4	Corporate Services	2.1	Jan 2020	*Apr 2023
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
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
557	Contrast shortage - Radiology & Cath Lab	5x3	Medicine		Apr 2026	Apr 2026
413	Haematology Specialty Nursing Team ***(NEW)***	4x4	Medicine	2.1	Jul 2025	May 2026
1.2 Children and young people not having timely and safe access to elective, urgent and follow up care (5x3=15)						

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
462	Children and young people will not receive their ASD assessment within the agreed timescale	4x4	Community	1.4	Jul 2021	*Apr 2023
455	Breaching waiting time standards in the Eating Disorder Service (EDYS) service	3x5	Community	1.1	Oct 2025	Jan 2026
1.3 Building and infrastructure defects that could affect quality and provision of services (4x4=16)						
1.4 Increased waiting times for Specialist Mental Health community services. (3x5=15)						
462	Children and young people will not receive their ASD assessment within the agreed timescale	4x4	Community	1.2	Jul 2021	*Apr 2023
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
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
409	Inability to provide safe staffing levels	4x4	Corporate Services	1.1	Jan 2020	*Apr 2023
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 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

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
545	Booking and Scheduling (Care Co-ordination Team) Staff Shortage	4x4	Community		Apr 2026	Apr 2026
413	Haematology Specialty Nursing Team ***(NEW)***	4x4	Medicine	1.1	Jul 2025	May 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)						
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
525	Potential loss of NWNODN Pharmacy role	4x4	Other – NW Neonatal ODN	1.1	Apr 2026	Apr 2026
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
368	Digital infrastructure capacity and age	4x4	Corporate Services		May 2025	May 2025
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

* risk movement data not available pre-move to InPhase

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
Chief Corporate Affairs Officer

Inability to deliver safe and high quality services.

Risk Number	Strategic Objectives
1.1	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety and Quality Assurance Committee

Description

Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards in the current challenging financial environment.

Control description	Control assurance (How is this control monitored?)
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
Administration of IV antibiotics within 1hr for CYP with suspected sepsis	Monitored monthly through SQAC
Brilliant Basics	Formal and informal training and coaching available to support departments to make positive changes. Reported to board bi-annually including update against NHS Impact Self-Assessment.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Internal: Patient safety meeting actions monitored through SQAC External: Care Quality Commission (CQC), MIAA
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board
Programme of quality assurance rounds, ward and departmental accreditation is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC. Triangulation of data through Aggregated Analysis Reports to SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I)	Annual QIA assurance report and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAs
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. External: Care Quality Commission, MIAA, NHS Improvement
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
The Trust has a Patient Experience Group that reports against the workplan derived from the Patient Experience Strategy based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. Chairs report to SQAC.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.

Gaps in Controls / Assurance

1. 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	June 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
Effective		Adam Bateman

Risk Rating		
Actual	Target	Assurance Committee
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	June 2026	
		Due Date	Action Update
3. Deploy Ambient Artificial Intelligence to improve productivity	Deploy Ambient Artificial Intelligence to improve productivity	30/03/2026	
4. Move to a self-check in model for some patients, using a digital solution	Move to a self-check in model for some patients, using a digital solution	30/03/2026	Draft paper in progress currently meeting with suppliers to identify most suitable opportunity.
5. Establish performance reports on the number of patients seen per clinician	Establish performance reports on the number of patients seen per clinician	30/03/2026	
2. Open Same Day Emergency Care Centre	Expanded Paediatric Assessment Unit	31/08/2026	Delays related to building and estate works for grouynd 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
1. Improve timeliness of care and experience through a same day emergency care centre	Expanded Paediatric Assessment Unit	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.

Building and Infrastructure defects that could affect the quality and provision of services					
Risk Number			Strategic Objectives		
1.3			Outstanding care and experience		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Safe		Rachel Lea	16	4	• Finance Transformation & Performance Committee • Safety and Quality Assurance Committee • 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	June 2026	
		Due Date	Action Update
Appropriate Legal Advice	Continue to seek appropriate legal, commercial and technical advice	31/05/2026	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.
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	31/05/2026	Project co have been requested to share plans of monitoring and rectification strategy. 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	The defect survey now 31 March 2026 to allow for SPV coordination
Combined Heat & Power	Combined Heat & Power non-operational for ~18 months.	24/03/2027	CHP non-operational for ~18 months. Was initialy started mid May and ran for one week. Did not close down on standbye as is under further investigation. Risk: Loss of efficiency, resilience and increased operational cost exposure. Requirement: Defined, time-bound recovery plan. No confirmed reinstatement plan or timeline.
Air & Ground Source Systems	Clear plan, timelines, and performance assurance from Project Co.	31/03/2027	Ongoing unresolved issues affecting system performance and reliability. No confirmed root cause or resolution plan. Risk: Impact on environmental control and long-term system performance. Requirement: Clear plan, timelines, and performance assurance from Project Co. Ongoing unresolved issues affecting system performance and reliability. No confirmed root cause or resolution plan.
Chillers	Persistent performance issues with no confirmed delivery programme for full reinstatement.	31/03/2027	Persistent performance issues with no confirmed delivery programme for full reinstatement. Project plan received but lacks firm timelines and assurance. Risk: Reduced resilience and capacity, particularly during peak demand. Requirement: Time-bound delivery plan and programme assurance. Project plan received but lacks firm timelines and assurance.
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. Legal position on defects under review. Fortnightly defects meetings in place; defects tracker issued.
Water Safety	Enhanced monitoring, tap filter regime in place.	31/03/2027	Continued management of out-of-range water temperatures via Water Safety Group. Further SPV Board report received and under review. Dosing system remediation ongoing with no confirmed resolution date. Risk: Ongoing non-compliance and potential clinical impact. Mitigation: Enhanced monitoring, tap filter regime in place. Next Step: Ensure deal is signed to unlock works. Continued management of out-of-range water temperatures via Water Safety Group. Further SPV Board report received and under review. Dosing system remediation ongoing with no confirmed resolution date. Next Step: Consideration of Trust step-in rights if resolution is not achieved.

Increased waiting times for Specialist Mental Health community services.

Risk Number	Strategic Objectives
1.4	Outstanding care and experience

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
15	4	Finance Transformation & Performance Committee

Description

Since 2020 there has been a significant increase in demand for Specialist Mental Health Services at Alder Hey, which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours, there has also been an increase in the clinical urgency of referrals received.
This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Control description	Control assurance (How is this control monitored?)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software
Existing BI Dashboard developed to support management of open caseload	Open caseload dashboard routinely reviewed by clinical leads and assistant clinical leads with practitioners
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required. Meetings and regular meeting with commissioners to update on service delivery and any challenges.	Monthly assurance processes include: Monthly contract statements Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Ongoing attendance at Cheshire and Merseyside Mental Health Workforce Planning groups	- Reviewed attendance across the range of meetings and Alder Hey lead/s identified - Feedback loop agenda item as part of Mental Health Business Meeting - Cheshire and Merseyside Lead attends Alder Hey business meetings.
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Trajectories developed to support improvement in access and waiting times	Monitored through - leadership meetings - weekly waiting times & access to care - regular meetings with divisional director - regular meetings with commissioners
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Weekly performance monitoring in place for operational teams which includes: Weekly Tuesday/Wednesday meeting with PCOs Divisional Waiting Times Meeting each Thursday Trust Access to Care Delivery Group fortnightly This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)

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	June 2026	
		Due Date	Action Update
78+ week waits	To review CYP reported as 78+ weeks without a ROM - to ensure all CYP have ROM attached	30/06/2026	
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	31/07/2026	work ongoing to streamline services, introduction of risk and triage calls to Liverpool CAMHS in Aug 2025 regular meetings to be scheduled with clinical leads to progress
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/07/2026	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
Review of RTT performance trajectories and improvement plans for Liverpool and Sefton CAMHS	Performance trajectories and improvement plans to be produced and shared at Access to Care on a regular basis to track progress. Latest date for performance (Sefton) to be met end of September 2025. Liverpool's trajectory in progress - capacity and demand underway to be reviewed monthly as part of BAF Risk Review	31/08/2026	Trajectories for improvement are in place, and agreed with commissioners: **Liverpool CAMHS:** 92% CYP receiving urgent choice within 2 weeks of referral by 30.06.2025 - not achieved by end of June, but achieved and maintained from August onwards 0 CYP waiting over 52 weeks by 30.09.2025 - not achieved, but 0 expected by 31.10.2025 92% CYP receiving choice within 6 weeks of referral by 31.10.2025 - off track, but RTT improved in Sept. Expected to achieve. 0 CYP waiting over 40 weeks by 31.01.2026 - on track 75% CYP receiving partnership withing 18 weeks of referral by 31.1.2026 - on track 10% WNB rate by 31.12.2025 - off track, WNB rate for Aug higher than expected. Work ongoing **Sefton CAMHS:** 92% CYP receiving choice within 6 weeks of referral by 31.1.2026 - on track 92% CYP receiving partnership within 18 weeks of referral by 30.4.2026 - on track
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

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	
Risk Number	Strategic Objectives
2.1	Support our People

CQC Domains	Linked Risks	Owner
▪ Safe ▪ Well-Led		Melissa Swindell

Risk Rating		
Actual	Target	Assurance Committee
16	4	People 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 FTPC
Health and Wellbeing Forum	Health and Well being Forum Terms of Reference - reporting through to People Committee
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
Monthly monitoring through Ops Board, Board, Execs and People Committee	Regular reporting of delivery against compliance targets via divisional reports
Nurse Retention Lead	Bi-monthly reports to PC
Nursing Workforce Report	Reports to People Committee, SQAC and Board
PDR and appraisal process in place	Monthly reporting to Board and PC
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
People Policies	All Trust Policies available for staff to access on intranet
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Workforce Efficiencies Programme	Monitored at FTPC, and People Committee

Gaps in Controls / Assurance

1. Training/development
2. Sickness absence levels higher than target
3. Lack of alignment of people services to the organisational systems (HWWWITF)
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	June 2026	
		Due Date	Action Update
3. Lack of alignment of people services to the organisational systems	3. Through HWWWITF, 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 impacti	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
Caring Safe Well-Led		Melissa Swindell

Risk Rating		
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	HWWWIF 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	June 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	
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.	28/05/2026	Safety culture development programme finalised and being piloted with Sunflower House on 28th May 2026. Consideration also being given to running a pilot programme in ED as second pilot site
Responsive communications	Links to be strengthened with communications team to ensure that communications are responsive to organisational need, values based and aligned to the culture. To be achieved via attendance at newly developed Communications Board and via closer links with comms team in values working group and other relevant fora	30/06/2026	Comms, SALS and OD teams continuing to meet to ensure connected leadership approach is embedded and responsive to organisational need. Ask for an Exec team based approach operational and being evaluated. Connected leadership team meeting once per month to review approach and make improvements based on feedback. Group also working to establish effective evaluation methods for all aspects of the approach, including briefings and exec connect sessions. Once approach fully embedded group to stand down task and finish group and consider ongoing links through existing comms led forums.
Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	31/07/2026	Draft framework has now been piloted by members of the Values working group. Feedback being collated and framework amended. Plan to share new version for comment with Execs in May and then present at People Committee in June for final sign off.
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training	28/09/2026	New deteriorating patient learning forum commenced being led by Patient Safety Lead and Director of Culture & OD. CMO is SRO and has commissioned this approach based on learning through the deteriorating patient workstream which identifiied the need for a psychologically safe and restorative forum for teams to come together to learn and repair relationships which may have been affected during adverse incidents. First session took place in April with next session planned for 19th May
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).
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards. Thriving Staff Index and Thriving Teams Index to be developed.	30/09/2026	Staff survey team level data analysed according to Thriving categories and shared with execs and divisional leads. Data being used to scope interventions in challenges areas in discussion with wider Thriving Teams MDT. Data will also be used to inform targeted support plan for teams and leaders during the organisational restructure.
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.

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. Focus on closing feedback loops with discipline to ensure that staff voice leads to credible, timely, and visible action	30/09/2026	Themes from targeted listening sessions with impacted groups of staff undergoing organisational change analysed and shared with HWWWITF Steering group to inform action.
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.

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
Effective Well-Led		Melissa Swindell

Risk Rating		
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	June 2026	
		Due Date	Action Update
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	'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.
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	
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	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
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.	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
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
▪ Effective ▪ Safe		Rachel Lea

Risk Rating		
Actual	Target	Assurance Committee
6	4	Finance Transformation & Performance Committee

Description

The Alder Hey long term vision for the 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	June 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
Well-Led		Kate Warriner

Risk Rating		
Actual	**Target**	**Assurance Committee**
16	4	Finance Transformation & Performance Committee

Description
Risk of failure to continue to deliver the ambitions of Vision 2030 given multiple competing demands of the system coupled with variable capacity, balancing 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	
Executive sponsor roles within the programme	
Medium Term Plan	Medium Term Plan incorporates Vision 2030 deliverables (2025/26)
Programme Assurance Framework	FIP Strategic Command, Clinical Transformational collaboratives, Digital Data & AI Collaborative, HWWWIF Steering Group, Growth and Opportunities Acceleration Group
Semi-independent programme assurance	Internal audits of framework
Transformation Board	Transformation Board in place chaired by CEO

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.

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	June 2026	
		Due Date	Action Update
2. Maintain organisational focus on strategic priorities and transformational change	Ensure resources, programmes and leadership attention remain aligned to delivery of Vision 2030.	31/03/2026	**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.**
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	**Governance arrangements continue to provide oversight of strategic priorities, with ongoing review through Strategy Board, Transformation Board and Portfolio Board to ensure alignment to Vision 2030 and organisational priorities.**

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments.

Risk Number	Strategic Objectives
3.4	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Effective Responsive Safe Well-Led		Rachel Lea

Risk Rating		
Actual	Target	Assurance Committee
20	4	Finance Transformation & Performance Committee

Description

Failure to deliver financial targets in particular the level of efficiency and cost reduction required.
Inability to invest in the capital programme due to constrained capital and cash allocation.
Detrimental impact due to system performance.

Control description	Control assurance (How is this control monitored?)
Active engagement within ICB, NHSE both regional and national.	- Attendance at system forums. - Cascade of system and national information on a regular basis. - Advocate for CYP - Hosting of Beyond programme
Capital Management Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend. Updated 5 year capital plan shared with FT&P and Trust Board. Oversight by FTPC through monthly updates at top 5 key risk
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through Operational Board and FT&P with divisional leads ('3 at the Top'). Clear escalation to FTPC where required for high risk areas.
Financial Improvement Programme (FIP) 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

Action	Description	June 2026	
		Due Date	Action Update
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan 2. Working closely with the ICB	31/03/2027	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

Risk Number	Strategic Objectives
3.5	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

Risk Rating		
Actual	Target	Assurance Committee
16	4	▪ Growth and Opportunities Committee ▪ Strategy Board

Description

Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory and political and system environment.

Impact of membership of a system that is in national financial recovery.

Risk of failure to keep CYP prioritised in the wider NHS context and competing priorities, and therefore risk to delivery of Vision 2030.

Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.

Control description	Control assurance (How is this control monitored?)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually). 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 June 26 Update: The BMTF system is being co-designed with senior leaders at present.
Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for CYP.	Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25. 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	June 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	No further update this month
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	We continue to proactively engage with multiple partners across the system with an aligned ambition around the three shifts in the 10 year health plan
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	No further update

Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.

Risk Number	Strategic Objectives
4.1	Pioneering Breakthroughs

CQC Domains	Linked Risks	Owner
• Caring • Effective • Safe • Well-Led		John Chester

Risk Rating		
Actual	Target	Assurance Committee
9	4	Growth and Opportunities Committee

Description

Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries.
Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities.
Risk of exposure to ethical challenges and national and international reputational risks.

Control description	Control assurance (How is this control monitored?)
Clear management structures and operational accountability within Futures including the Clinical Research Division, Innovation team and Futures aspects of Education and Digital	Reports to Futures Management Board
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP adherence
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
External performance targets mandated (by NIHR for research, LCR Combined Authority for Paediatric Open Innovation Zone)	Reports to Futures Management Board
Futures Management Board Delivery and performance measurement of R and I activities plus education and digital elements of Futures	Reports to GO Committee
Growth and Opportunities (GO) Committee Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board
Protection +/- exploitation of intellectual property	Adherence to Trust policy - escalations to Futures Management Board
Risk registers	Reports to Risk Management Forum and Future Management Board
Staff probity - via online declaration of interests portal (gifts & hospitality, sponsorship etc.)	Adherence to Trust Policies, Declarations of Interest Register and digital audit trail to audit committee
Strategic commercial partnerships with industry partners and commercial vehicles	Reports to Futures Management Board

Gaps in Controls / Assurance

1. Integration of R&I activities into Futures not yet fully determined.
2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable.
3. Financial model and levels of income not yet consistent with growth and sustainability.
4. Capacity and capability of clinical staff and services to participate in R&I activities.
5. Comms Strategy for Futures not yet fully described.

Action	Description	June 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
▪ Effective ▪ Safe		Kate Warriner

Risk Rating		
Actual	Target	Assurance Committee
16	4	Finance Transformation & Performance Committee

Description

Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Control description	Control assurance (How is this control monitored?)
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence tracking delivery
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
Digital 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	June 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	30/06/2026	On track, Resource being bolstered via Org Change and wider review being collated into a report.
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.	28/08/2026	Organisational Change process now complete. Recruitment has commenced to key roles.
Digital systems review	Digital systems review	30/10/2026	First service migrated to EMIS in June. Remainder aiming to complete by September
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	Core data centre work delayed due to issues with supplier. Revised date is now July. Network tender close to completion. Telephony not yet started. Device Replacement is ongoing with no issues to report.

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

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Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

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Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. NHS Premises Assurance Model (PAM) (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. Insightful provider board guide (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).

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For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

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safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

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Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)
The full text of these recommendations can be found in the Phase 2 Report (pp.264-265).
Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).
Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)
The full text of these recommendations can be found in the Phase 2 Report (p.265).
Supporting guidance
Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
The Insightful provider board guide (see entry 3 in Annex 1).
Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

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Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the Phase 2 Report (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

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Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis. The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps. In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

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Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

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Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance Statement	Confirmed (Yes / No)	Additional comments
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	Policy has recently been updated and this will be including in a regular testing plan.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	The Trust has an action plan that is monitored through SQAC and on to trust board to monitor compliance.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	The Chief Nursing, AHP and Experience officer is the executive lead for safeguarding people after they die.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	This is included in the action plan.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the	Yes	The Trust will undertake the self-assessment and the data will be submitted within the time frame.

current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission		

Alder Hey Children's NHS Advanced Foundation Trust.

[Insert Signatures]

John Ginell, Chief Executive Officer

Dame Jo Williams, Chair

Date: