

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 4th June 2026, commencing at 9:35am
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 (9:35am - 9:50am)							
1.	26/27/77	9:50 (1 min)	Apologies.	Chair	To note apologies.	N	For noting
2.	26/27/78	9:51 (1 min)	Declarations of Interest.	All	Board members to declare an interest in particular agenda items, if appropriate.	R	For noting
3.	26/27/79	9:52 (2 min)	Minutes of the Previous Meeting.	Chair	To consider and approve the minutes of the meeting held on: 7th May 2026.	D	Read enclosure
4.	26/27/80	9:54 (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.	26/27/81	9:55 (10 mins)	Chair's/Chief Executive's Update, including: • Application for Advanced Foundation Trust Status. • Southport Public Inquiry (Phase 2).	Chair/ J. Grinnell J. Grinnell	To receive an update on key issues and discuss any queries from information items. For information and discussion.	N	Verbal
						N	Read enclosure
				E. Saunders	To discuss Phase 2 of the Southport Public Inquiry.	N	Verbal
Strategic Update							
6.	26/27/82	10:05 (10 mins)	CYP System Update.	D. Jones	To receive an update on the current position.	N	Presentation
7.	26/27/83	10:15 (10 mins)	Health Bill Briefing Note.	E. Saunders	To note.	N	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	26/27/84	10:25 (5 Mins)	Clinical Strategy (2026-2030).	M. Ashe	To receive and approve.	D	Read report (<i>Publication date: September 2026</i>)
9.	26/27/85	10:30 (20 mins)	Vision 2030/Transformation Programme Update; including: • HWWWTF overall programme update. • Digital, Data and Technology Update.	J. Grinnell/ K. Warriner/ A. Bateman/ M. Swindell K. Warriner	To receive an update on progress.	A	Read report
					To receive an update on progress.	A	Read report
Performance Against Annual Plan							
10.	26/27/86	10:50 (35 mins)	Evidence of Our Performance: • Flash Report. • Integrated Performance Report for M1, 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 R. Lea Divisional Directors	To receive the Trust’s Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	A	Read report
Unrivalled Experience							
11.	26/27/87	11:25 (5 mins)	Compliments, Complaints and PALS Report, Q4.	N. Askew	To receive the PALS and Complaints Report for Q4.	A	Read report
12.	26/27/88	11:30 (5 mins)	Nursing Workforce Annual Report, 2025/26.	N. Askew	To receive the Nurse Staffing Annual Report for 2025/26.	R/A	Read report
13.	26/27/89	11:35 (5 mins)	Infection, Prevention and Control Report, Q4.	A. Bass	To receive the Infection, Prevention and Control Report for Q4.	R/A	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action:		Preparation
					Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		
14.	26/27/90	11:40 (5 mins)	Mental Health Act Annual Report, 2025/26.	L. Cooper	To receive the Mental Health Act Annual Report for 2025/26.	A	Read report
15.	26/27/91	11:45 (5 mins)	Use of Restrictive Physical Interventions Annual Report, 2025/26.	L. Cooper	To receive the Use of Physical Interventions Annual Report for 2025/26.	A	Read Report
16.	26/27/92	11:50 (5 mins)	Quality Account, 2025/26.	N. Askew	To receive the Quality Account for 2025/26.	R/A	Read report
17.	26/27/93	11:55 (5 mins)	Safety and Quality Assurance Committee: - Chair's Highlight Report from the meeting held on the 20.5.26. - Approved minutes from the meeting held on the 22.4.26.	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 22.4.26.	A	Read enclosures
18.	26/27/94	12:00 (5 mins)	Mass Casualty Major Incident Plan.	N Askew	To Ratify the Mass Casualty Major Incident Plan.	D	Presentation
Collaborating in Communities							
19.	26/27/95	12:05 (5 mins)	Liverpool Neonatal Partnership Board: Chair's Highlight Report from the meeting held on the 11.5.26.	A. Bass	To receive an update and escalate any key risks.	A	Read enclosure
Supporting our People							
20.	26/27/96	12:10 (10 mins)	Strategic People Update.	M. Swindell	To receive an update on the current position.	A	Read report
21.	26/27/97	12:20 (5 mins)	People Committee:	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 26.3.26.	A	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- Chair’s Highlight Report from the meeting held on the 13.5.26. - Approved minutes from the meeting held on the 26.3.26.				
22.	26/27/98	12:25 (15 mins)	FTSU Update: - FTSU Annual Report. - Review Tool for Boards.	K. Turner/J Fitzpatrick E. Saunders	To receive an update on the current position.	A	Read report
Strong Foundations (Board Assurance)							
23.	26/27/99	12:40 (5 mins)	Finance, Transformation and Performance Committee: - Chair’s verbal update from the meeting held on the 1.6.26. - Approved minutes from the meeting held on the 27.4.26. 2026/27 Priority Areas.	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 27.4.26.	A	Read enclosure/ slide
24.	26/27/100	12.45 (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 report
25.	26/27/101	12:50 (4 mins)	Any Other Business.	All	To discuss any further business before the close of the meeting.	N	Verbal
26.	26/27/102	12:59 (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
Lunch (13:00-13:30)							
Date and Time of Next Meeting: Thursday, 2 nd July 2026, LT1, Institute in the Park.							

REGISTER OF TRUST SEAL

The Trust seal was used in May 2026:
435: Settlement Agreement – Galliford Try
436: Phase 4 Demolition – J. Freeley Demolition

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION

Financial Metrics, M1, 2026/27	R. Lea
Financial Improvement Programme Update	R. Lea

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Draft Minutes of the meeting held on **Thursday 7th May 2026** at
Lecture Theatre 1, Institute in the Park

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

Patient/Staff Story

The Chair welcomed the Clinical Lead for Organ Donation, Dr. Carla Thomas, who had been invited to May's Board to provide an update on organ donation.

The Board received a presentation which provided information on paediatric organ donor figures, transplants, and the active transplant list in the UK. The presentation moved beyond data reporting to provide a more patient-centred narrative, illustrating the impact of organ donation through clinical experience and real patient stories.

Attention was drawn to the high number of patients, including children, awaiting transplants. It was noted that, while paediatric donors are relatively low, outcomes can be maximised as children go into donation much healthier than adults and therefore are usually able to donate more organs.

The presentation outlined the clinical pathways for organ donation, including donation following brain death and donation following circulatory death. It was emphasised that donation requires highly coordinated, multi-disciplinary working across clinical teams and national transplant services.

Through Louis', Evan's and Rory's story, the Board heard how advances in clinical practice and innovation had directly improved outcomes for children. In particular, the introduction of new technologies and approaches to transplantation was highlighted as having a transformational impact, enabling transplants in cases that would previously not have been possible.

The Board also noted recent developments, including the delivery of a Northwest paediatric organ donation training course and participation in research aimed at understanding family decision-making in respect to organ donation.

The Chair thanked Dr. Thomas for the presentation, noting that it had brought the work of the team to life. The Board felt that the update had been highly informative and had increased understanding of the scale of involvement required. It was recognised that Dr. Thomas has provided strong leadership in an area that has been challenging for the organisation and has led a significant cultural change at Alder Hey.

26/27/47 Welcome and Apologies

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

26/27/48 Declarations of Interest

The following declarations were made:

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

26/27/49 Minutes of the previous meeting held on 2nd April 2026.

Resolved:

The minutes from the meeting held on the 2.4.26 were agreed as an accurate record of the meeting.

26/27/50 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

26/27/51 Chair's and CEO's Update

The Board was informed of the regional meeting of providers and ICBs that was held on the 24.4.26 as part of NHS England's (NHSE's) engagement with regional teams. The Chair, CEO and CFO of NHSE attended and the new Regional Chair, Kathy Cowell was introduced. It was noted that Kathy Cowell is expected to visit Alder Hey in the near future.

Key messages from the NHSE Board included the importance of considering inequality more broadly, looking not only at deprivation but also at the impact of wealth. This linked to a second point about the potential for higher levels of testing

driven by more assertive or affluent families. Members noted the need for a holistic approach, including monitoring postcodes and understanding which families place the greatest demand on services.

Outpatients remain a key priority for NHSE and is central to their thinking about the future direction of the NHS. It was reported that Alder Hey received strong recognition and significant praise for the work it is leading on regionally and nationally.

The Chair reported on the recent two-day innovation event, which attracted a broad range of international contributors and organisations from across the world. The event was described as highly inspiring and encouraged the Trust to think more ambitiously about its international role.

An update was provided on two recent senior appointments within partner Organisations; Sheena Cumiskey has been appointed Chair of Mersey Care, and Joan Spencer, previously serving in an acting capacity, has been appointed Chief Executive of Clatterbridge.

It was reported that organisational performance remains strong, with RTT performance described as exceptional. Financial and workforce pressures continue to present challenges; however, the Trust's standing across the system remains positive. It was also noted that Alder Hey has been recognised as one of only 21 exemplar organisations, and a large event is due to take place w/c 11.5.26, at which Alder Hey will deliver a significant presentation on digital.

The Board was updated on the recent launch of a mobile cancer unit, which was recognised as a significant step in improving access to care for children and young people (CYP). Attention was also drawn to the significant progress made on the new NICU and Urgent Care Unit, which was described as exceptional. It was confirmed that arrangements will be made to enable Board members to visit the new development.

John Grinnell commended teams for their response to recent periods of industrial action and noted that this is likely to remain a longer-term challenge, with further industrial action anticipated.

Resolved:

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

26/27/52 Southport Public Inquiry Update

The Board received an update on the current position with regard to the Southport Inquiry following publication of the Chair's report from Phase 1 on the 13.4.26. It was confirmed that Alder Hey has issued a statement expressing the Trust's condolences to the families affected, alongside a clear commitment to learning and improvement.

On the day that the Phase 1 report was published it was announced that Phase 2 of the Inquiry would commence immediately, and the terms of reference were published by the Home Secretary later that day. The Trust will now consider its involvement in Phase Two of the Southport Public Inquiry, and it was recommended that the Trust proceed with an application for core participant status, noting that the process required submission by the 15.5.26. It was explained that the application will set out the nature of the Trust's

potential involvement and relevance to the Inquiry terms of reference, particularly in areas relating to CYP. Board members were asked to note the terms of reference for phase 2.

The Board was advised that the Safety and Quality Assurance Committee (SQAC) has begun to consider the implications of the Southport Public Inquiry report, with an initial discussion held during April's meeting. This has enabled the Committee to start identifying priority areas for future work, recognising the significance and breadth of the Inquiry's findings. Given the scale and complexity of the work required, a subgroup of the Committee has been established to provide more focused time and scrutiny. It was confirmed that SQAC will continue to include this item on each agenda, review the report in full, and add further actions to the action plan as required.

Resolved:

The Board noted the terms of reference for Phase 2 of the Southport Inquiry and Alder Hey's potential role in the process in light of the recommendations from Phase 1.

26/27/53 Vision 2030 Update

Transformation Programme

The Board was advised that since the last meeting the programme has moved from mobilisation into early delivery, supported by clearer prioritisation, strengthened governance and closer alignment with the Trust's Financial Improvement Programme (FIP). The following points were highlighted:

- The Transformation Programme now comprises of five established programmes, and the Transformation Programme Board meets monthly under the chairmanship of John Grinnell. It was also confirmed that Alder Connect went live in April, and that 82% of letters are now completed using voice technology.
- The Urgent and Emergency Care (UEC) system strategy has been approved. As the programme develops, it will begin to reflect the system-wide work previously presented to the Strategy Board.
- In relation to outpatients, a number of existing schemes are progressing, and strategic opportunities are also beginning to emerge through the development of a single point of access and wider national changes.
- From June onwards, the transformation scorecard will be incorporated into the Integrated Performance Report (IPR) enabling the Transformation Programme to be monitored via the IPR. Significant work has also been undertaken on financial benefits realisation to align annual transformation benefits with the CIP programme, supporting a more integrated approach.
- A macro report on a page for the five programmes is in the process of being developed, with milestones and gateways to be monitored via the Transformation Board and the Finance, Transformation and Performance Committee (FTPC).

How We Will Work in the Future (HWWWITF)

In February, Alder Hey launched a staff engagement programme in relation to How We Will Work in the Future (HWWWITF) and how the organisation should be structured going forward. Following the close of that engagement, work moved into designing the new systems and organisational structure. The five-system model has now been agreed, and appointments have been made for some of the new roles. By the end of May, the grouping of clinical services within each system is also expected to be finalised. Focus will then shift to a leadership development programme to support the new leadership teams.

Resolved:

The Board noted the update on Vision 2030 and the Transformation Programme.

26/27/54 CYP System Update

The Board was provided with an update on key system activity to date. The following points were highlighted:

- Significant work has been undertaken and will continue to do so to strengthen primary care engagement. This has included collaboration with the ICB GP lead and the potential for a future visit from NHSE's Medical Director. Engagement has also begun with GP leaders across Liverpool, Sefton and Knowsley, in partnership with North Mersey Provider colleagues to consider neighbourhood working, respiratory pathways, and how best to align collective approaches and assets across the area.
- Similarly, the Cabinet Office's Test, Learn and Grow Programme which the North Mersey Provider Partnership is directly linked with, is underway to explore what a neighbourhood multidisciplinary team (MDT) model might look like, particularly in relation to respiratory care. In addition, Sefton and a local neighbourhood are participating in a national pioneer of neighbourhoods.
- *Liverpool City Region*: There are a number of opportunities emerging through the Trust's engagement with the city region. The Paediatric Open Innovation Zone (POIZ) continues to progress, and last month Alder Hey hosted the Liverpool City Region Business and Enterprise Board, with a visit to the Innovation Hub which generated strong interest and valuable new connections. Through colleagues at Liverpool City Council, the Trust has been introduced to the Liverpool Global National Framework Board, and the Chief Strategy and Partnerships Officer has been invited to attend meetings on a quarterly basis. This forum is focused on strengthening the Liverpool brand and better aligning the city region's collective assets.
- *Cheshire and Merseyside (C&M)*: The Trust continues to work closely with the C&M system. Positive progress is being made through new models of care, including the C&M-wide PCAS model and AVT, while further changes to the ICB operating model are still expected.
- *North West (NW)*: The Trust is working with the Royal Manchester Children's Hospital (RMCH) to refresh the draft Memorandum of Understanding (MoU) for the NW Paediatric Partnership Board.

John Grinnell reflected on the CYP system update and highlighted the importance of setting time aside during June's Strategy Board to consider this work from a long-term perspective in relation to Alder Hey's system proposal. It was noted that formal commissioner decisions will be needed soon, as progress will be

constrained without this. An engagement session is due to be arranged shortly and is expected to inform governance discussions. It was also emphasised that a clear ask, supported by clarity on the resources required, should be agreed in advance of meeting with commissioners.

The Board discussed developments in relation to the Liverpool Health Partnership, noting that it was entering a refreshed phase of development with a revised structure and renewed focus. It was reported that a new model was emerging, bringing together key partners across the city, including major health organisations, universities and research institutions, with representation from Alder Hey and other system partners.

Resolved:

The Board noted the CYP update.

26/27/55 Advanced Foundation Trust Assessment Update

It was reported that the Trust was invited to a feedback meeting as part of the Advanced Foundation Trust (AFT) process. The meeting provided an opportunity to receive feedback on the Trust's current position/progress and an overview of the next steps in the assessment process. It was reported that the outcome of the assessment is expected to be announced by 11.5.26.

Resolved:

The Board noted the update on the AFT assessment process.

26/27/56 C&M Financial Position Update

The Board was provided with an update on the Cheshire and Merseyside (C&M) financial position as at the 31.3.26. It was reported that subject to audit the system closed the year with a deficit of £288m against a £178m plan, representing an adverse variance of £110m.

The Board reviewed the system's financial trajectory and forecasting, noting that the final position had improved compared to earlier forecasts but remained above the original plan. It was noted that a number of providers did not meet their control totals, contributing to the overall system variance.

It was pointed out that not every organisation has had a plan approved for the 2026/27 financial year and are being progressed on an individual basis via the North West region.

A discussion took place about the work undertaken to develop a three-year proposal if C&M get back to plan. As part of the Medium Term Plan, a roadmap has been set out to achieve this; however, the scale of the challenge in year one means that it's not being accepted as a three-year plan currently.

Resolved:

The Board update on the Cheshire and Merseyside (C&M) financial position as at the 31.3.26.

26/27/57 Evidence of Our Performance

The Board received the revised Flash Report for M1 which was presented in a clearer and more streamlined format to improve visibility of key performance metrics and support more effective Board discussion.

It was reported that the Trust ended the year in a strong performance position and particular attention was drawn to achievements in Referral to Treatment (RTT) performance, Emergency Department performance, and delivery of the diagnostic standard. It was confirmed that the Trust has maintained a position within Segment 1 of the National Oversight Framework, reflecting overall strong organisational performance, although there had been a slight movement in ranking.

Alongside these positive results, the report also identified areas requiring continued focus, particularly within patient safety and workforce domains. Sickness absence was highlighted as a key challenge, and reference was made to the ongoing work in relation to infection control which is under scrutiny by SQAC.

Integrated Performance Report

Support Our People

Sickness absence remains a significant challenge; however, the Trust is approaching a 2% reduction and is on track to meet its target if current progress continues. The HR team is identifying areas of concern and working with SALs to support the management of sickness absence. The target operating model will also include team management of sickness absence. Staff turnover is expected to be higher in the coming months due to voluntary redundancies and workforce reduction.

For noting

It was noted that it would be helpful to distinguish turnover from voluntary redundancy, as this could otherwise mask the underlying position.

Pioneering

It was pointed out that the Trust is managing risks linked to POIZ relating to investment and delivery particularly in the context of capital and resource allocation. The Board was advised that the Chief Digital and Transformation Officer, Kate Warriner has been appointed as the Senior Responsible Officer (SRO) for POIZ.

Community and Mental Health Division

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

Division of Medicine

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

Division of Surgery

An update was provided on the Day Case Improvement Plan. It was reported that the Division has successfully completed two pilots on Ward 3A which demonstrated reductions in bed utilisation alongside positive feedback from both

patients and staff. It was pointed out that this work formed part of a broader programme to optimise surgical pathways and improve productivity, including future plans to expand day case capacity and further develop recovery space. Following discussion, it was felt that there is an opportunity to raise the profile of the day case model and further promote this work both internally and externally.

It was suggested that there may be a link between WNB, patient initiated follow-up and the length of time patients remain on the waiting list. It was felt that further analysis is needed to understand the percentage as this may impact both the number of appointments offered and how they are allocated, particularly if current approaches are unnecessarily extending waits for both the Trust and CYP.

Resolved:

The Board:

- Noted the Flash Report for M1.
- Noted the content of the IPR for Month 12.

26/27/58 2026/27 IPR Proposal

The Board received a paper setting out the proposed approach to the Integrated Performance Report (IPR) for 2026/27. The proposal described a refreshed format intended to reflect the Trust's objectives and priorities for 2026/27.

The new IPR will incorporate a number of key developments, including the integration of the transformation scorecard, alignment with the National Oversight Framework, and clearer linkage to the Medium-Term Plan. A visual refresh of both the IPR and the Flash Report has also been proposed, with the aim of improving clarity and supporting more effective Board-level assurance. Further refinement of the IPR is ongoing, including work with the SROs to finalise metrics.

During discussion, Board members reflected on the opportunity for the revised IPR to place greater emphasis on drawing out key issues for Board discussion, including divisional performance and financial positions, particularly in the context of emerging new systems. Members also noted the potential for the refreshed IPR to support more forward-looking and focused Board discussion, rather than retrospective reporting.

Resolved:

The Board supported the proposed direction of travel for the 2026/27 IPR and noted that further development and refinement will continue ahead of full implementation.

National Oversight Framework Update, Q3

The Board received an update on Q3 performance in the National Oversight Framework (NOF). Moving into 2026/27, it is proposed that the NOF becomes part of business as usual; a summary of the NOF is going to be included in the Integrated Performance Report, and quarterly updates are going to be presented at the relevant sub committees for monitoring and assurance.

The Chief Operating Officer, Adam Bateman, highlighted limitations in the way some national metrics are constructed and presented, particularly in relation to patient safety and infection-related measures. It was explained that a number of these indicators are calculated on a rolling 12-month cumulative basis, meaning that where an incident or adverse position occurs earlier in the year, the metric can

remain flagged as red for the remainder of the year, even if no further incidents occur and improvement actions are implemented. As a result, the metric may not reflect more recent improvement or current performance.

Following discussion, it was agreed to explore a process for feeding back on improved figures rather than metrics remaining red all year. It was requested that this issue be raised with the National Oversight Group, especially in terms of infection metrics.

26/27/58.1 Action: AB

Resolved:

The Board noted the National Oversight Framework update for Q3.

26/27/59 Learning from Patient Safety Incidents, Q4.

The Board was provided with an update on activity in Q4 and an overview of identified areas of system-wide learning, improvement and next steps. The following points were highlighted:

- *Commissioned Subject Matter Review* – It was initially anticipated that the review would conclude in Q1 2026/27; however, this timescale will not be met due to the recent withdrawal of external Subject Matter Expert (SME) reviewers. The Trust is currently in the process of appointing alternative external members, following which a revised timeline for completion of the SME review will be confirmed. The Board was assured that progress on the remaining elements of the investigation has continued unaffected.

Resolved:

The Board noted the Learning from Patient Safety Incidents report for Q4.

26/27/60 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 25.3.26 were submitted to the Board for information and assurance purposes.

It was reported that the appendix in the Chair's Highlight report for April, sets out the Committee's commitment to studying Phase 1 of the Southport Public Inquiry report and provides an overview of the areas of focus. It was confirmed that this matter will remain a significant focus for the Committee throughout the year.

The Committee is also focussing on the ongoing pressures within the Neurodevelopmental Service, recognising the continued challenge of managing demand. The Committee discussed the risk of caseload growth potentially overwhelming the service again and acknowledged the need for further work to ensure a sustainable approach.

Resolved:

The Board noted the Chair's Highlight Report from the meeting held on the 22.4.26 and the approved minutes from the meeting held on the 25.3.26.

26/27/61 Growth and Opportunities Committee

The approved minutes from the meeting held on the 26.2.26 were submitted to the Board for information and assurance purposes.

During April's meeting the Committee reflected on the artificial intelligence (AI) learning from the recent international visit to Toronto, and the success of the innovation conference which marked 10 years of innovation at Alder Hey. It was reported that the event was well attended and generated positive feedback, celebrating the Trust's leadership in innovation and collaboration across health, academia and industry.

The Committee also received an update on health equity activities in research, including small grant funding linked to the Trust's recent Marmot accreditation, and considered a paper on research and innovation financial sustainability.

Resolved:

The Board noted the Chair's update from the meeting held on the 30.4.26 and the approved minutes from the meeting held on the 26.2.26.

26/27/62 Strategic People Update

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

- *Thriving Culture:* The Staff Advice and Liaison Service (SALS) continue to provide an invaluable service to staff in the organisation. Available data demonstrates a continued rise in contacts from teams in the Community and Surgery Division directly affected by the ongoing impact of the Southport Inquiry, and many more individuals who feel impacted as a result of witnessing and observing outcomes. SALS have also supported staff following the death of a colleague.
- *Organisational Change:* SALS have sign posted staff impacted by the recent changes, to HR who have offered support.
- *Liverpool City Region Anti Racism Strategy:* Alder Hey has played an active role in the development of the Liverpool City Region (LCR) Anti-Racism Strategy through engagement with the LCR Race Equality Hub. This work aligns directly with delivery of the Trust's EDI Improvement Plan, particularly commitments relating to anti-racism, inclusive leadership, system partnership working and tackling inequalities in experience, opportunities and outcomes.
- A celebration event was held in May to mark the successful delivery of the Mutual Mentoring Programme. The event provided a positive milestone to recognise the success and impact of a highly valued programme that has contributed to inclusive leadership, culture change and staff development.

Attention was drawn to Alder Hey's 'Day of Inclusion' event on 28.5.26, and Board members were asked to ensure the date was in their diaries.

The Board expressed concern regarding personal development review (PDR) completion rates and emphasised the need for clear expectations, accountability and timely completion. It was agreed that further work is required to strengthen compliance and address the cultural expectations associated with PDRs, with consideration given to additional reporting and escalation.

Resolved:

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

26/27/63 Statement of Going Concern for the 2025/26 Annual Accounts

The Board received and considered the Statement of Going Concern for the 2025/26 Annual Accounts, as recommended by the Audit and Risk Committee.

A review of the Trust's going concern status has been undertaken in the preparation of the 2025/26 accounts. It was reported that Trust Directors have a reasonable expectation that Alder Hey Children's NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements.

The Board was advised that cash and liquidity have been a key consideration within the going concern assessment. It was explained that, while the Trust remains satisfied that it is appropriate to prepare the accounts on a going concern basis, cash management will require continued close oversight. Liquidity is a critical dependency, and it was confirmed that a specific risk relating to cash and liquidity will be included on the risk register to ensure enhanced visibility, monitoring and assurance.

Resolved:

The Board confirmed its support that the 2025/26 annual accounts and associated financial statements should be prepared on a going concern basis and considers it appropriate for the Trust to prepare its 2025/26 financial statements on this basis.

26/27/64 Audit and Risk Committee

The approved minutes from the meeting held on the 12.2.26 were submitted to the Board for information and assurance purposes.

Attention was drawn to the 2026/27 Internal Audit Plan (*Appendix 2 in the Chair's Highlight Report*). It was reported that the outcome of audits are shared with respective Committees in the event any issues arise and for information purposes.

The Chair of the Audit and Risk Committee emphasised the need to ensure all significant risks are captured, including commercial matters linked to system risks discussed in the private Board session. It was suggested that further work be undertaken to ensure that such risks are consistently reflected within the risk register for completeness and alignment of risk reporting to the Board.

26.27.64.1 Action: ES

Resolved:

The Board noted the Chair's Highlight Report from the meeting held on the 16.4.26 and the approved minutes from the meeting held on the 12.2.26.

26/27/65 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 25.3.26 that were submitted to the Board for information and assurance purposes.

During April's meeting the Committee debated the top 5 areas of risk, workforce numbers, the related £ and the timing required to close the gap and achieve the CIP target.

Resolved:

The Board noted the approved minutes from the meeting held on the 25.3.26 and the Committee's top key risks in M12.

26/27/66 Risk Appetite and Tolerance

The Board received a report on the outcome of the Risk Appetite and Tolerances Annual Review and an update on the current position in relation to the Risk Appetite and Risk Tolerance work within the organisation.

It was reported that a discussion took place during the Assurance Committee Chairs' meeting with Executive Leads about whether the Trust should (A) relax its approved Risk Appetite and Tolerances to better reflect prevailing operational pressures or (B) retain the approved Risk Appetite and Tolerances and instead require clear justification, recording of mitigating actions and time-bound review for any decisions resulting in deviation. It was confirmed that the group agreed upon option B to ensure continuity across the Trust.

It was pointed out that there are practical challenges where risks span more than one category and are subject to different risk appetites, which has the potential to slow decision-making. It was also noted that, as the environment is changing rapidly, Risk Appetite and Tolerance must continue to be tested to avoid misalignment and the emergence of new risks. Attention was drawn to the importance of revisiting this on a regular basis.

Following discussion, The Board approved the proposed approach to setting Risk Appetite and Tolerance levels, confirming that these should remain stable and not be adjusted in response to short-term external pressures. It was agreed that, where necessary, the Trust should instead make explicit, well-documented decisions if it chose to operate outside its agreed risk appetite, rather than altering the appetite itself. The Board approved the updated tolerances set out in Appendix A of the report, and supported the continued practical rollout and testing of the framework across the organisation. It was agreed that risk appetite and tolerances would be kept under regular review, particularly in light of ongoing internal and external change, with oversight via the Audit and Risk Committee and reporting back to the Board as appropriate.

Resolved:

The Board approved:

- The proposed approach to setting Risk Appetite and Tolerance and agreed that any required deviations are clearly justified and recorded.
- The Risk Appetite and Tolerances set out in Appendix A.
- Risk Appetite and Tolerance is to be reviewed on a quarterly basis.

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.

- It was reported that colleagues have carefully considered the risks they own, which remain highly fluid at the present time.

- The BAF will continue to be reviewed regularly, including consideration of whether risk scores remain appropriate in light of the evolving internal and external context, to ensure the Board maintains effective oversight and assurance.
- Attention was drawn to the alignment between strategic objectives and the articulation of key risks, particularly in respect to the culture element of the People risk.

The Board challenged the RAG rating of the People risk and questioned whether it remained appropriate in light of organisational change and external pressures. It was noted that the current score reflects the significant mitigations already in place, although external factors, such as the cost of living, are more difficult to capture. While the risk remains high, the work undertaken has reduced its likelihood. The cultural aspect of the People risk will continue to be kept under close review, with further discussion at Board and Committee level to ensure it remains accurately described and appropriately managed.

For noting

A suggestion was made about broadening the 'inclusion' element of BAF risk 2.3 to include Alder Hey's patient population.

Resolved:

The Board noted the contents of the Board Assurance Framework Report for March 2026.

26/27/67 Any Other Business

There was none to discuss.

26/27/68 Review of the Meeting

The Chair reflected on the meeting as a whole, noting the breadth and volume of the information considered and acknowledging the significant work undertaken by the Executive Team and the Divisions during a period of sustained organisational pressure and change.

A concern was raised about the balance between public and private Board sessions, observing that, at times, substantive discussion and challenge have already taken place in private or via Assurance Committees, which risked the public Board becoming overly procedural. The Chair also commented on the presentation of Divisional performance data, noting that repetition of information previously considered via other routes could limit meaningful discussion during the public element of the Board. The Chair welcomed the suggestions made about reshaping Board conversations and supported a shift towards more forward-looking, risk-focused and strategic discussions, and the continued development of the new IPR, to create greater space for challenge and strategic debate.

The Chair thanked colleagues for their engagement and contributions throughout the meeting.

Date and Time of Next Meeting: Thursday 4.6.26, 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 June 2026							
8.1.26	25/26/293.1	Mid Term Plan	Discussion to take place to determine/formalise Assurance Committee responsibility for the new national performance standards.	A. Bateman/ F. Beveridge/ E. Saunders	Apr-26	May-26	
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	On track May-26	
Actions for July 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	Jun-26	
6.11.25	25/26/223.1	Alder Hey in the Park Campus Development Update	Strategic planning session to be scheduled in the new financial year to explore future development opportunities for the Campus.	D. Powell	Apr-26	Jun-26	
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	On track July-26	

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

Date	Ref	Item	Action	By whom?	By when?	Status	Update
7.5.26	26/27/64.1	Audit and Risk Committee	<i>Risks</i> - Ensure all significant risks are captured, including commercial matters linked to system risks discussed in the private Board session. Undertake further work to ensure that such risks are consistently reflected within the risk register for completeness and alignment of risk reporting to the Board.	E. Saunders	Jul-26	On track July-26	
Status							
Overdue							
On Track							
Closed							

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

Date	Ref	Item	Action	By whom?	By when?	Status	Update
2.4.26	26/27/17.1	Neighbourhood Health Framework	Undertake a deep dive into the Neighbourhood Health Framework during June's Strategy Board to look at the implications for the Trust, particularly the organisation's Community and Mental Health services.	Board	4.6.26	Closed	3.6.26 – This action is being addressed during June's Strategy Board session. ACTION CLOSED
2.4.26	26/27/24.1	Mortality Report, Q3	<i>Potential Data Issue on the Reporting of Deaths</i> - Review the sign-off process and conduct a retrospective evaluation.	K. Warriner/ J. Grice	7.5.26	Closed	3.6.26 – This action has been addressed. ACTION CLOSED
Status							
Overdue							
On Track							
Closed							

To: Dame Jo Williams (Chair)
John Grinnell (Chief Executive)
Alder Hey Children's NHS
Foundation Trust

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

cc. Dr Liz Bishop
Interim Chief Executive
NHS Cheshire and Merseyside ICB

27 May 2026

Louise Shepherd CBE
North West Regional Director
NHS England

Dear Jo and John,

Application for advanced foundation trust status

We are pleased to inform you that NHS England has reviewed your trust's application to become an advanced foundation trust and is satisfied that it meets the relevant criteria set out in the [Advanced Foundation Trust Programme - Guide for Applicants](#) (version published for consultation on 12 November 2025).

Alder Hey Children's NHS Foundation Trust is therefore approved as an advanced foundation trust and as of 1 June 2026, you will be able to exercise the freedoms and flexibilities set out in the Advanced Foundation Trust Programme Policy Framework, which will be published separately.

As set out in the Guide for Applicants, we remind you that advanced foundation trust status will not be static, with the possibility of removal where standards and, critically, provider capability drops in the future. The advanced foundation trust designation is also subject to review every 5 years, to help incentivise continuous improvement, or earlier if triggered by a material and ongoing deterioration in delivery and/or capability.

Advanced foundation trusts will be subject to a rules-based, capability-focused oversight approach which will provide greater operational autonomy for trust boards with less central

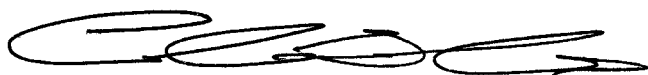
oversight. Advanced foundation trusts will also have greater financial flexibilities to use their surpluses to support revenue or capital spending, subject to the arrangements set out in the Advanced Foundation Trust Policy Framework and any supporting guidance. In return for these freedoms, we expect an open and transparent relationship, with advanced foundation trusts informing the centre of any material concerns on a 'no surprises' basis and unless there are serious concerns requiring immediate attention, advanced foundation trusts will have more time to address operational issues.

We expect advanced foundation trusts to demonstrate how they are using their freedoms to deliver improved care, be local leaders and actively drive the three shifts – prevention, digital and community-based care. This will inform the oversight relationship.

As mentioned in the application kick-off meeting, we welcome the opportunity to carry out a two-way feedback session to seek your views on the advanced foundation trust process itself and for the team to provide further details on improvement areas identified during the course of our review. A member of the assessment team will contact you soon to arrange a time to discuss feedback from the review.

Finally, I would like to recognise the significant commitment and professionalism shown by you and your team throughout the assessment process. Congratulations on achieving advanced foundation trust status. I look forward to seeing how you use the freedoms this confers to lead innovation, strengthen outcomes and deliver lasting improvements in population health for the communities you serve.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Glen Burley', with a stylized, flowing script.

Glen Burley

Deputy Chief Executive,
NHS England

Guidance on advanced foundation trust financial flexibilities

The financial flexibilities for advanced foundation trusts provide the opportunity for advanced foundation trusts to access any surplus in their aggregate position from 2024/25 onwards to support capital or non-recurrent revenue expenditure in future years.

For the purposes of the advanced foundation trust financial flexibilities, we use the term aggregate position to refer to the net value of the trust's adjusted revenue outturn position in 2024/25 and each subsequent financial year. The amount available for use in 2026/27 as part of the advanced foundation trust capital or revenue financial flexibilities will be adjusted for any utilisation of the existing capital flexibilities for high-performing trusts in 2025/26.

The revenue financial flexibility should be used to support transformation or revenue costs associated with capital. Use of the revenue and capital flexibilities must be funded from the trust's cash reserves.

For 2026/27, the process for agreeing any use of the financial flexibilities comprises a board assurance statement and an update to in-year financial reporting, which we have summarised below.

Board assurance statement

The Board should formally agree the planned additional capital or revenue expenditure. Where additional revenue expenditure is planned, the Board assurance statement should certify that any revenue spend is non-recurrent, relates to the revenue costs associated with capital or supports transformation, aligns to locally agreed priorities and that the trust expects to continue to maintain balance in their aggregate position since 2024/25. The Chief Executive of the trust should share the agreed assurance statement to the NHS England Regional Director of Finance (RDoF).

In-year financial reporting

Once the board assurance statement has been agreed and shared with the RDoF, trusts should report planned and actual capital/revenue spend against the financial flexibilities through in-year reporting returns.

Capital returns will require trusts to report planned and actual capital spend during the year, for the schemes supported by this flexibility, but will not require a capital plan reforecast for utilisation of the flexibility. Revenue returns will require a plan re-forecast during 2026/27 to identify the new plan position inclusive of the additional non-recurrent revenue expenditure supported by the flexibility. The delivery of the updated plan position will not trigger the financial override in the NHS Oversight Framework, where it does not exceed the surplus in the aggregate position since 2024/25.

We expect that advanced foundation trusts will be able to include any use of financial flexibilities in future years (2027/28 onwards) as part of the planning process.

The capital flexibilities sit alongside the wider reforms to the capital regime, specifically the previously announced increases to delegated capital approval limits as set out in the guidance [Addendum to the Capital investment and property business case approval guidance for NHS trusts and foundation trusts – capital delegated limits and capital approvals](#).

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Health Bill 2026 - Board Briefing
Report of:	Erica Saunders, 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	Health Bill
Strategic Context This paper links to the following:	Outstanding care and experience ☒ Collaborate for children & young people ☒ Revolutionise care ☒ Support our people ☒ Pioneering breakthroughs ☒
Resource Implications:	N/A.

Does this relate to a risk? Yes ☒ No ☐

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

Risk number	Risk description	Score
	The new Health Bill 2026 will span numerous risks across the register.	

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

To provide an overview of the proposed Health Bill (2026) and highlight the key reforms, strategic implications, principal risks, and recommended Board actions.

2. Executive Summary

The Bill represents a significant structural reform of the NHS in England, centred on:

- Abolition of NHS England
- Re-centralisation of control to the Secretary of State
- Strengthening of Integrated Care Boards (ICBs)
- Expanded regulatory, financial and data oversight

The reforms will materially affect governance arrangements, commissioning responsibilities, and organisational accountability across the system.

3. Key Reforms

System Architecture and Governance

- Abolition of NHS England, with transfer of functions to the Secretary of State, ICBs, and providers.
- Increased direct ministerial oversight, including powers to direct ICBs and intervene in failing organisations.
- Removal of Foundation Trust Council of Governors, consolidating governance within Boards.

Integrated Care Boards (ICBs)

- Expanded responsibilities, including commissioning of primary care services.
- Introduction of formal performance assessment and strengthened accountability.
- New requirements for joint planning with local authorities, including “neighbourhood health plans”.

Commissioning and Service Delivery

- Greater centralisation of commissioning powers, with the Secretary of State holding direct commissioning capability.
- Enhanced patient choice and involvement duties, with formal appeals processes.

Financial and Regulatory Oversight

- Strengthened financial controls across trusts and ICBs, including the ability to cap expenditure.
- Alignment of audit and accountability frameworks across NHS organisations.
- Expanded role for regulators, including consolidation of safety investigation functions into CQC.

Data and Digital

- Introduction of a single patient record across health and social care.
- Mandatory data sharing with strengthened compliance and enforcement requirements.

Public and Stakeholder Voice

- Abolition of Healthwatch England and Local Healthwatch.
- Responsibility for patient and public involvement moves to ICBs and local authorities.

4. Implications for the Trust

Governance

- Increased central oversight and intervention risk.
- Requirement to review committee structures, assurance processes and statutory compliance.

System Working

- Greater reliance on ICBs as system leaders, requiring strengthened partnership working.
- Transition to neighbourhood-level planning will change local engagement models.

Operational Impact

- Significant transition activity linked to redistribution of responsibilities.
- Increased expectations around performance management, reporting, and compliance

Digital and Data

- Need for readiness for integrated patient record systems and enhanced data-sharing requirements.

5. Conclusion

The Health Bill introduces fundamental changes to the NHS operating model, with a clear shift towards centralised accountability and strengthened system leadership through ICBs. Early Board oversight and preparation will be essential to ensure organisational readiness and maintain assurance during transition. The full report can be found [HERE](#)

6. Suggested areas of activity in the coming year – subject to progress through Parliament

- ❖ Commission a full impact and gap analysis across governance, commissioning and compliance.
- ❖ Strengthen risk management and assurance frameworks, aligned to the new regulatory environment.
- ❖ Oversee transition planning, including workforce, contracts, and system relationships.
- ❖ Review governance and committee structures to ensure readiness for new accountabilities.
- ❖ Engage proactively with system partners (ICB and local authorities) on emerging arrangements.
- ❖ Assess digital and data readiness, particularly in relation to the single patient record.

Erica Saunders
Chief Corporate Affairs Officer

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Overall Transformation Report
Report of:	CEO: John Grinnell Chief Transformation and Digital Officer: Kate Warriner Director of Transformation and Change: Natalie Palin
Paper Prepared by:	Director of Transformation and Change: Natalie Palin

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☐
Summary / supporting information	Vision 2030 Transformation Programme 2030 Medium Term Plan
Strategic Context This paper links to the following:	Outstanding care and experience ☒ Collaborate for children & young people ☐ Revolutionise care ☐ Support our people ☐ Pioneering breakthroughs ☐ Strong Foundations ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☒ No ☐		
If "No", is a new risk required? Yes ☐ No ☐		
Risk number	Risk description	Score
BAF 401	Failure to mobilise Vision 2030	16
BAF 402	Failure to meet financial targets	

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

This paper provides Trust Board with a strategic update on the Transformation Programme, covering overall delivery progress, benefits realisation, financial significance and the main risks affecting delivery confidence. The programme has moved into delivery, with governance, oversight and delivery cadence continuing to strengthen. As a multi-year portfolio, programmes remain at different stages of maturity, with progress most evident in HWWWITF, Revolutionising Care and Digital, Data, AI & Advancement.

The wider portfolio also includes the CYP System and Financial Sustainability. This report focuses primarily on the Trust's three main transformation priorities:

- **HWWWITF:** operating model redesign
- **Revolutionising Care:** including outpatient transformation, neighbourhood care and urgent care
- **Digital, Data, AI and Advancement** – productivity and experience

Together, these programmes aim to improve access and flow, redesign pathways around value and clinical need, increase productivity, expand digitally enabled care and support a more clinically led and financially sustainable organisation.

The programme is intended to deliver wider organisational benefits, but the Trust continues to face significant financial pressure. Many of the largest remaining opportunities sit within the emerging HWWWITF Phase 2 redesign agenda, much of which is not yet fully scoped or mature.

The main assurance challenge is no longer mobilisation, but ensuring capacity is focused on the highest-value redesign opportunities most likely to deliver measurable operational and recurrent financial benefit. Delivery discipline and organisational grip have improved, but the programme cannot yet consistently show that activity is translating into impact at the pace and scale required.

The overall assurance position is assessed as: **Moderate (Improving)**

Recommended: Maintain focus on the highest-value changes, strengthen operational ownership and benefits realisation, and continue embedding more integrated assurance so the organisation remains focused on the right changes, at the right pace and with sufficient capacity to realise measurable benefit.

2. Overall Transformation Portfolio Position

The Transformation Programme is now a multi-year portfolio covering organisational redesign, service transformation, workforce redesign, digital enablement, pathway optimisation and financial recovery.

Governance and oversight have strengthened, with the Transformation Board now operating routinely, milestone planning improving, a four-week delivery cadence in place and FIP increasingly serving as the single route for financial validation and assurance.

However, the portfolio still faces significant pressure from programme interdependencies, workforce redesign complexity and the scale of recurrent financial improvement required. The table below provides a high-level summary of the main organisational outcomes being pursued across the portfolio, the programmes contributing to them and the benefits and early indicators of progress now emerging.

Table 1: Strategic Outcomes and Emerging Benefits

Strategic Outcome Theme	Primary Contributing Programmes	Intended Organisational Outcome	Emerging Benefits
Right Care, Right Time, Right Place, First Time	Revolutionising Care – (Outpatients, Urgent Care, Neighbourhood), CYP System, Digital, Data, AI and Advancement	Children, young people and families receive more timely, connected and personalised care with improved access, reduced waits and better experience	- Advice & Guidance expanded across 17 specialties, - Non-Admitted RTT improved from 73.1% to 74.7%, - Over 45,000 Patient Portal registrations, increasing use of digital access models and outpatient redesign activity underway
Thriving People, Delivering Sustainable Services	HWWWITF, Workforce Redesign, Digital, Data, AI and Advancement	The organisation operates through clearer accountability, improved workforce productivity, clinically led redesign and more sustainable ways of working	- New operating model implemented across key areas, leadership and governance redesign progressed, - Material pay-related savings from vacancies, voluntary redundancy and redesign 1,200 active Lyrebird users and increasing automation of clinical administration
Delivering Sustainable Services	FIP, HWWWITF, Outpatient Productivity, Digital, Data, AI.	Transformation and transactional schemes activity delivers recurrent and sustainable financial improvement which supports delivery of Vision 2030 and protects future investment in services	- FIP increasingly operating as the single route for benefits validation, - Significant progress throughout May on identification of CIP schemes with the in-year gap of unidentified schemes now reduced to £699k (3%), however this includes identification of some high risk and early-stage ideas which are currently included in red.

The remainder of this report focuses on the three priority areas currently most critical to delivery confidence, benefits realisation and overall assurance.

4. Strategic Transformation Priorities

4.1 HWWWITF Phase 1

Aim: HWWWITF Phase 1 is focused on establishing the organisational, leadership and operating model foundations required to support delivery of Vision 2030. The programme is intended to create a more clinically led, empowered and connected organisation, with structural changes that support clearer accountability, improved decision-making and more sustainable ways of working.

Progress to Date: The programme remains on track to complete the planned structural changes by September 2026, with organisational redesign and governance alignment progressing as planned. Phase 1 is also beginning to evidence financial benefit delivery, including material pay-related savings within the wider CIP position.

Key Issues and Risks: Whilst Phase 1 is progressing, Programme Board discussions recognised that many of the Trust's largest remaining operational and financial opportunities now sit within the emerging HWWWITF Phase 2 clinical redesign agenda, which currently carries an indicative £4m

target but has not yet been fully scoped, sequenced or developed to sufficient maturity. The key risk is therefore not Phase 1 delivery itself, but the pace at which the organisation can convert emerging Phase 2 redesign into a clinically owned, prioritised and deliverable programme.

Table 2: HWWWITF Critical Milestones

Milestone	Key Step	Purpose
June	- Final service placement decisions following consultation - Approve the next phase approach—beginning with job planning, with services progressing into structured improvement only where needed, and delivery owned at service level.	Confirm the operating model and group structure Sustainable services – meeting CYPF needs
End of June	Commence all remaining structural organisational change processes	Maintain pace and delivery discipline across the programme
September	Planned completion of the remaining organisational change processes	Move from design into implementation

Next Steps: The immediate priority is to complete the remaining structural changes to plan, sustain delivery pace and strengthen the definition, sequencing and operational ownership of the emerging Phase 2 redesign agenda. Taken together, the milestones above show that Phase 1 is moving from structural redesign into implementation, with the next phase requiring sharper prioritisation and clinically led delivery if the wider operational and financial opportunity is to be realised.

The focus on the next phase will be Taken together, the milestones above show that Phase 1 is moving from structural redesign into implementation, but the next phase now requires sharper prioritisation and clinically led delivery if the wider operational and financial opportunity is to be realised.

4.2 Revolutionising Care

Aim: Revolutionising Care brings together the collective endeavour across Outpatient Transformation, Urgent Care and Neighbourhoods to redesign how care is delivered so that children and young people receive more timely, effective and least-disruptive care, with improved access, flow and experience. Collectively, these programmes are intended to reduce variation, strengthen referral and pathway management, expand digitally enabled and alternative models of care, and create more sustainable services with clearer intended operational and financial benefit.

Progress to Date: Advice & Guidance is now live across 17 specialties, outpatient template changes have been implemented across medicine and surgery, and work is progressing on Single Point of Access, integrated referral management and AI-supported triage. The programme has also advertised for a Clinical Lead for Outpatients to ensure this work is clinically led, and Alder Hey has been included in the Cheshire & Merseyside bid for a Referral Management System.

Key Issues and Risks: The main issues now relate to limited clinical capacity, overlapping change activity and uneven maturity across the programme. There remains a need to avoid duplication between outpatient and digital workstreams, strengthen governance routines and improve operational ownership so that progress is translated more consistently into measurable access improvement, productivity gain and recurrent financial benefit.

Next Steps: The immediate priority is to focus capacity on the highest-value changes, particularly referral management, outpatient productivity and urgent care pathway redesign, while ensuring each

area has clear ownership, milestones and benefit measures. The next phase should focus on converting current activity into demonstrable operational and financial improvement, maintaining alignment with digital enablers and neighbourhood care developments.

Table 3: Revolutionising Care Key Milestones and Current Status

Key Milestone / Deliverable	Current Status	Why it Matters
Clinical Lead for Outpatients	Advertised	Ensures outpatient redesign is clinically led
Referral Management System	Included in the Cheshire & Merseyside bid	Supports stronger referral management and reduced variation
Advice & Guidance	Live across 17 specialties	Demonstrates pathway redesign at scale
Single Point of Access, integrated referral management and AI-supported triage	In progress	Critical to future pathway redesign and conversion into measurable benefit

4.3 Digital, Data, AI & Advancement

Aim: Digital, Data, AI & Advancement aims to use digital, data, automation and AI to improve productivity, experience and clinical workflow, while supporting more sustainable models of care and ways of working across the Trust.

Progress to Date: The programme continues to show the strongest evidence of active delivery and adoption across the portfolio. Current progress includes more than 1,200 active Lyrebird users, over 45,000 Patient Portal registrations, AI-enabled workflow redesign, data platform development and wider digital infrastructure improvements, including AlderCare 2.2.

Key Issues and Risks: The main challenge now is to convert technology deployment and adoption into measurable productivity improvement, workforce efficiency and recurrent operational benefit. This requires stronger operational ownership, consistent workforce adoption and clearer alignment between digital delivery and wider service redesign.

Next Steps: The immediate priority is to strengthen the conversion of digital adoption into demonstrable operational and financial benefit while maintaining pace on core delivery milestones. This includes embedding AVT and Patient Portal more consistently, progressing the data platform and wider AI-enabled workflow redesign, and ensuring digital remains an enabler of service transformation rather than a standalone programme.

5. Current Assurance Concerns

Despite improvement in governance, cadence and oversight, several material assurance concerns remain. The current assurance position is based on programme reporting, milestone delivery, governance review and FIP financial validation where available. The main assurance gap is no longer mobilisation, but the organisation's ability to convert delivery activity into measurable operational impact and validated recurrent benefit.

This risk is most acute where the remaining opportunity depends on emerging redesign work, particularly within HWWWITF Phase 2 and other clinically led transformation areas that are not yet

fully scoped or sequenced. Organisational capacity, programme interdependency and change saturation continue to create risk to pace, execution and delivery confidence.

The organisation also does not yet have a fully embedded single version of truth across milestones, risks, benefits and delivery reporting. Taken together, these factors continue to support the current overall assurance position of Moderate (Improving).

6. Financial Improvement Programme

Current programme reporting provides a clearer view of financial opportunities and validated savings routed through FIP governance. However, a material assurance gap remains between identified opportunities, validated deliverable savings and recurrent benefits realised in-year, particularly where larger clinical transformation opportunities remain at an earlier stage of maturity.

The key assurance issue is therefore no longer simply identifying opportunities, but ensuring benefits are robust, deliverable, recurrent, operationally achievable and not duplicated across programmes.

7. Immediate Priorities for the Next Phase

The immediate focus for the next phase is to close the gap between transformation activity and measurable operational and financial impact. This next phase now needs to prioritise three things: sharper focus on the highest-value redesign opportunities, stronger delivery conversion through clearer ownership and cadence, and more integrated assurance through the Transformation Scorecard.

In practice, this means tightening prioritisation and sequencing across the portfolio so the organisation remains focused on the right changes, at the right pace and with sufficient capacity to realise measurable benefit. It also requires clearer operational ownership of delivery and benefits, with each programme led by a named SRO and particular focus on areas where the remaining opportunity depends on emerging HWWWITF Phase 2 redesign.

Alongside this, the next phase should focus on embedding the Transformation Scorecard as the route to a more integrated view of milestones, risks, benefits and outcomes, with supporting detail provided in the appendix. Schemes will also be subject to semi-independent assurance next month to provide a more robust assessment of deliverability, benefits maturity and residual risk.

8. Recommendations

Trust Board is invited to:

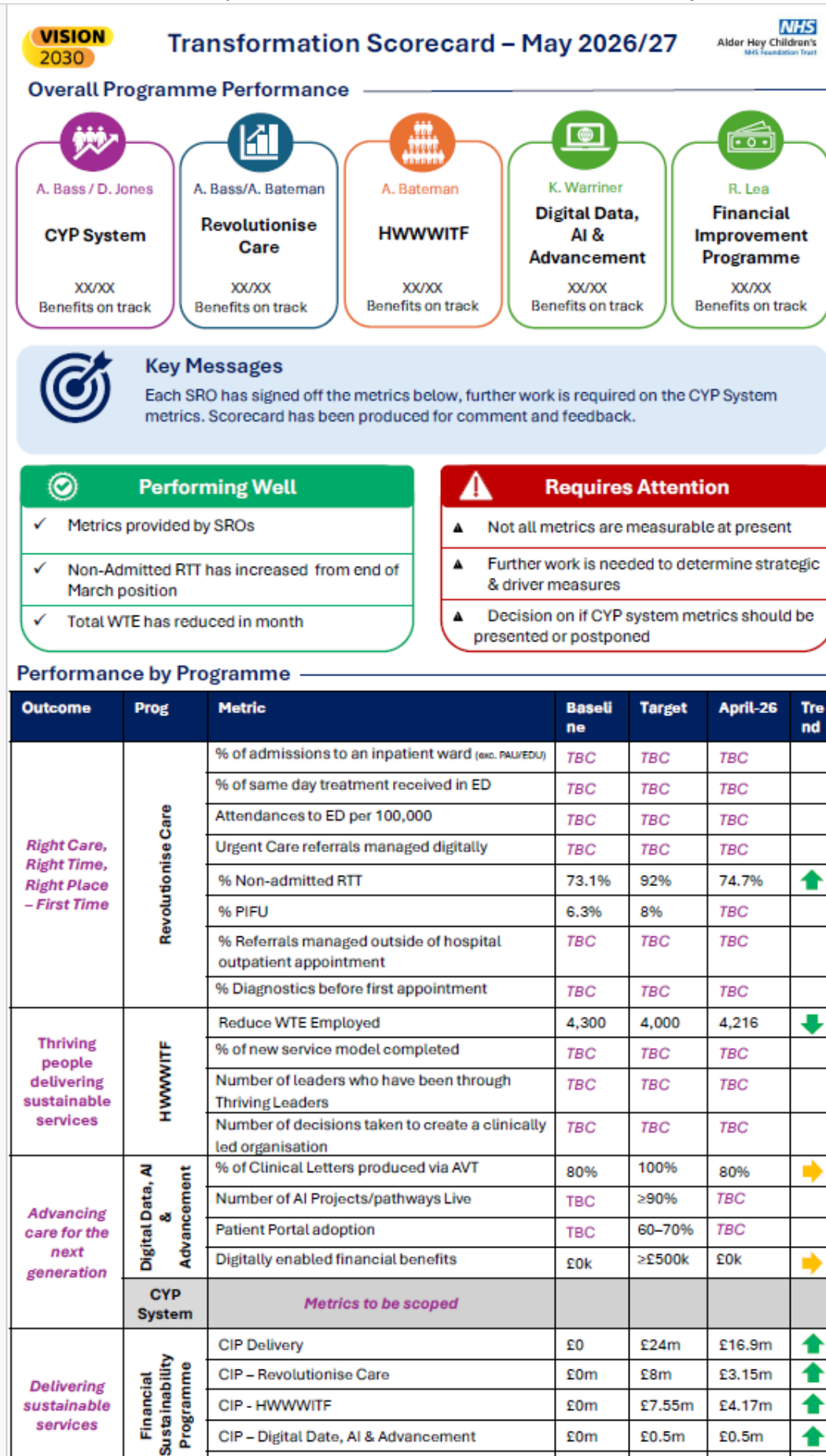
1. Note the current overall assurance position as **Moderate (Improving)**.
2. Note the progress made across the Trust's three main transformation priorities and the wider programme.
3. Note the key risks affecting delivery confidence, including the maturity of the emerging HWWWITF Phase 2 redesign agenda and the challenge of converting activity into validated recurrent benefit.
4. Support the continued focus on sharper prioritisation, clearer ownership and strengthened assurance as the programme moves further into implementation.
5. Note the appendices as supporting detail on the Transformation Scorecard and high-level milestone delivery plan.

Appendices

Appendix 1: Transformation Scorecard / Driver Measures

Appendix 2: High-Level Transformation Milestone Delivery Plan

This will be in-development and will be added to the IPR from July 26



BOARD OF DIRECTORS

Thursday, 4th June 2026

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

Purpose of Paper:	Decision ☐ Assurance ☒ 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 ☒
Resource Implications:	N/A

Does this relate to a risk? Yes ☒ No ☐					
If "No", is a new risk required? Yes ☐ No ☒					
Risk Number	Risk Description				Score
4.2	Digital and Data Strategic Development & Delivery				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	☒ 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		

Digital, Data and AI Update

1. Executive Summary

The purpose of this report is to provide the Board of Directors with an update on progress on Digital, Data and Artificial Intelligence (AI). It reports on the overall service, key areas of transformation and operational performance.

There has been significant progress made over this reporting period with implementation of digital change programmes supporting Vision 2030 ambitions as part of the digital, data and AI transformation collaborative.

AH has had significant AI external presence strategically across the local system, city region, nationally and internationally.

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

2. National and Regional Updates

2.1 Digital Skills Development Network – Stage 3 Accreditation

Alder Hey's Digital and Transformation service has achieved Digital Skills Development (DSD) Level 3 accreditation, demonstrating a strong, embedded culture of digital capability, leadership, and continuous development.

The assessment highlighted clear executive leadership at Board level, a highly engaged CXIO model linking digital with clinical and operational teams, and a consistent focus on children and young people across digital delivery.

The Trust was also recognised for its open, inclusive leadership culture, strong staff engagement, and commitment to wellbeing and development. Clinical safety was identified as a particular strength, with robust leadership embedded across digital change.

Collectively, this reflects a mature, sustainable approach to digital capability, directly supporting the Trust's Vision 2030 and transformation ambitions.

2.2 Cheshire and Merseyside ICB Digital, Data and AI Update

Collaborative work continues across Cheshire & Merseyside Integrated Care Board (ICB) in relation to digital, data and AI, with an established programme of work and governance in place. Chief Information Officers (CIOs) continue to meet weekly to drive the system agenda forward, with a focus on identifying opportunities to collaborate at scale. Ambient Voice Technology (AVT) programme stands out as a strong example of a system-wide initiative that is progressing well across the region.

In parallel, a reset of the system strategy and digital, data and AI blueprint remains underway, aligned to NHS England direction of travel.

2.3 Liverpool City Region AI Developments

In May, Alder Hey hosted the Liverpool City Region (LCR) team, showcasing progress across Ambient Voice Technology (AVT), the Patient Portal, and the wider AI agenda,

alongside broader digital and innovation work. This has strengthened links and highlighted opportunities for future collaboration.

Work will continue over the coming months, with plans for Alder Hey to visit LCR to further explore partnership opportunities aligned to the 'AI for Good' agenda, which focuses on health, education and transport.

2.4 International Developments – Sick Kids Hospital Toronto Partnership

Following the visit to SickKids in Toronto earlier this year, partnership discussions have continued to progress, with a shared focus on innovation and digital transformation. Alder Hey is now exploring the potential use of Hero AI, a solution currently used in Emergency Departments to provide real-time visibility of a patient's journey.

Engagement between both organisations remains active, with an initial kick-off meeting scheduled shortly to further explore opportunities for collaboration and potential deployment within Alder Hey.

3. Vision 2030 – Digital, Data and AI

3.1 Optimising Digital Systems

The MEDITECH Expanse 2.2 upgrade programme has progressed through its technical phase. The hosting environment is now confirmed, with infrastructure delivery now completed. Governance arrangements will commence this month, with a Senior Responsible Owner now appointed and programme mobilisation underway, including a kick-off meeting held last week. The upgraded test system is expected to be available in July.

Alder Hey has successfully transitioned to the Cheshire and Merseyside Picture Archive Communication System (PACS) solution. Updated workflows and system enhancements went live on 10 March, improving image availability, performance and integration with clinical systems. These changes support improved diagnostic access and a more resilient imaging infrastructure.

3.2 Outstanding Care, Experience and Safety

The Theatres Paediatric Early Warning Score (PEWS) digital solution went live in mid-March, providing standardised, PEWS recording. This implementation strengthens compliance with national PEWS standards, reduces reliance on manual prompts and supports safer practice within complex theatre environments. Early feedback indicates improved clarity and consistency for theatre recovery teams. Work is being expedited to stabilise the integration on the Phillips Observation monitors across certain wards.

3.3 Broadening Virtual Care – Blinx Collaboration

Significant progress has been made in delivering a digital-first patient communication and engagement platform through the Patient Portal. The system was launched in April, supporting appointments and clinic letters, with over 45,000 families registered, demonstrating strong adoption. Work is ongoing to resolve outstanding issues ahead of formal closure of Phase 1 in June.

Planning is underway for future phases, including proxy access, mood diaries, direct messaging, and the sharing of test results, with delivery expected over the next 6 - 12 months.

3.4 Advancing AI

Lyrebird Ambient Voice Technology (AVT) is now live across outpatient clinics, with all specialties expected to be live over the next week, completing rollout across the Trust. Over 1324 clinicians are onboarded, significantly streamlining documentation workflows. Focus is now shifting to future phases, including use of AVT in theatres for operative notes, Multi-Disciplinary Teams for clinical scribing, and ED for real-time documentation.

Initial trials are underway in these areas, alongside work to firm up benefits, including supporting achievement of the ED 4-hour standard and improving overall experience for both staff and children and young people.

Further work is being scoped to accelerate the use and adoption of AI solutions across Alder Hey, supported by trust-wide clinical leadership capacity, dedicated resource and appropriate governance arrangements. This will create a clear route for colleagues to bring forward AI ideas, which can be assessed, developed and progressed from concept into safe, operational solutions embedded into core practice.

In parallel, a dedicated Radiology AI programme is being established as a priority area, providing a focused framework to explore, test and deploy AI solutions within Radiology, aligned to the overarching Trust governance and assurance model.

3.5 Data Driven Care

Updates from the Data Platform Board confirm continued progress in strengthening the Trust's reporting and analytics capability, with delivery aimed for completion over the summer. Rebuild of priority dashboards and statutory returns is progressing in line with clinical and operational priorities, with a clear focus on rationalisation and consolidation to ensure only decision-critical reporting is migrated.

Alder Hey is exploring the development of a Secure Data Environment (SDE) to support safe, compliant use of data for analytics, research and innovation. The Trust is seeking to bring in dedicated specialist resource, aligned to the POIZ programme, to shape the approach and support delivery. This includes developing a clear strategy for how Alder Hey connects with regional and national SDEs, and establishing the appropriate governance, controls and assurance arrangements to ensure data is managed securely, ethically and in line with national standards.

4. Digital Centre of Excellence and Performance

4.1 Digital Technology

The regional Private Cloud Datacentre Refresh has experienced delays due to technical issues, which are currently being reviewed in collaboration with the supplier. A revised plan is in place, with completion now targeted for June.

The Meditech Data Centre refresh project has now been completed. The Trust successfully migrated servers to the new environment following a revised migration on 17

April, which had been rescheduled due to NHS industrial action on 9 April. The project is now formally closed.

The Trust is progressing with the upgrade to Multitone Nucleus, the new cloud-based bleep platform designed to provide a far more stable, secure and resilient service than the current system. The project is in the stages of finalising the migration plan and it is expected that the project will be live at the end of June

4.2 Cyber Security

Cyber monitoring continues to provide strong assurance across systems, with robust investigation processes in place. Any high-priority alerts are promptly reviewed and resolved within agreed timeframes. Compliance with High Severity Alerts remains strong, alongside continued adherence to medium-level alerts issued by the NHS England Cyber Security Operations Centre.

A new Cyber Security Group was established in April, chaired by a Non-Executive Director and reporting into the Finance, Transformation and Performance Committee. The inaugural meeting agreed the Terms of Reference and standard reporting pack, providing a clear structure for ongoing oversight. The group also undertook a deep dive into the recent remote access audit, with findings and actions now being progressed through the governance route to FTPC.

4.3 Operational Performance

Performance has remained broadly stable across the period October 2025 to May 2026, with a strong correlation between incidents logged and resolved. A programme of improvement initiatives has also been implemented to strengthen the digital support function, including enhancing first-line resolution and reducing SLA breaches through more structured review of overdue incidents and improved communication with users.

4.4 Information Governance

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

- DSPT 2026 is now underway, with initial audit meetings completed and the Trust on track to submit all evidence ahead of the June deadline.
- IG and cyber incidents reported in 2025/26 (184 incidents) show an 8.5% reduction compared to 2024/25.
- FOI performance in April is 92% compliant.
- Annual assurance reports for Data Protection and Freedom of Information have been received by the Audit and Risk Committee, providing oversight of progress and forward plans for 2026/27.

4.5 Access to Health & Transcription

Compliance and performance for disclosure of health records under the Data Protection Act 2018 and other legislative frameworks achieved 80.08% compliance in 26/26. A total of 2544 requests were received during the reporting period, which is comparative to 2522 requests received during the same period the year previous, however a reduction in disclosure timeframe compliance was observed. Current performance for 26/27 is at 62% which is a result of sickness and workforce challenges

The following actions are being implemented to support improved compliance and to reduce risk with current processes:

- iDigital organisational change which will enhance and consolidate leadership structure aligning Access to Health and Information Governance Teams.
- Automated data extract solution is now live which will rapidly improve turnaround times and accuracy.
- Full review of operational processes to streamline end to end procedures whilst maintaining legal compliance.

There is full confidence in the above mitigations remediating the current position in the next 3 months.

5. Risks

The Board Assurance Framework Digital risk remains at a score of 16, reflecting a combination of factors including ageing infrastructure, cyber security threats, and workforce pressures.

The service continues to actively manage operational risks through the Trust Risk Management Forum, with the most significant relating to workforce capacity and service demand. Transcription services have now stabilised into steady state, and clinical coding performance is improving through the addition of targeted resource.

Capital infrastructure programmes are progressing well, with data centre work now over 70% complete across both projects, including the successful completion of the MEDITECH element. Further work remains on the core data centre infrastructure. In addition, both the network refresh and telephony replacement have received provisional support this year, which will support further risk reduction.

Organisational change is nearing completion, and CIP delivery remains in a strong position. It is anticipated this will enable recruitment into a number of key vacant roles, strengthening overall service resilience.

Cyber risk remains heightened given the current global threat landscape and is being closely monitored. While the overall risk score remains at 16, the position will be formally reviewed this month in light of the progress made across infrastructure, workforce, and programme delivery.

6. Summary and Recommendation

In summary, progress with digital, data and AI developments and delivery at Alder Hey remain good and on track against plans. There are several challenges however mitigations are in place.

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

Flash Report May 2026

Performance is subject to change



Alder Hey Children's
NHS Foundation Trust



REVOLUTIONISE CARE



83.9%

ED: % Treated
within 4 Hours



196

Number of RTT
Patients waiting
>52 weeks



70.1%

% Patients
waiting within
18 weeks (RTT)



93.4%

Diagnostic
Performance



OUR PEOPLE



-30

Estimated
Workforce Plan



10.2%

Staff
Turnover



75.0%

% PDRs
Completed



OUTSTANDING CARE AND EXPERIENCE



1

Severe / Fatal
Incidents /
Never Events



0

Patient Safety
Incident
Investigations



90.7%

FFT - %
Recommending
Trust



4

Healthcare
associated
Infections



16

Patients
deteriorating
from an
inpatient bed



HIGHLIGHTS

- ✓ Sustained performance for time to be seen and treated in ED – 14th consecutive month 80%+.
- ✓ Improved performance for % patients waiting under 18 weeks for treatment.
- ✓ 0 Never Events or PSIs.
- ✓ Estimated Workforce below plan.



CHALLENGES

- x1 incident of severe harm; An initial review is being undertaken, and the incident is being discussed at PSIRI Panel on Thursday (4th June)
- Infections - x3 E.Coli and x1 MSSA.
- Reduction in performance of diagnostic under six weeks (pending validation).



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.



FINANCIAL SUSTAINABILITY

- I&E position (actual in month) – £1.5m deficit
- I&E Forecast – £0.7m in line with plan *(No full forecasting exercise has been completed in M2)*
- CIP (Forecast vs full year target) – £1.2m in year gap and no recurrent gap



Performance is subject to change. Data as at 31 May 2026.

**VISION
2030**

NHS

Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report



Published: May 2026



Performance: April 2026



Compassion

We see you and act



Courage

We speak up and
step forward



Commitment

We keep our promises



Community

We lift each other up



Integrated Performance Report Contents

**VISION
2030**

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

NHS

Alder Hey Children's
NHS Foundation Trust



STRATEGIC DOMAINS



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DIVISIONAL SUMMARIES



Community & Mental Health 17



Medicine 20



Surgery 23



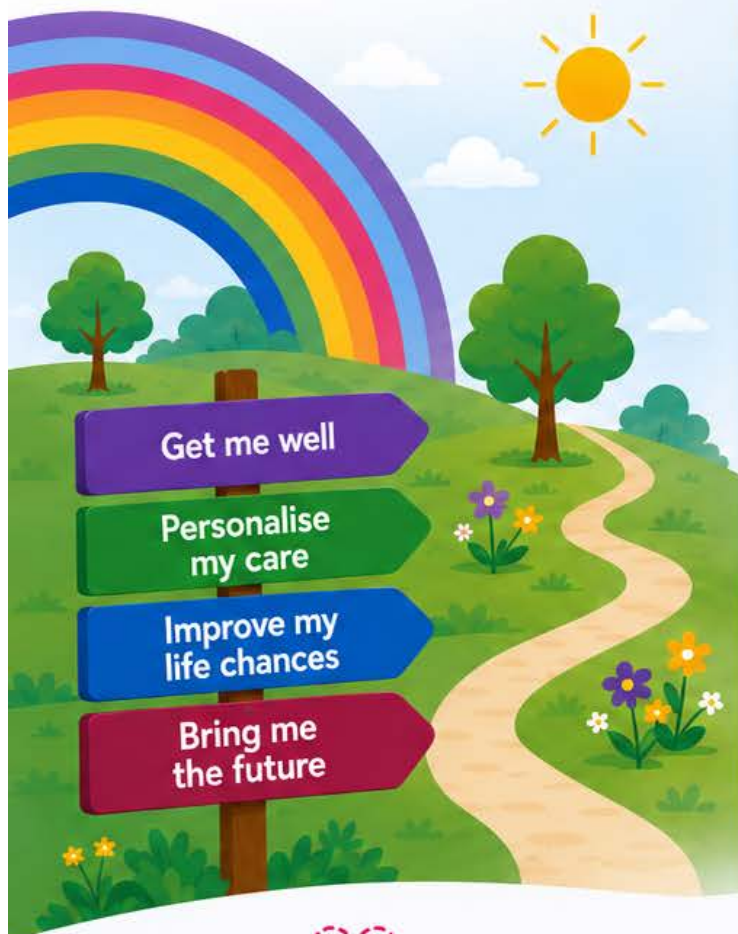
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ASSURANCE & BENCHMARKING



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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

OUTSTANDING CARE & EXPERIENCE

Performance remains strong across several key safety indicators, with 100% of inpatients requiring antibiotics for sepsis receiving them, alongside 90% compliance in ED.

There were no incidents of major harm, no cases of C. difficile, and no Category 2, 3 or 4 pressure ulcers reported. There has also been a significant reduction in unplanned admissions from HDU to PICU, indicating improvement in escalation and care management.

However, patient and family experience indicators remain challenged. Feedback on experience of services continues to fall below the 95% target, and there has been a reduction in the timeliness of responses to PALS concerns and formal complaints, with 88% responded to within 5 days and 65% within 25 working days respectively. Formal complaints have increased significantly over recent months, partly associated with a rise in AI-generated complaints.

Actions are underway to address these areas, including the launch of new cleaning products and associated training during "Clean Start" week commencing 15 June, a review of the complaints management process, and a wider review of the Experience of Care Framework. This will include exploring more diverse ways to capture patient and parent feedback, ensuring the Trust uses this intelligence to identify themes, target improvements, and strengthen overall experience of care.

Key measures

	Value	Target
 Patients deteriorating from an inpatient bed admitted to PICU	9	n/a
 Incidents per 1,000 bed days – No Harm	77	77.8
 Incidents per 1,000 bed days – Low Harm and above	17	15.2

REVOLUTIONISE CARE

Access performance in April showed several areas of improvement, particularly within urgent and emergency care, where 87.2% of patients were treated within 4 hours, an improvement from 83% in March. Acute RTT performance also remained ahead of plan, with 69% of patients waiting less than 18 weeks against a planned position of 63.8%. Community RTT performance was 70%, below the year-end plan of 78%, but remains an important area of continued focus.

There has also been sustained improvement in the number of children and young people waiting over 104 weeks for mental health support, suggesting that the processes introduced to address long waits are now embedded within the team.

There were, however, some areas of concern in April. Diagnostic access within 6 weeks reduced from 97% to 94%, largely driven by gastroscopy performance. Cancer performance also reduced, with 84% of patients receiving first treatment within 31 days of an urgent referral for suspected cancer; this is the first time this metric has fallen below 100% in at least 18 months. Data quality also requires attention, with valid ethnicity recording reducing for a second consecutive month to 83%.

Looking ahead, a recovery action plan for gastroscopy has been requested both internally and externally, with performance to be monitored against agreed recovery trajectories. Continued oversight will also be maintained on the 104-week mental health wait metric to ensure the reduction is sustained. This is not expected to remain an issue once 2025/26 data has been refreshed and submitted in May 2026.

Key measures

	Value	Target
 ED % Treated Within 4 Hours	87.2%	85%
 RTT Waiting List Within 18 Weeks	69%	63.8%

SUPPORT OUR PEOPLE

Workforce performance in April showed a mixed but broadly stable position. Total workforce was below the 2026/27 WTE plan by 29.83 WTE, although delivery of the planned workforce trajectory remains challenging.

Key workforce compliance indicators remain strong, with mandatory training compliance sustained above 90% and PDR completion for Band 7 and above remaining above the 90% target.

Recruitment performance also remains positive against the Trust's internal time-to-hire target, with offer-to-contract completed within 25 days against a 30-day standard. However, performance against the NHS England recruitment standard remains challenged, with the Trust achieving 55 days from advert to completion of pre-employment checks against the 40-day target. The 3-month rolling position of 44.3 days places Alder Hey 4th out of 13 Cheshire and Merseyside Trusts, with only two Trusts currently meeting the national 40-day standard.

Sickness absence increased slightly in April and continues to be an area of concern. This remains subject to regular monitoring, detailed reporting and targeted action, including enhanced Occupational Health training and focused support for areas with higher absence levels.

Looking ahead, maintaining workforce delivery against the 2026/27 WTE plan will remain challenging. The voluntary redundancy scheme closed on 30 April 2026, with applications now under review, and further work is progressing through the HWWWITF programme to support workforce sustainability and delivery of the required plan.

Key measures	Value	Target
 Workforce Plan (WTE)	4,215	4,245
 Staff Turnover	11.4%	10%
 Sickness Absence (Total)	5.8%	4.5%

FINANCIAL SUSTAINABILITY

The Trust reported a £0.9m deficit in April, which is in line with plan. The in-month impact of industrial action, valued at £329k, has been managed through a risk-adjusted review of accruals.

No full forecasting exercise has been completed at Month 1; however, the Trust is currently forecasting delivery of a £0.7m surplus in line with plan, subject to the delivery of CIP and the management of associated risks.

CIP delivery remains a key area of concern. The programme was £0.3m behind plan in Month 1, with £7m transacted in-year, £5.6m fully developed and in progress, £4.4m identified as opportunities, and a remaining gap of £7.6m. Recurrently, £7m has been implemented, leaving a significant recurrent gap of £17.5m. Delivery of the full £24.5m savings requirement remains challenging, with significant work continuing through the FIP and HWWWITF programmes.

Cash remains in line with plan, while capital expenditure is behind plan due to phasing and awaiting approval of NHSE strategic funding. It is recognised that the capital allocation is unlikely to be sufficient to meet all capital requirements.

Looking ahead, continued cost control will be essential to support delivery of the planned year-end position. There will need to be a sustained focus on recurrent efficiency, with divisions continuing to develop transformation schemes through FIP to identify recurrent savings and benefits for 2026/27. Cash strategy will also remain a key area of focus 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	£1.85m	£2.35m
 ERF Income (YTD)	£8.2m	£8.7m

Outstanding Care & Experience: Safe & Caring

Executive Summary

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

Highlights

- 100% of patients requiring antibiotics for sepsis received treatment within target.
- 90% of ED patients achieved sepsis treatment standards.
- No incidents of major harm reported.
- No cases of C-Diff.
- No Category 2, 3 or 4 pressure ulcers.
- Significant reduction in unplanned admissions to PICU from HDU.

Areas of Concern

- Timeliness of service feedback responses remains below target.
- Reduction in compliance with 5-day PALS response standard.
- 88% achievement of 25-day response to formal complaints.
- Formal complaints continue to increase compared to previous months.
- AI-generated complaints contributing to rising complaint volumes.

Forward Look (with actions)

- Launch of "Clean Start" programme and cleaning product rollout.
- Review of complaints management process.
- Review of Patient Experience Framework.
- Explore additional methods of collecting patient and parent feedback.
- Use insight from complaints and feedback to drive service improvement.

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



Current (Apr 26)	Previous Month (Mar 26)	vs Previous Month
12	9	↑ 3

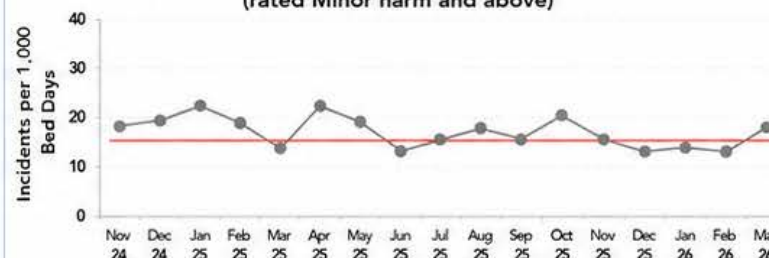
Technical Analysis:

Common cause variation observed with 12 patients deteriorating from an inpatient bed to PICU with an average of 15 a month during the last 18 months.

Priority Actions:

All cases reviewed; Deteriorating Patient improvement working group report directly to Patient Safety Board.

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



Current (Apr 26)	Target Monthly Average	Position
17.4	15.2	Above Target

Technical Analysis:

Common cause variation with performance of 17 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:

Incidents reviewed at Patient Safety Meeting and Patient Safety Incident Response Investigation Panel weekly.

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



Current (Apr 26)	Target Monthly Average	Position
76.5	77.8	Below target

Technical Analysis:

Common cause variation observed with 77 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.

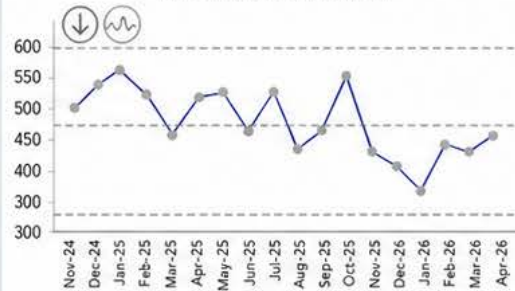
Priority Actions:

Staff encouraged to report incidents of no harm and near miss to share learning and identify opportunities for improvement.

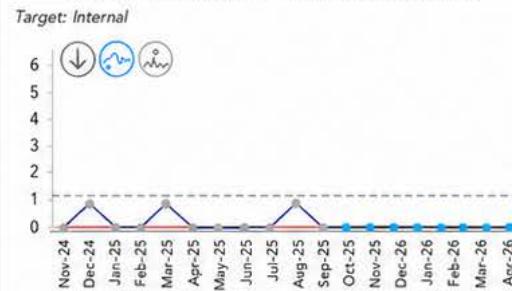
Outstanding Care and Experience – Safe & Caring - Watch Metrics

Watch Metrics

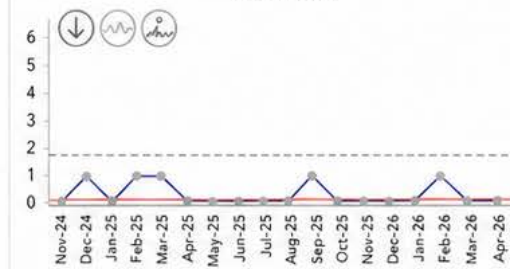
Patient Safety Incidents (All)



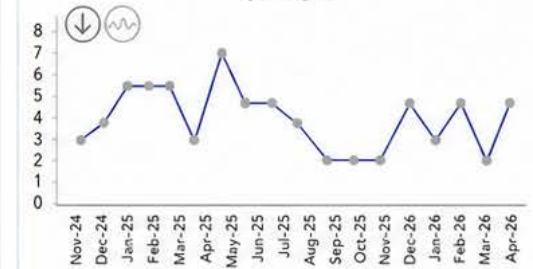
Severe or Fatal Incidents – Physical & Psychological



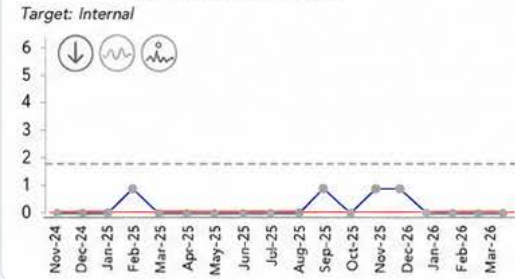
Number of PSIs (Patient safety incident investigation) undertaken



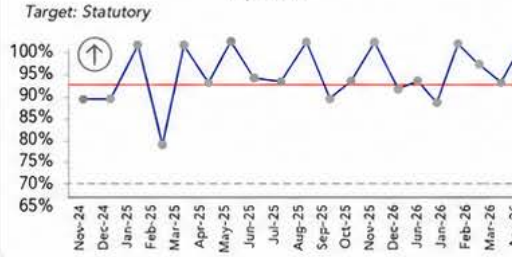
Medication Errors resulting in Harm (Physical and Psychological)



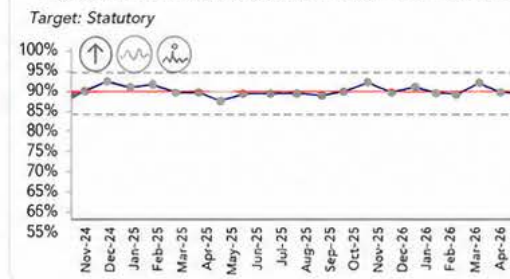
Number of Never Events



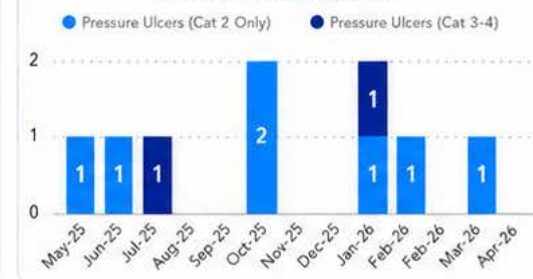
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



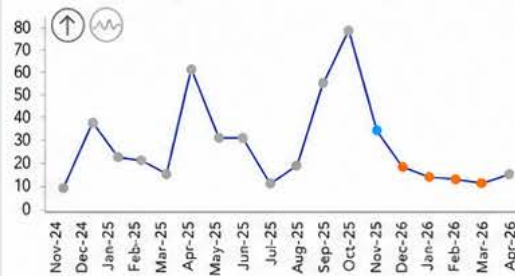
Sepsis % Patients receiving antibiotic within 60 mins for ED



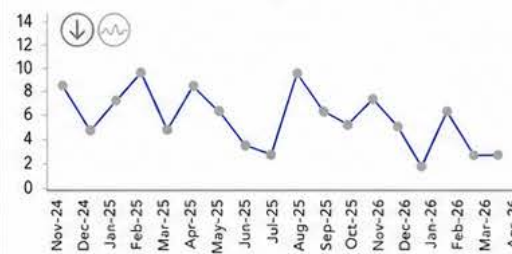
Pressure Ulcers Category 2-4



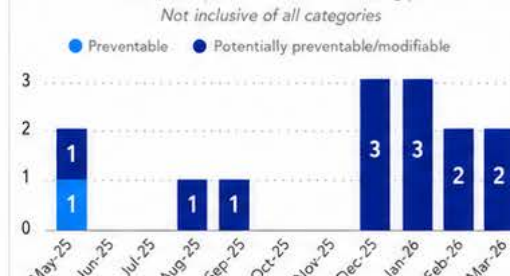
Recording of restrictive interventions



Number of patients deteriorating from HDU admitted to PICU



Predictable and preventable deteriorating patients

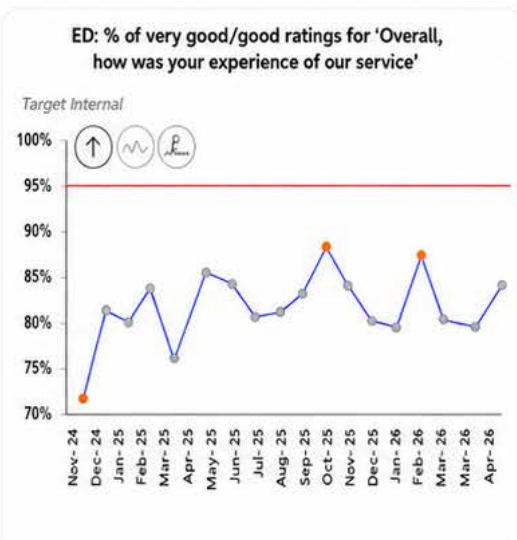
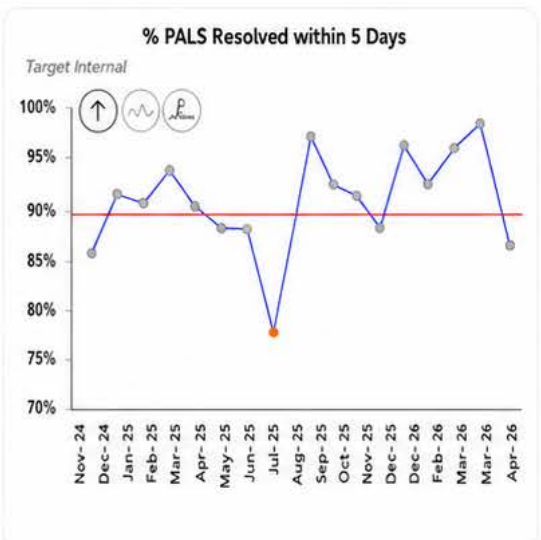
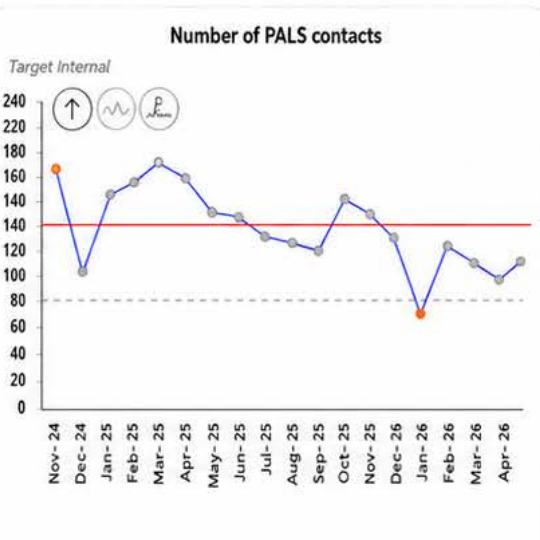
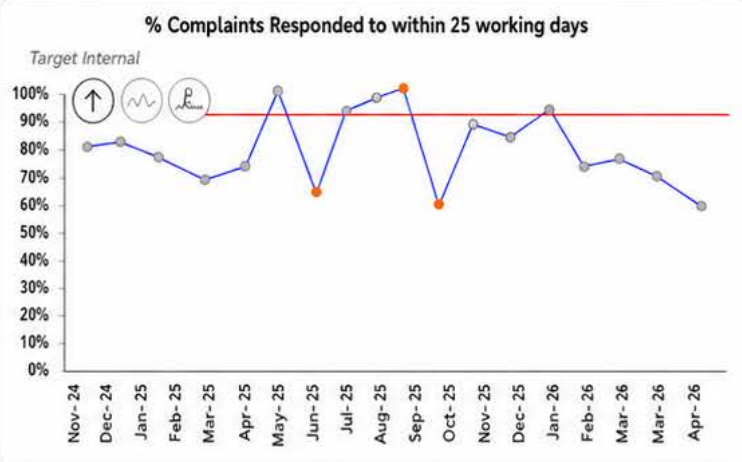
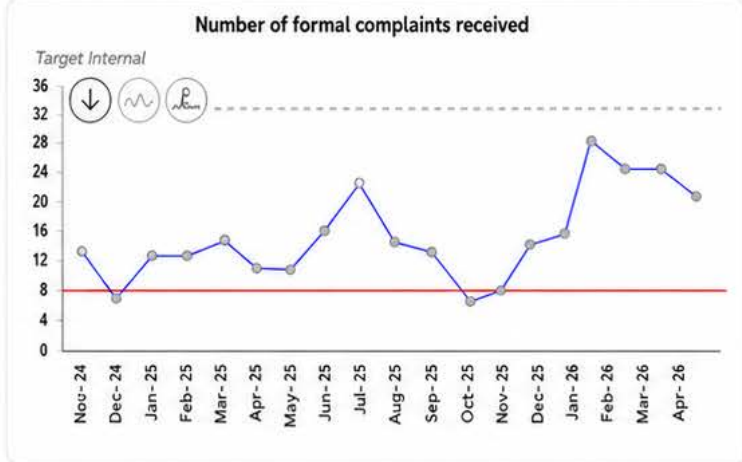
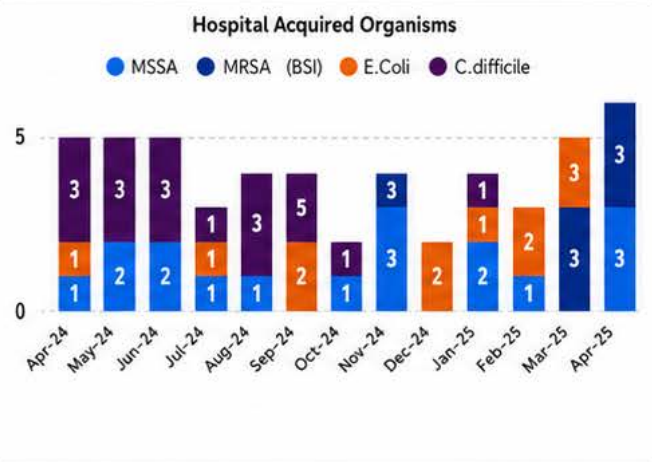


Martha's Rule



Outstanding Care and Experience - Safe & Caring - Watch Metrics

Watch Metrics



Revolutionise Care – Effective & Responsive

SRO: Operational: Adam Bateman,
Chief Operating Officer

2030 Transformation Programme: Kate Warriner,
Chief Transformation and Digital Officer

Clinical: Alf Bass,
Chief Medical Officer

Highlights

- Consistent delivery of timely urgent and emergency care: April saw **87.17%** of patients treated within 4 hours, an increase from **83.60%** in March.
- The April 18 week RTT position for acute services was **69.01%** against a plan of **63.8%**.
- The April 18 week RTT position for community services was **79%** against a year end plan of **78%**.
- There has been a continued reduction in the number of CYP with mental health waits over 104 weeks, indicating that the processes put in place have rectified the issue and have been embedded within the team.

What's Working Well

✓ ED Performance

4-hour performance has improved for 3 consecutive months and remains above the statutory target.

✓ RTT Pathways

18-week performance has grown steadily since February and is now above the internal trajectory.

✓ Percentage of patients waiting less than 18 weeks for Community Services

Continues to improve with 6 consecutive monthly increase, now achieving 26/27 target.

Areas Requiring Attention

! DM01 Performance

Dip in performance for access to diagnostics within 6 weeks, dropping from 97% to 94%. This was largely due to gastroscopy performance.

31 31 day urgent cancer referral

One breach in-month for 31 days from urgent referral for suspected cancer first treatment.

✓ Ethnicity Capture

% of activity with a valid ethnicity recorded has dropped for a second consecutive month, reducing to 83%.

Forward Look (Key Actions)

- Recovery action plan for gastroscopy has been requested both internally and externally, and performance will be monitored against the recovery plan.
- Continue to monitor the 104 mental health wait metric to ensure reduction is sustained. This is not expected to be an issue once 2025/26 data has been refreshed & submitted in May 2026.



Key Performance Indicators

1 ED: % treated within 4 Hours

Latest (Apr 2026)

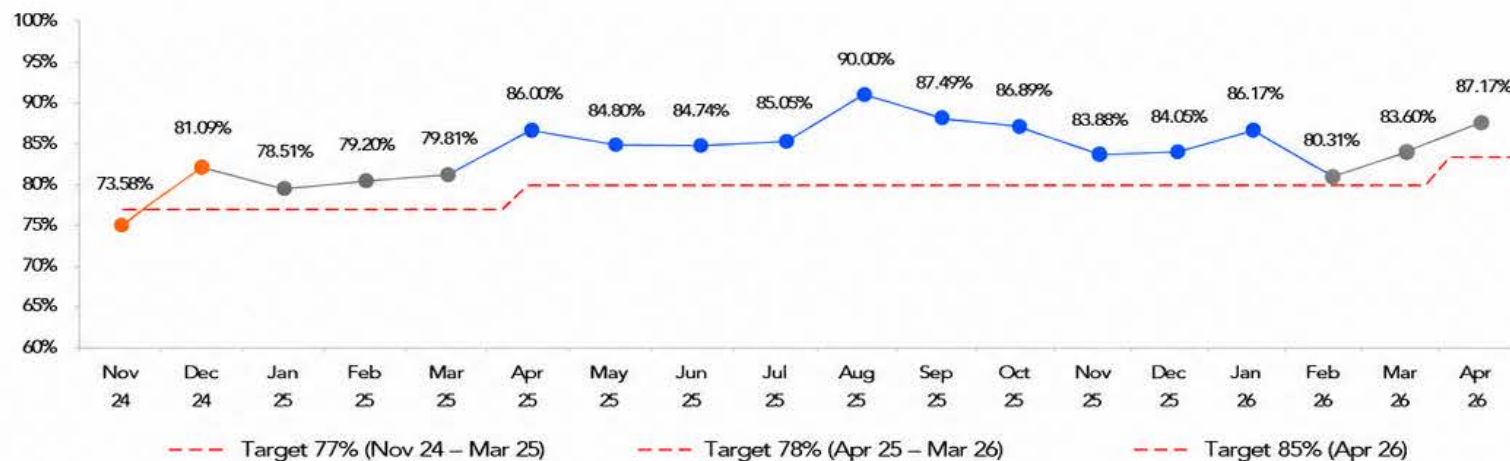
87.17%

Target (Statutory)

85%

↑ 3.57%

vs Mar 26
(83.60%)



2 RTT waiting list within 18 weeks

Latest (Apr 2026)

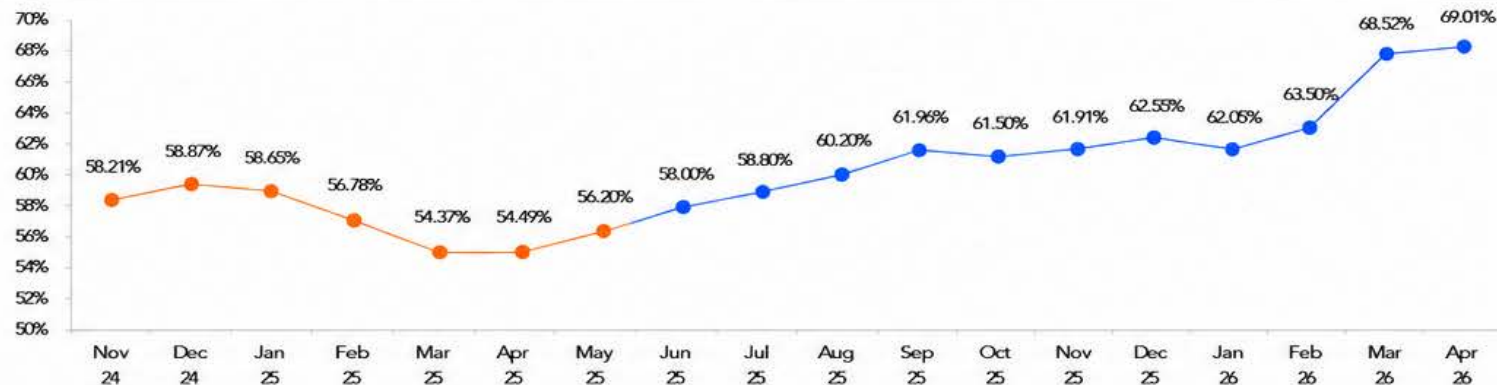
69.01%

Target (Internal Plan)

63.8%

↑ 0.49%

vs Mar 26
(68.52%)



Technical Analysis

1 Achieved the national target in April-26 with the 17th consecutive month above target with performance of 87.2% in April 2026, an increase from Mar-26 (83.6%). Apr-26 represents performance +1.17% compared to Apr-25 (86%) whilst Apr-26 experienced +393 extra attendances compared to Apr-25.

2 Special cause variation with current performance of 69.01% against a year end target of 70.1% by March 2027. This is an increase from March 2026 position of 68.52%.



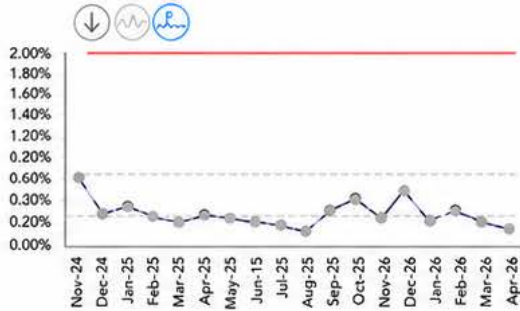
Priority Actions

1 UEC team have created a plan to achieve the 95% target. UEC is also a priority within the Trust Transformation Programme for 2026/27, bringing together internal and external improvements and the CYP UEC strategy to support achieving the 95%.

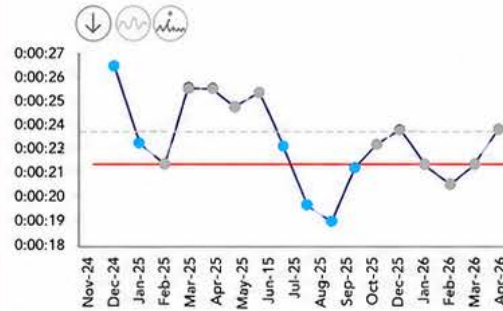
- 2
- AVT clinic template changes have been made to increase new outpatient capacity, supporting 18 week performance
 - Deep dive into short notice cancellations in theatres to be carried out to support both productivity & access to care.

Revolutionise Care – Effective & Responsive – Watch Metrics

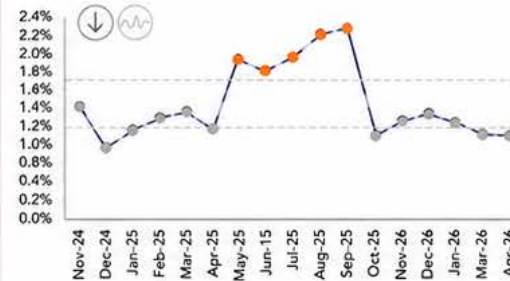
% of ED attends over 12 hours



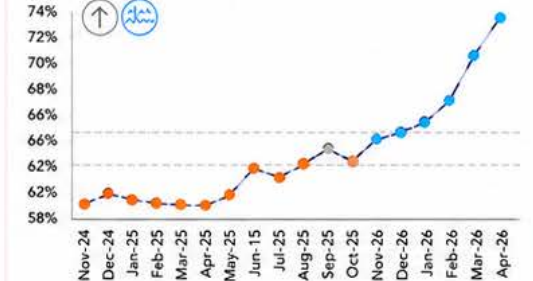
Average Ambulance Vehicle to Handover Time



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

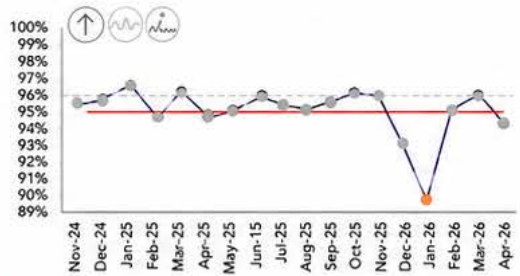


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



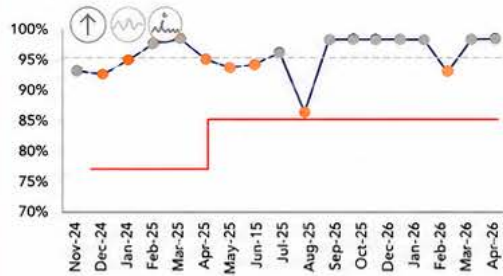
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



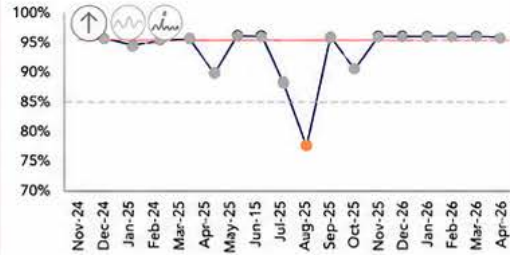
Cancer: Faster Diagnosis within 28 days

Target: Statutory



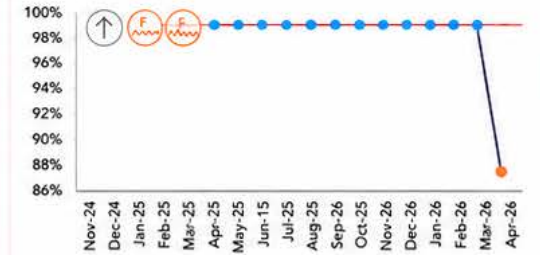
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

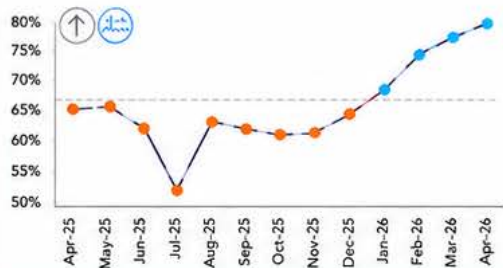
Target: Internal (Stretch)



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

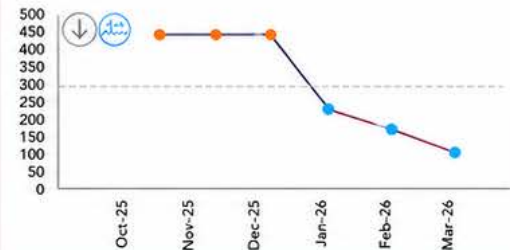


Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less

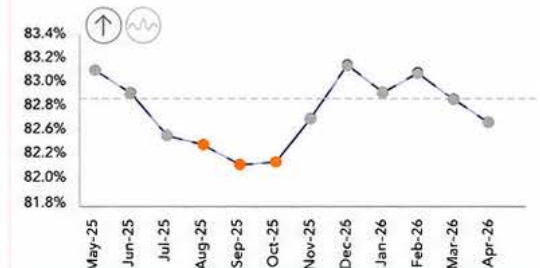


Number of CYP with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period

Target: Internal



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



Support Our People

Executive Summary

SRO
Melissa Swindell, Chief People Officer

Highlights

- Total workforce for April was below the 2026/27 WTE plan (by 29.83 WTE).
- Mandatory training compliance remains over 90% • PDR (87+) completion has remained above the 90% target • Time to Hire remains under the Trust target (30 days), at 25 days (offer to contract) • The NHS England target is set at 40 days (advert to pre-employment checks complete).
- In April the Trust achieved 55 days. When reviewing the Trust's 3-month rolling position (44.3 days) with the other Trusts in Cheshire and Merseyside, Alder Hey are ranked 4th out of the 13 Trusts. There are only 2 Trusts achieving the 40-day target (Countess of Chester at 35.8 days and Mersey Care at 38.3 days).

Areas of Concern:

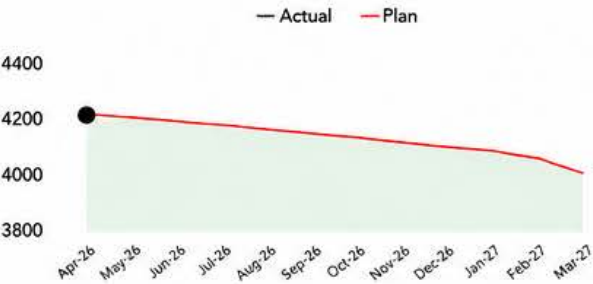
Sickness absence increased slightly in April. The position remains challenging and is subject to regular, detailed reporting and action, including an enhanced training offer from OH, and specific targeted support for areas with high levels of absence.

Forward Look (with actions)

Whilst total workforce for April was below the 2026/27 WTE plan, achievement of this going forward remains challenging. The voluntary redundancy scheme closed on 30th April 2026 with a review of applications on-going. There is significant work underway through the HWWWiTF programme.

Total Workforce - WTE

Target: Internal 26/27



Target (Internal)	Actual (Apr 26)	vs Plan
4,245.47	4,215.65	↓ 29.83 WTE

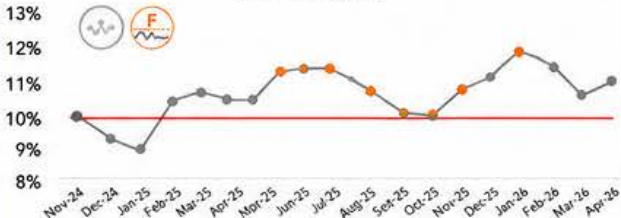
Technical Analysis:

Total workforce for the end of April 2026 was 29.8 WTE below plan. M1 Total workforce was 4,215.65, against a plan of 4,245.47.

Actions:

Achievement of the 2026/27 WTE plan remains a challenge. Whilst there has been a reduction in bank use and spend in April, overtime spend increased. The voluntary redundancy scheme closed on 30th April 2026, with applications currently being reviewed. Significant work is underway through the HWWWiTF programme, alongside other work to support achievement of the 2026/27 WTE plan.

Staff Turnover



Target (Internal)	Apr 26	vs Target
10%	11.4%	↑ 1.4%

Technical Analysis:

Common cause variation observed with performance of 11.4% in April 2026 against an internal target of 10%. Increase from 11.1% the previous month however a consistently failing metric.

Actions:

Turnover remains above the Trust target and has increased slightly in April compared to March. The top 3 reasons for leaving in April include voluntary redundancy (37%), voluntary resignation (36%), and retirement (16%).

Sickness Absence Overall



Target (Internal)	Apr 26	vs Target
4.5%	5.83%	↑ 1.33%

Technical Analysis:

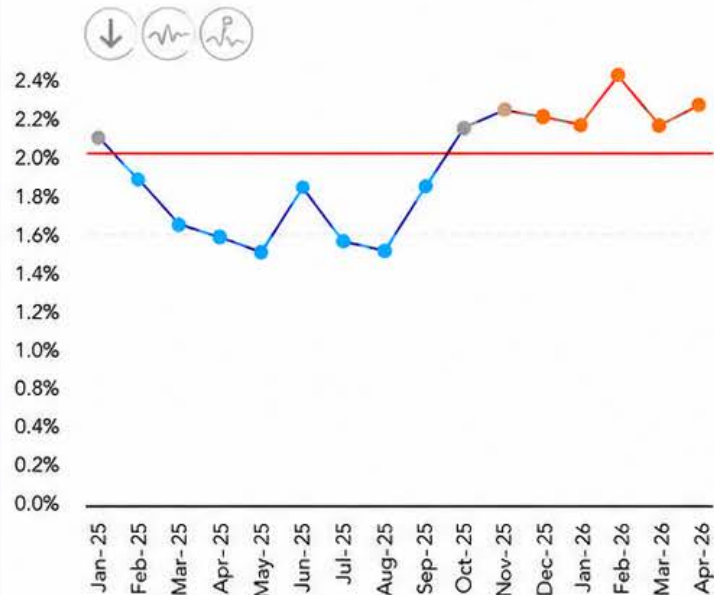
Common cause variation observed. Total sickness absence in April 2026 is 5.83% which is above the monthly target of 4.5% however 3rd consecutive month below 6%. Apr-26 0.21% increase from Mar-2026. April 2026 performance comprises STS at 2.26% and LTS at 3.58%. Monthly target being 4.5% in 2026/2027.

Actions:

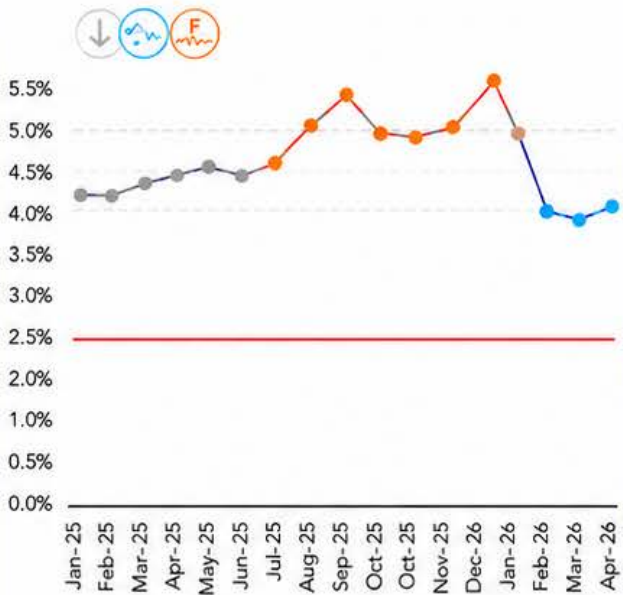
There is a focus on areas with the higher sickness absence rates and targeted support is being provided. The focus remains on prevention, working with SALS, OH and TU colleagues with support for stress risk assessments, reasonable adjustments and enhanced wellbeing support from OH.

Supporting Our People - Watch Metrics

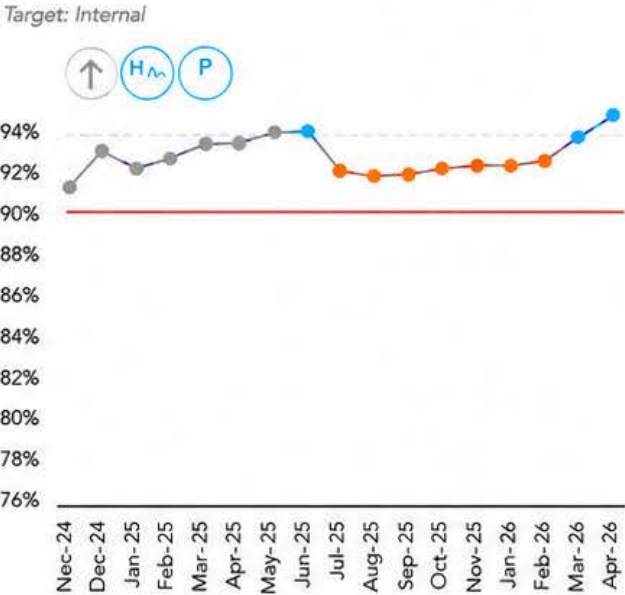
Short Term Sickness



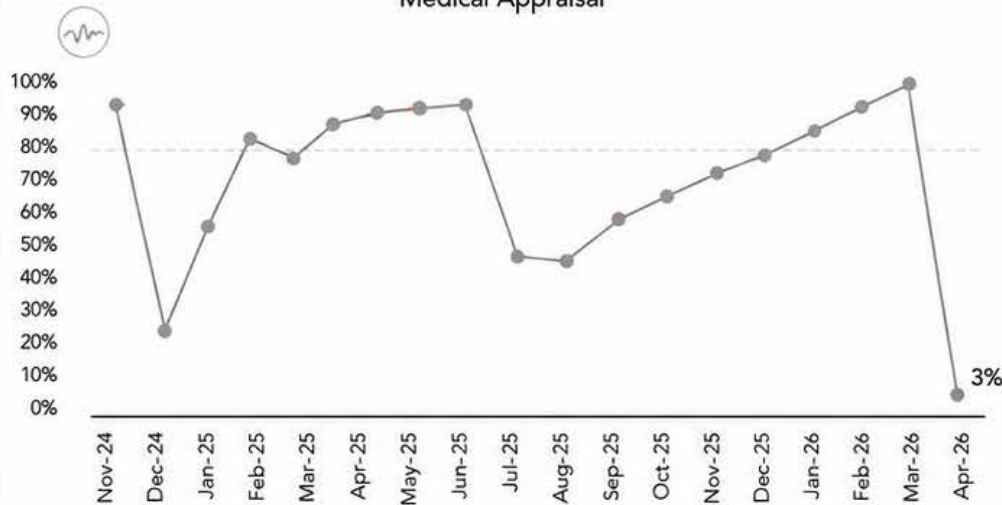
Long Term Sickness



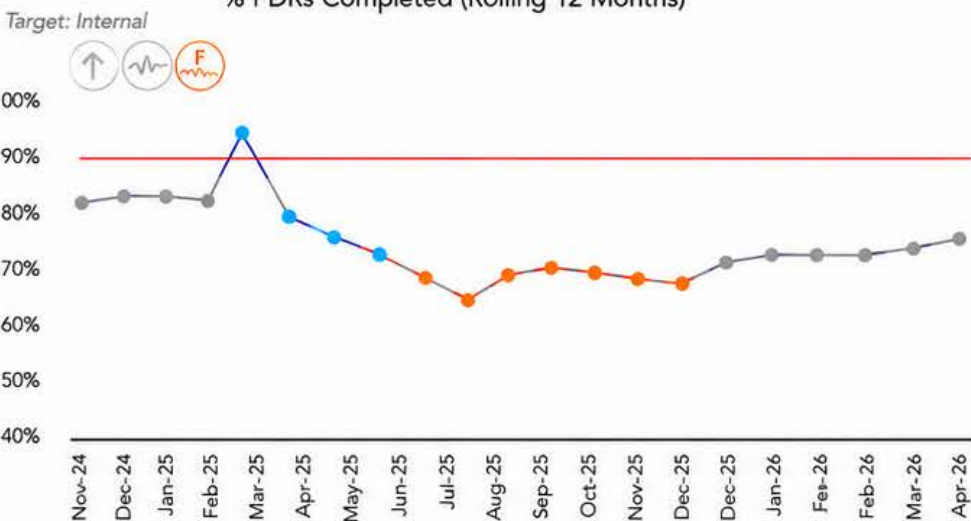
Mandatory Training



Medical Appraisal



% PDRs Completed (Rolling 12 Months)



Pioneering Breakthroughs

Executive Summary



SRO

Kate Warriner

Chief Transformation and Digital Officer

Alf Bass

Chief Medical Officer

Highlights

- Bring me the Future System briefing doc shared with proposed SLT and comments invited for further discussion at BMFT SLT meeting on 8th June.
- Project plan for development of Alder Hey Secure Data Environment finalised and change request submitted to LCR Combined Authority to utilise capital allocation in POIZ budget in this financial year (awaiting response).
- Transfer of RPA team to digital on track with budget moves complete in 1M and line management transfer planned from 1st June.
- Successful external funding awards for Andrew McArdle (NIHR Senior Clinical and Practitioner Research Award, £273,729) and Grace Petrovic (NIHR Doctoral Fellowship, £234,161).
- Exploratory discussions between Radiology team and CentileBio (Centile Bio | Quantitative Brain Imaging & Computational Neuroscience) supported by Research, Innovation and Digital.

Areas of Concern

- Research income in 1M is off track driven by underachievement against commercial income targets. This includes 3rd MRI, Paediatric Medicines Research Unit and overall commercial trial income. Delayed with legal documents required for POIZ business support impacting on delivery against metrics but external legal advice has been delivered and final drafts are under review at Exec level.

Forward Look (with actions)

- Monthly financial oversight meetings have been established for above 3 areas with actions in place to improve position.
- Opportunities for additional £10k saving under review including recurrent and non-recurrent options – to be agreed by end of Q1.
- Terms of Reference under review for independent audit of POIZ governance (commencing in June).

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



Current (Apr 26)

17

Previous Month (Mar 26)

17

vs Previous Month

→ 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 use AH Charity funding and Research Capability Funding to support grant writing and pilot activity to boost number of AH Chief Investigators.

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



Current (Apr 26 YTD)

£0.29m

vs Previous Year (Apr 25 YTD)

—

vs Previous Year (YTD)

—

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.

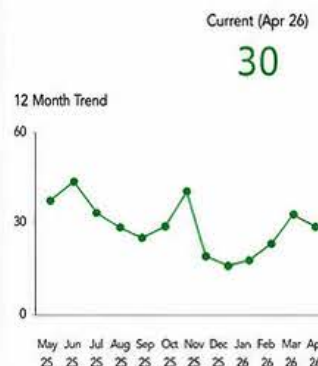
3. Number of participants recruited to all studies



Current (Apr 26)

99

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



Current (Apr 26)

30

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



Current (Apr 26)

0

6. Number of businesses supported by POIZ



Current (Apr 26)

0

Financial Sustainability: Well Led

Executive Summary



SRO

Rachel Lea, Director of Finance and Development



Highlights

- In April (M1), the Trust is reported £0.9m deficit, which is in line with plan.
- Cash has remained in line with plan and capital is behind plan due to phasing and awaiting approval of NHSE Strategic funding.
- Overall, £7m CIP has been transacted in year with £5.6m fully developed and in progress, £4.4m opportunity and £7.6m gap.



Areas of Concern

- Work is ongoing to deliver full savings of £24.5m and significant work is ongoing through FIP and HWWB/ITF programme.
- Forecasting to achieve £0.7m surplus which is in line, so delivery of CIP is essential.
- Capital allocation is unlikely to be sufficient to complete all capital requirements.

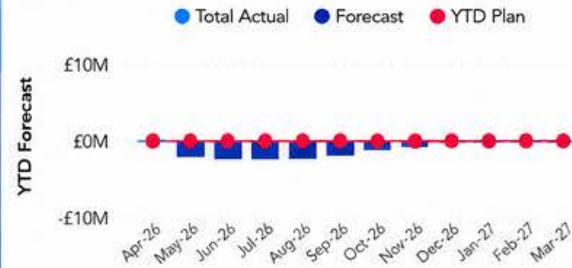


Forward Look (with actions)

- 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 (Forecast)

Target: Internal



Target (Internal)	Forecast (Year End)	vs Plan
£24.5m	£24.5m	→ 0

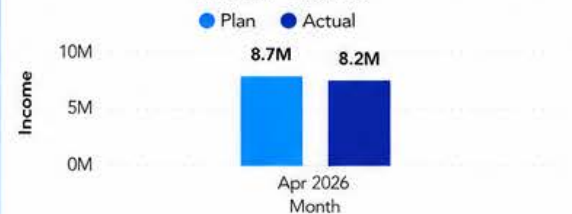
Technical Analysis:

Recurrent CIP identified and fully developed is £9.5m.

Actions:

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

YTD ERF Income



Plan (YTD)	Actual (YTD)	vs Plan
£8.7m	£8.2m	↓ £0.5m

Technical Analysis:

April performance is estimated at 94% in value terms. Actuals of £8.16m against a plan of £8.65m. Main driver being relatively low elective inpatient volume in high value specialties.

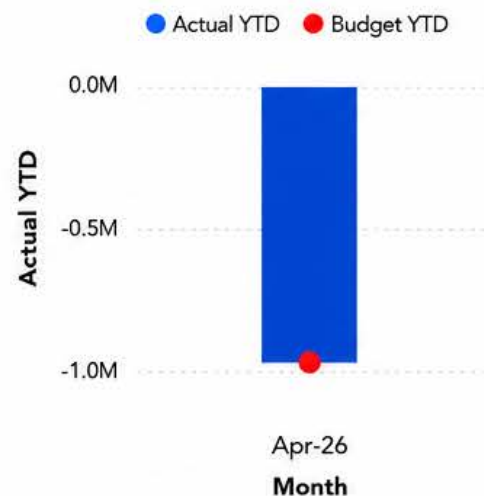
Actions:

There are exceptional reasons behind the April under performance (e.g. high NEL and IA), which the divisions are looking to recover going forwards.

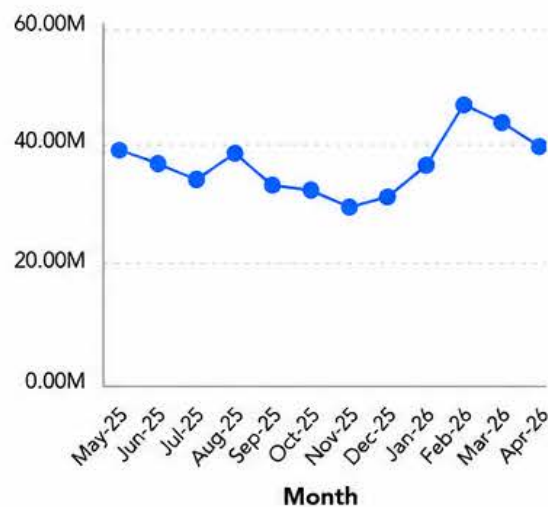
Financial Sustainability: Well Led – Watch Metrics

**I&E distance from target
(cumulative YTD)**

Target: Internal

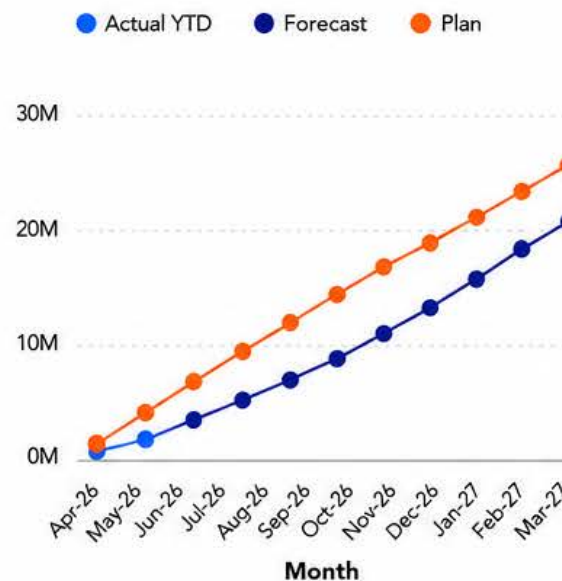


Cash In Bank



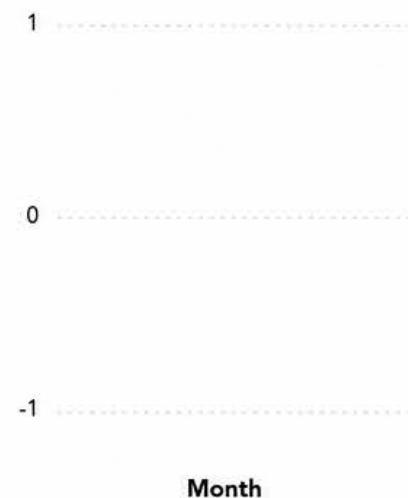
In Year CIP – forecast against plan

Target: Internal

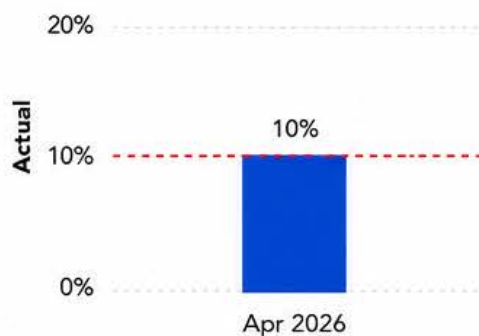


Capital – YTD spend and forecast against plan (Currently Unavailable)

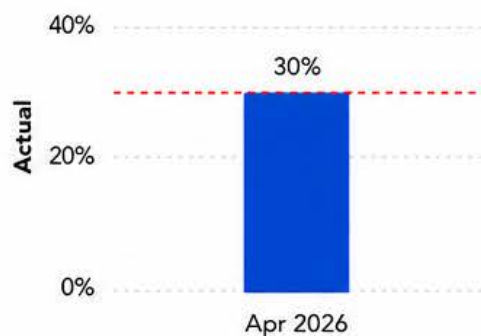
Target: Internal



**10% year on year reduction
in spend on bank staffing**



30% reduction agency in 26/27



Risk Management: Well Led

Executive Summary



SRO

Erica Saunders, Chief Corporate Affairs Officer

★ Highlights

- 100% of high risks within review date with actions past expected date of completion (all actions in date).
- 0% of high risks with actions past expected date of completion – maintaining last month's position.
- Continued positive engagement with risk owners/teams and strongest performance for 2026/27 YTD.

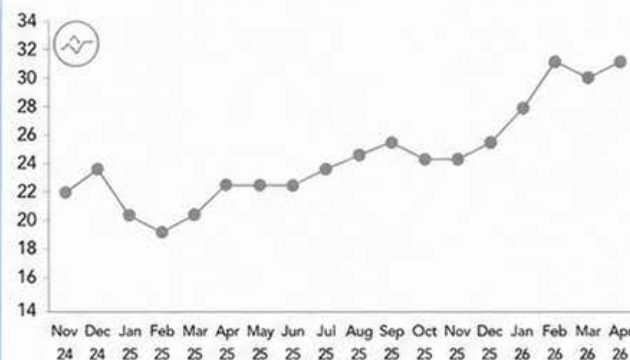
⚠ Areas of Concern

- There remains a lack of clarity and communication regarding the GO LIVE date for transition from the current divisional structure to new systems model impacting accurate committee assurance reporting for RMF/ SOAC/ARC.
- Updating and alignment of the InPhase apps to the new systems model affecting current capacity of teams and potential for inaccurate reporting into the IPR.
- Impact has been escalated via the HWW/IITF workstream including resource constraints highlighted via an SBAR and the inability to report April data based on the new structure.

🔍 Forward Look (with actions)

- Awaiting Board review and re-approval of Risk Appetite to enable recommendation of the roll out of risk appetite and tolerances across teams/divisions.
- Training on risk appetite and tolerances across the Trust is paused until such time the roll out of risk appetite and tolerances is approved.

Number of High Risks (scored 15 and above)



Current (Apr 26)	Previous (Mar 26)	vs Last Month
31	30	↑ 1

Technical Analysis:

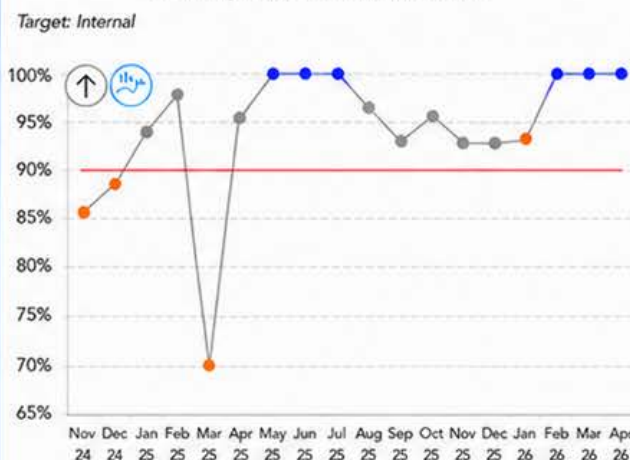
31 high risks on risk register as of 30th April 2026. Breakdown by category is listed below.

- Quality – Safety = 17 risks
- Workforce – Sustainability = 6 risks
- Compliance and Regulatory = 5 risks
- Commercial = 1 risk
- Financial – Compliance = 1 risk
- Financial – Investment = 1 risk

Actions:

High risks continue to be reviewed at corporate and divisional risk oversight meetings and at Risk Management Forum.

% of High Risks within review date



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

Technical Analysis:

Sustained performance of 100% of risks within review date for April 2026, 3rd consecutive month at 100%.

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

Actions:

High risks continue to be monitored via corporate and divisional governance processes leading to improved performance this month.



SRO: Lisa Cooper, Community & Mental Health Division



HIGHLIGHTS

- Sefton SEND inspection completed with positive feedback regarding children and young people centred care – awaiting formal feedback
- Alder Hey and the North and South Sefton SPOT teams won a national SEND award
- Mandatory training compliance has increased remaining above target (97%)
- Sickness absence rate remains steady (4%)
- Community Therapy Services continue to meet 18 week RTT (Community Dietetics – 100%; SALT – 97%, Physio – 99%, OT -96%)
- Continued improvement in Community Paediatrics RTT (89%) with no children or young people waiting over a year for follow up in Community Paediatrics, and reduction in overall waiting list size (766)
- Continued improvement in wait for first partnership – CAMHS (73%)
- Significant improvement in number of children and young people waiting over 52 weeks for treatment to start in Community Mental Health Services (Liverpool) (1)



AREAS OF CONCERN

- Reduction in number of children and young people seen within 4 weeks in Eating Disorder Service (63%)
- Staff turnover has further increased (12%)
- WNB rate remains higher than target (13%)
- Reduction in number of complaints responded within 25 days (42%) and PALS resolved within 5 days (76%)
- Reduction in the timeliness to triage for ND assessments (71%)
- Ongoing concerns regarding the number of clinical letters due to delays in transcription process – although improved slightly in M1 (72%)
- Ongoing challenges with ADHD medication shortages which is impacting on waiting times for the treatment pathway



FORWARD LOOK (WITH ACTIONS)

- ✓ Liverpool Community Mental Health Services performance improvement plan in place, which includes:
 - 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
 - Significant improvement in number of children and young people expected to wait over 52 weeks
 - Recruitment ongoing, with additional posts requested to mitigate for gaps in service.
- ✓ 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) delayed to 08 June 2026.



MENTAL HEALTH DATA REPORTING – WORK ONGOING

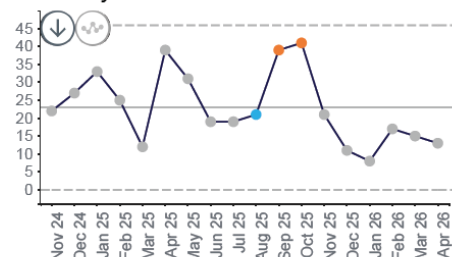
- Improvement in collection of Routine Outcome Measures - task & finish group to continue to improve collection and reporting
- Paper prepared to revise access and performance KPIs in line with NHSIE proposal of standards for access and waiting times for Children and Young People Mental Health Services – work ongoing to update reporting metrics and dashboards, trajectory in development.
- MHSDs Phase 2 (Crisis Care) Meditech developments live – BI work ongoing
- IT and Operational Team working with IAPTUS to review scope of IAPTUS to Meditech data migration



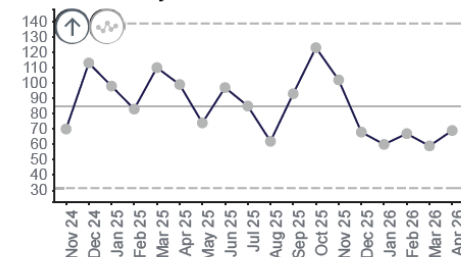
Work ongoing to provide psychological support to children impacted by the Southport critical incident. PIFU discharge pathway agreed to enable follow up until CYP turn 18.
Ongoing discussions with ICB regarding funding for this resource.

Divisional Performance Summary - Community & Mental Health

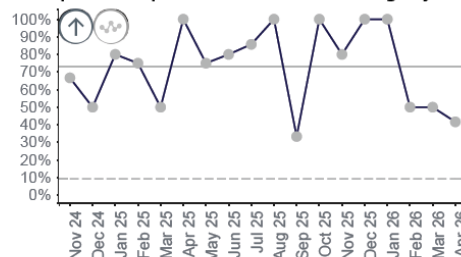
Patient Safety Incidents rated Low Harm & Above



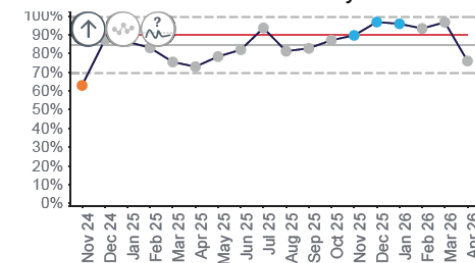
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

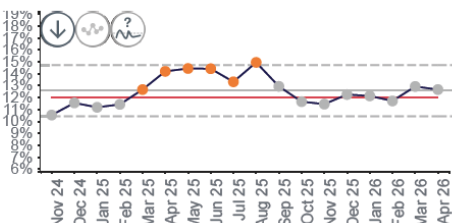


% PALS Resolved within 5 Days

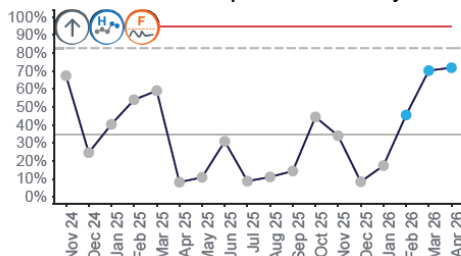


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

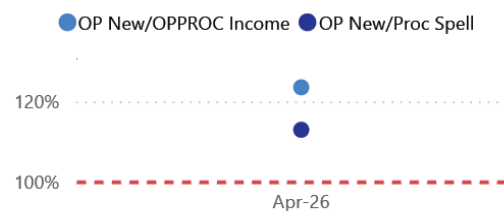


% of Clinical Letters completed within 10 Days

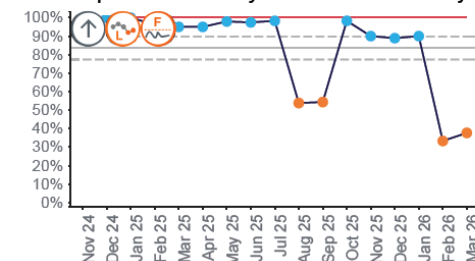


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

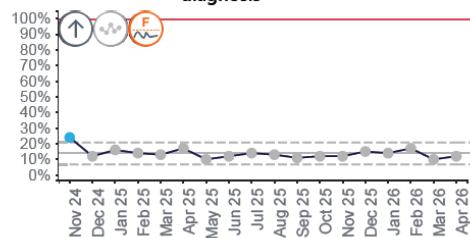
SLAM Performance



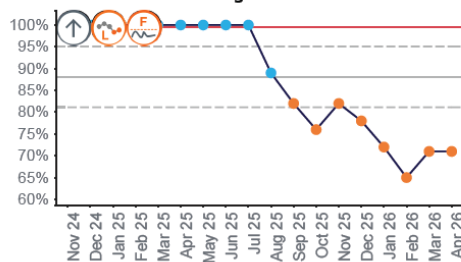
IHA: % complete within 20 days of referral to Alder Hey



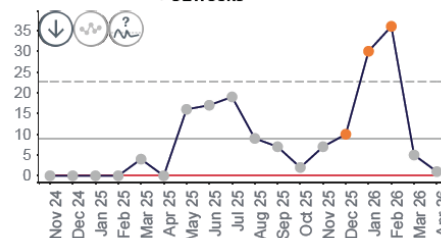
ND Assessment: % waiting <65 weeks for concluded diagnosis



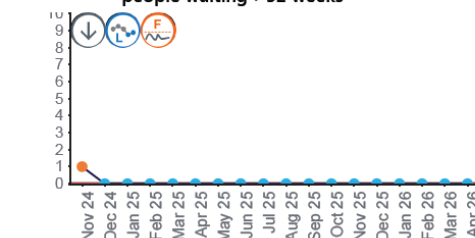
ND Assessment: % triage within 12 weeks



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

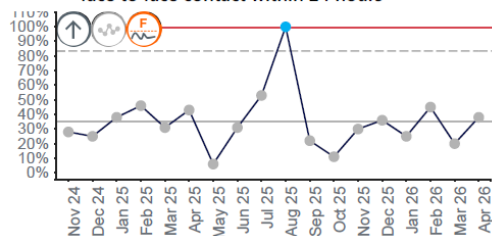


Community Paediatrics: Number of children and young people waiting >52 weeks

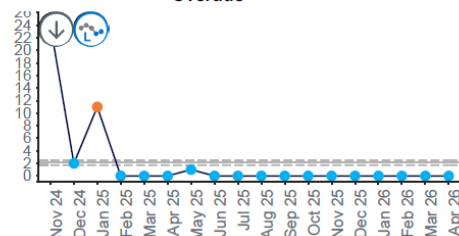


Divisional Performance Summary - Community & Mental Health

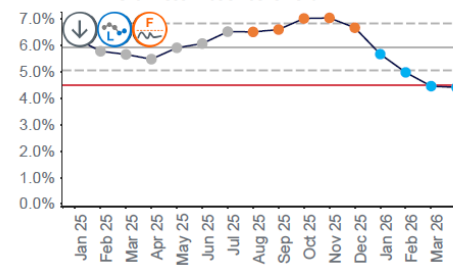
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours



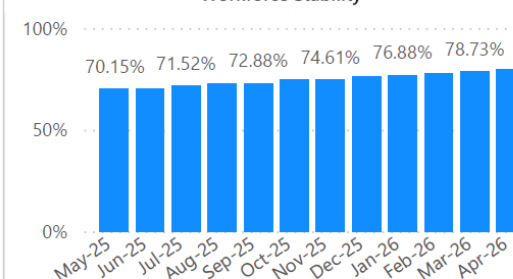
Volume of active outpatient follow up waits - 2 Years & Overdue



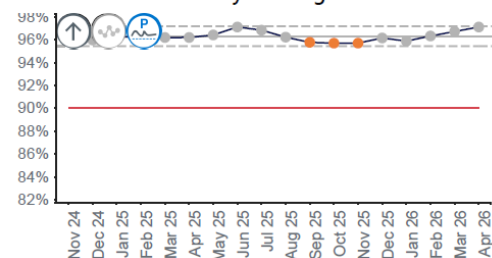
Sickness Absence Overall



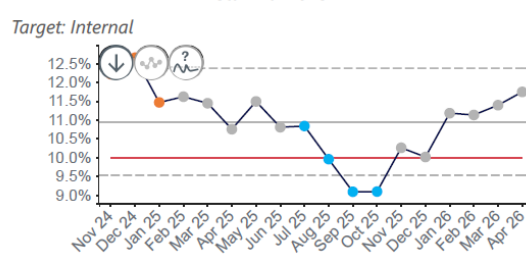
Workforce Stability



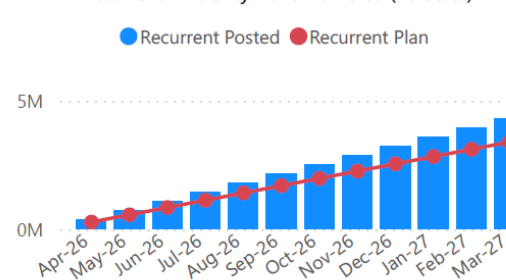
Mandatory Training



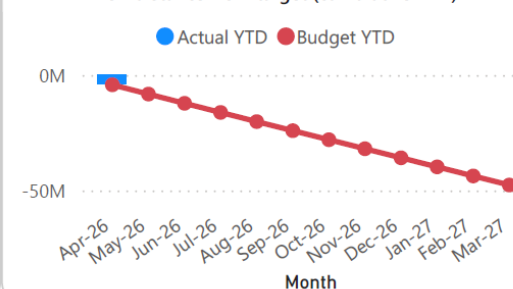
Staff Turnover



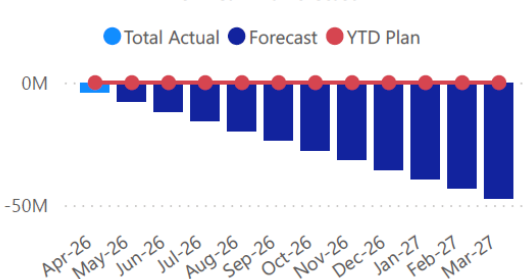
Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



I&E Year End Forecast





SRO: Urmi Das, Division of Medicine



HIGHLIGHTS

- ED performance improved in April from 84% to 87%.
- Daycase and elective activity was at 109% of plan; work is ongoing to maximise coding in this area.
- Clinic letters completed within 10 days have maintained their improvement at 68%, although is still not at target, is in the right direction.
- RTT improved further to 73.6% in April, although there was 1 >52 week breach within the CEW service.
- Mandatory training has improved further in April with 93% compliance.



AREAS OF CONCERN

- In April (n=22) we had an increase in incidents rates low harm and above compared to March (n=5). A proportion of these related to change in IPC reporting of which discussions are ongoing as to the approach taken.
- The WNB rate maintained above target at 9% in April; where possible clinics are overbooking to mitigate these WNB and maintain overall activity.
- In April we have challenges with responding to complaints (90%) and PALS (87%) within the timeframes. This is a direct correlation between an increase in complaints to respond to, an increase in complexity of complaints, often linked to AI software, and a decrease in capacity across nursing and operational teams to respond.
- OPD News were below plan in month with challenges in AHP based services and Neurology however work is ongoing to review seasonality in AHP services and new starters within Neurology to address.

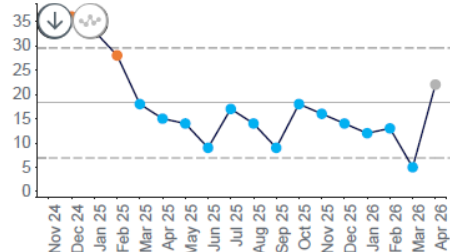


FORWARD LOOK (WITH ACTIONS)

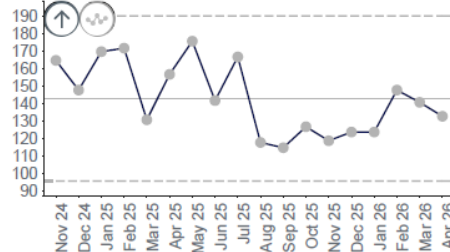
- ✓ The CEW service is challenge with demand above commissioned capacity result in an increased risk of 52 week breaches; a paper has been approved by the Executive Team with actions to address that are ongoing.
- ✓ The ED 4 hour target for this year is 95% by March 2027. The ED team have presented to the Executive Team a proposed action plan to progress towards improvement to this level.
- ✓ Lyrebird roll out continues with actions in place to move Cohort 2 onboard with template changes from quarter 2.
- ✓ Whilst DMO1 achieved in month in April, there is significant challenge in May within Gastroenterology. Work is ongoing to address and an action plan being pulled together.

Divisional Performance Summary - Medicine

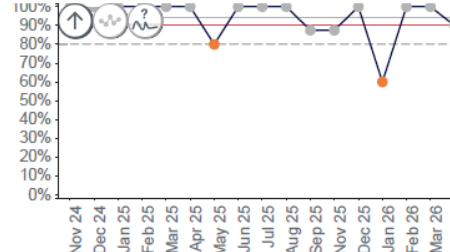
Patient Safety Incidents rated Low Harm & Above



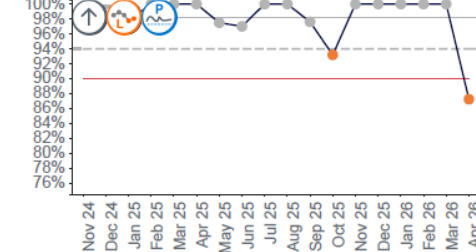
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

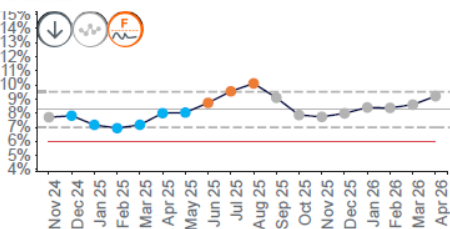


% PALS Resolved within 5 Days

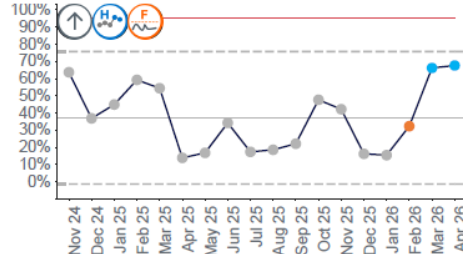


% Was Not Brought Rate (All OP: New and FU)

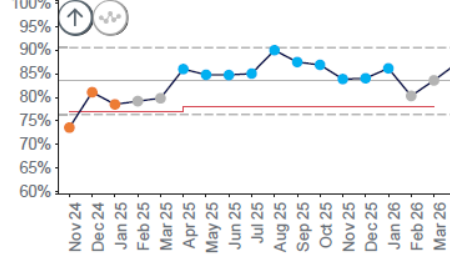
Target: Internal



% of Clinical Letters completed within 10 Days

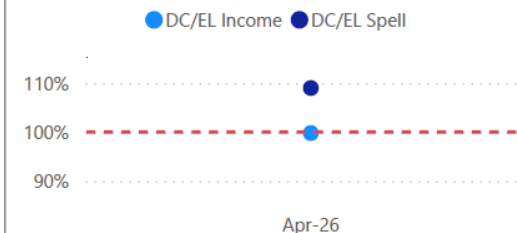


ED: % treated within 4 Hours



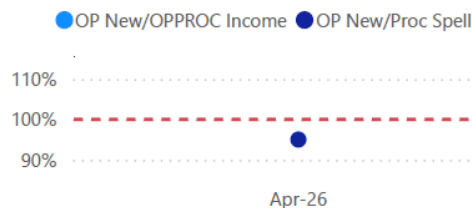
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

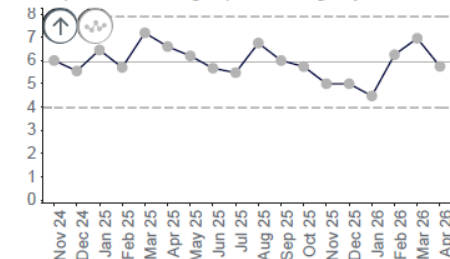


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

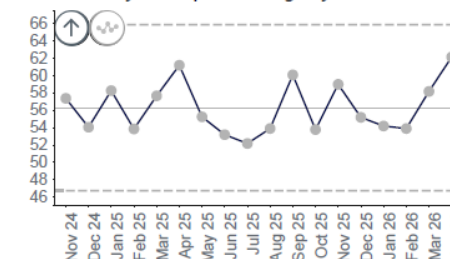
SLAM Performance



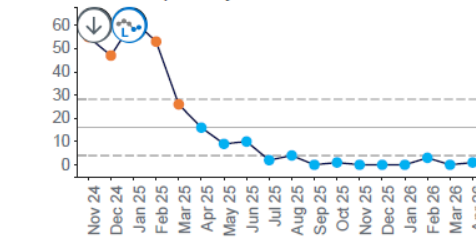
Inpatient Discharges per working day



Day Cases per working day

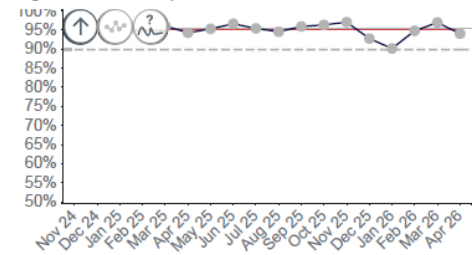


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)

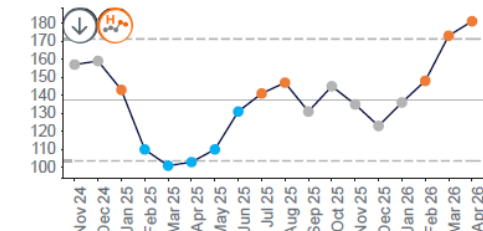


Divisional Performance Summary - Medicine

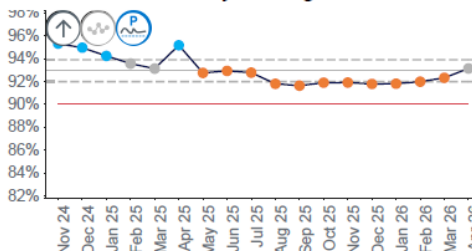
Diagnostics: % Completed Within 6 Weeks of referral



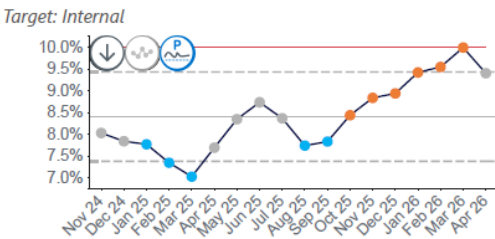
Volume of active outpatient follow up waits - 2 Years & Overdue



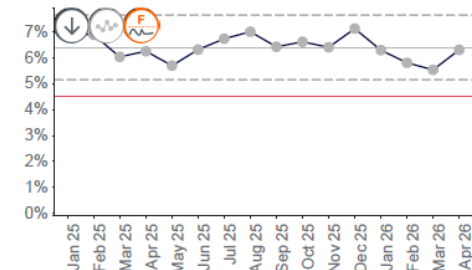
Mandatory Training



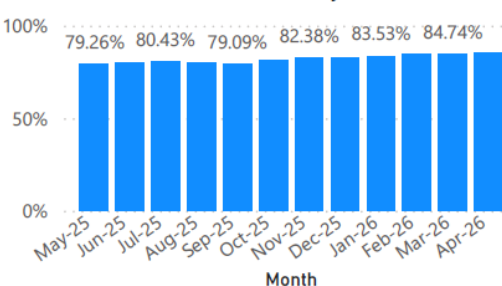
Staff Turnover



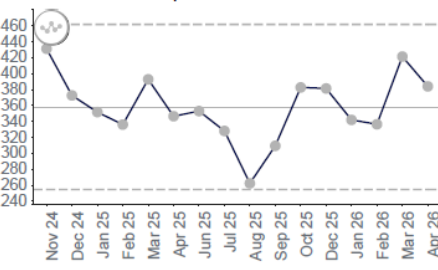
Sickness Absence Overall



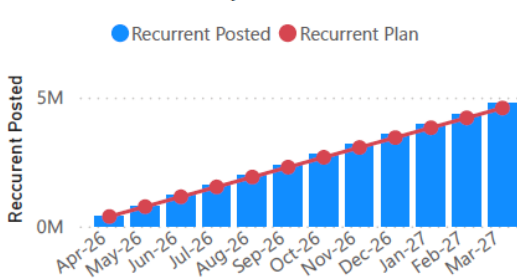
Workforce Stability



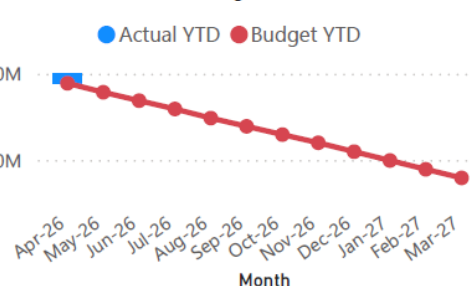
A&E Attendances per ED Consultant WTE



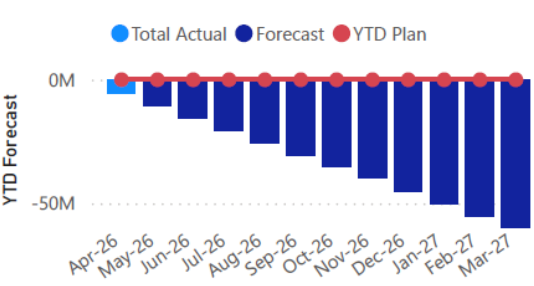
Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



I&E Year End Forecast



DIVISIONAL PERFORMANCE SUMMARY – SURGERY



SRO: Benedetta Pettorini, Division of Surgical Care



HIGHLIGHTS

- 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. Notably, 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.
- 100% response to PALS and complaints
- 80% clinical letters signed within 10 days – significant improvement
- The WNB rate trend continues to decrease, with a slight increase as expected in April due to half-term.
- Strong performance on outpatient new activity at 101.5% (income), 97.8% (activity) in month.
- Mandatory training remains above target at 93%
- Volume of CYP waiting over 52 weeks to access care remains high (211 in April).



AREAS OF CONCERN

- ~401k underperformance in month against plan for ERF elective activity. The key drivers are as follows: 110K can be attributed to industrial action. 123k in cardiac surgery, despite completing the same volume of operations in April 25, the proportion of non-electives was far greater than expected. 145k in cardiology is due to a vacancy; however, the consultant is due to join Alder Hey in June.
- Sickness continues to be above target at 7%
- Division remains with around 3.9k CYP overdue by 2 years for follow up, key areas include Paediatric Surgery, Plastic Surgery & Audiology.



FORWARD LOOK (WITH ACTIONS)



Key areas of challenge to achieve zero CYP waiting over 52 weeks in 2026/27 are Dental, Chronic Pain and ICC.



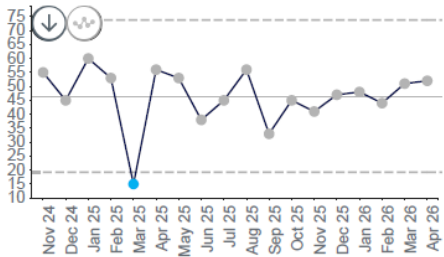
A consultant dentist has been appointed who will work across Alder Hey and Mersey Care. Paper being prepared to review the future of Paediatric Dentistry to support creating sustainable pathways with partners. Actions planned for Pain and ICC although challenging due to lack of specialist workforce.



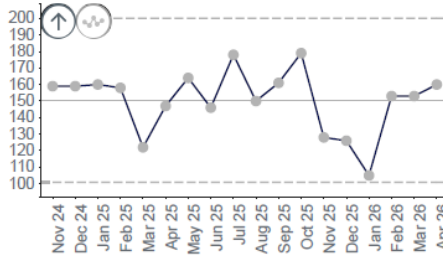
CYP waiting over 2 years for follow up continues to be a challenge, however actions taken in high volume specialties to expedite reduction via template increases and focus in weekly outpatient clinic utilisation meeting.

Divisional Performance Summary - Surgery

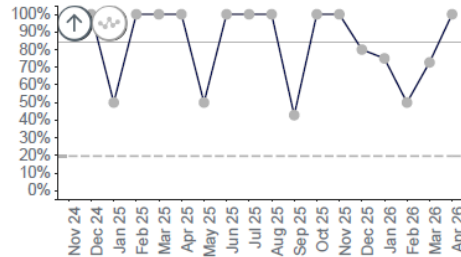
Patient Safety Incidents rated Low Harm & Above



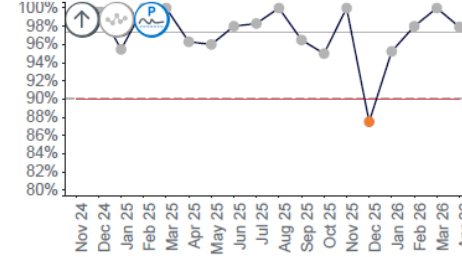
Patient Safety Incidents rated No Harm



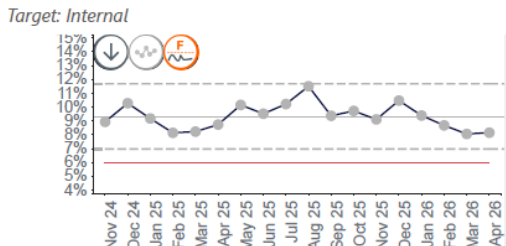
% Complaints Responded to within 25 working days



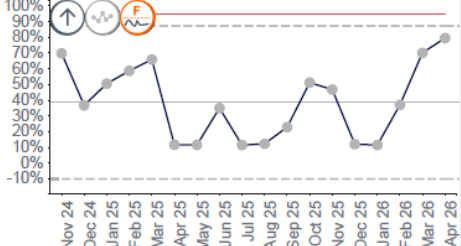
% PALS Resolved within 5 Days



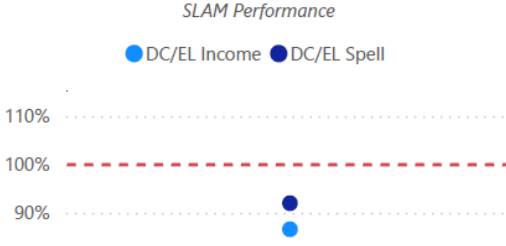
% Was Not Brought Rate (All OP: New and FU)



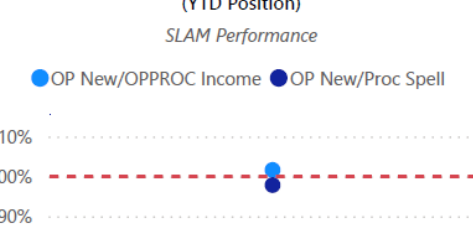
% of Clinical Letters completed within 10 Days



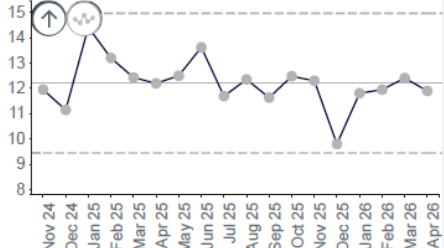
Elective & Daycase Income and Spells vs Plan (YTD Position)



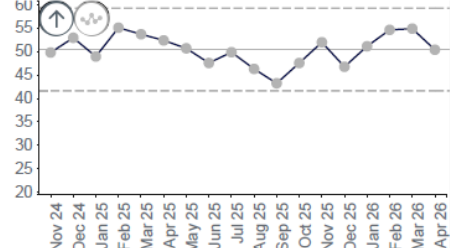
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)



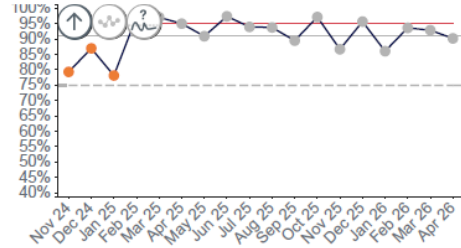
Inpatient Discharges per working day



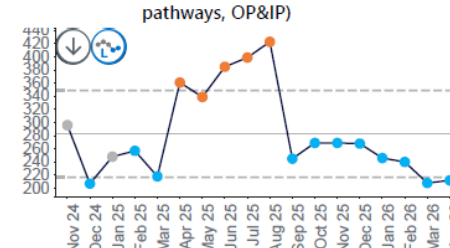
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral

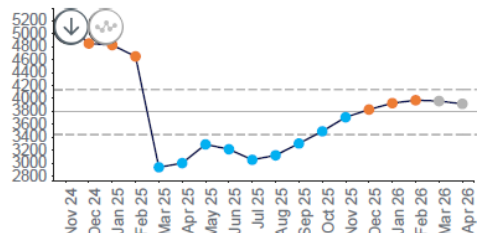


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)

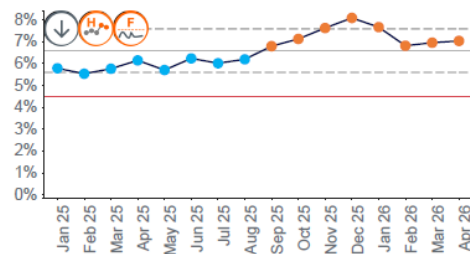


Divisional Performance Summary - Surgery

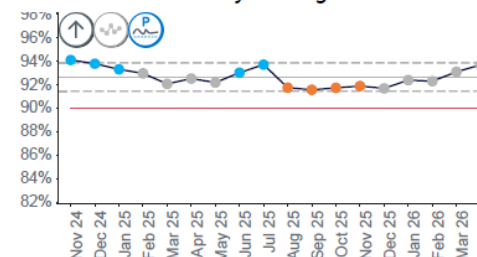
Volume of active outpatient follow up waits - 2 Years & Overdue



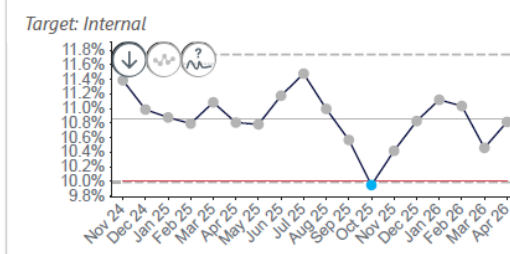
Sickness Absence Overall



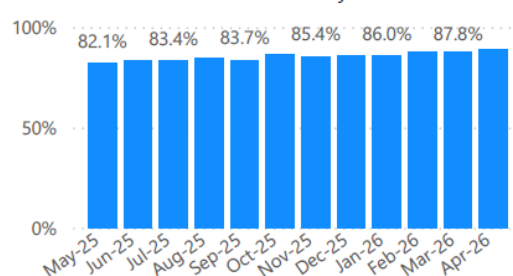
Mandatory Training



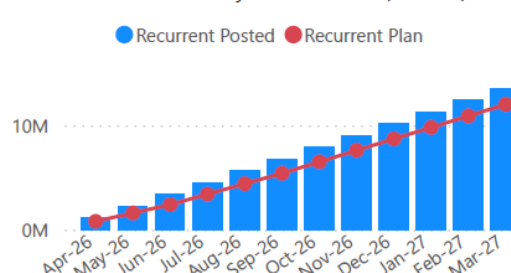
Staff Turnover



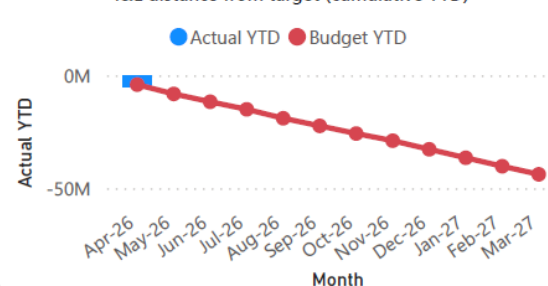
Workforce Stability



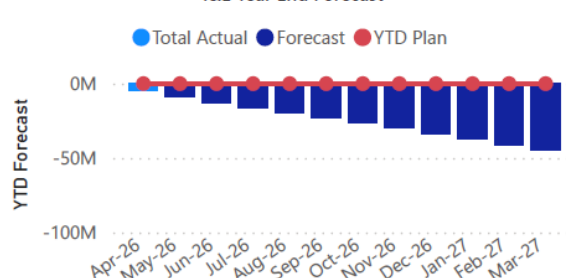
Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



I&E Year End Forecast



DIVISIONAL PERFORMANCE SUMMARY – CORPORATE



SRO: Erica Saunders, Chief Corporate Affairs Officer



HIGHLIGHTS

- The Corporate Services Collaborative did not meet in May during the transition to new systems. The data pack was shared with members for information. Key April highlights were:
- PDR compliance for B7+ remained above target at 96%.
- Mandatory training compliance remained above target at 93%.
- 92% of risks were in date (3 risk overdue) with Digital dominating the risk profile.
- 8 high risks
- 26 moderate risks
- 3 low risks
- £5.3m recurrent CIP identified, with £2.5m delivered (posted)
- Short term sickness absence: 1% (below target)



AREAS OF CONCERN

- Overall corporate document compliance at 92% (below 95% target) with a worsening trend since March 2026. 25 overdue documents remain across clinical governance, IPC, HR and estates.
- Long term sickness absence: 4% (above target, increasing)
- Overall sickness absence: 5% (above target)
- Overall PDR completion: 81% (below 90% target)
- £0.47m overspend in M01, driven by known cost pressures
- Academy (apprenticeship levy and income targets)
- Alder Hey in the Park (energy, water, room bookings)
- Facilities (linen, security, car parking)



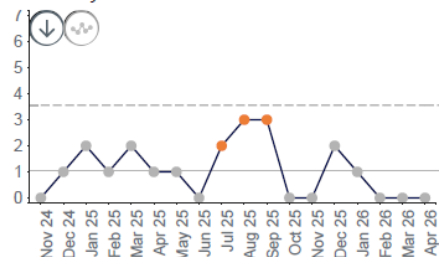
FORWARD LOOK (WITH ACTIONS)



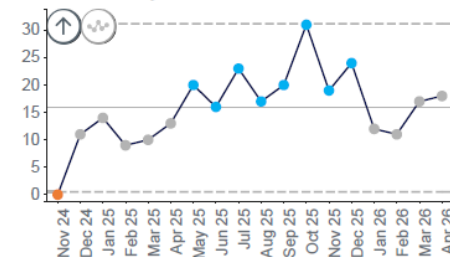
The division's forward plan will focus on strengthening financial recovery and CIP delivery, improving policy compliance, addressing key digital and estates risks, and improving workforce performance, particularly around sickness, turnover, and PDR completion, alongside maintaining strong training compliance.

Divisional Performance Summary - Corporate

Patient Safety Incidents rated Low Harm & Above



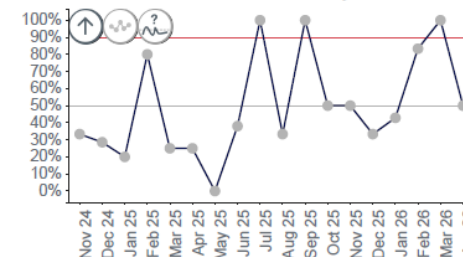
Patient Safety Incidents rated No Harm



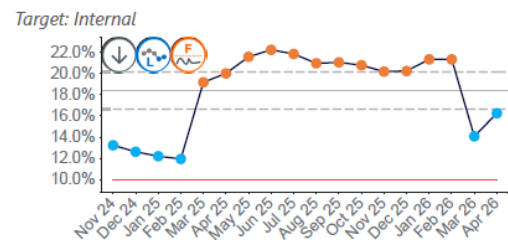
% Complaints Responded to within 25 working days



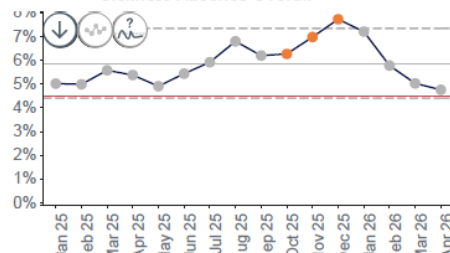
% PALS Resolved within 5 Days



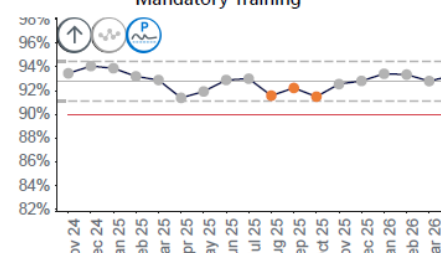
Staff Turnover



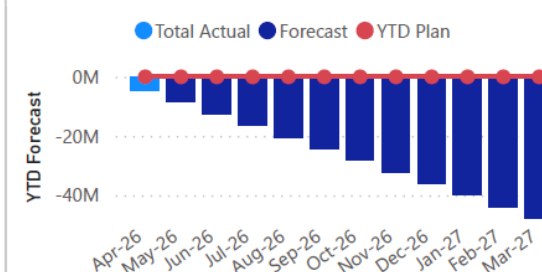
Sickness Absence Overall



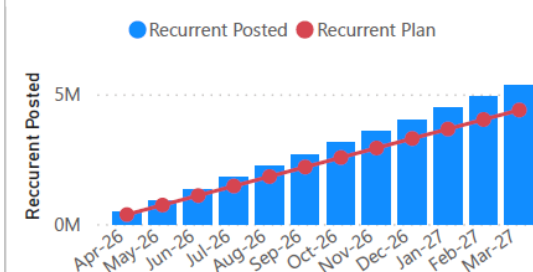
Mandatory Training



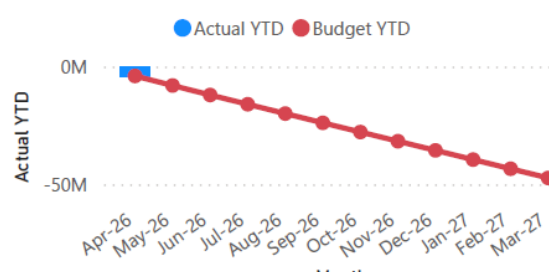
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Q3 2025/26 NOF

Mar-26 Published

Trust rank

14 out of 134

Previous quarter's rank: 10 out of 134

OVERALL DOMAIN PERFORMANCE



PERFORMING WELL		
	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	2.11
	ED 4-hour performance % admitted, transferred or discharged within 4 hours	1.00
	Financial position Combined finance & planned surplus/deficit	1.00

REQUIRES ATTENTION		
	Sickness absence rate High absence impacting workforce capacity	3.60
	C. difficile infections (12 months) Above target	4.00
	Proportion of E. coli bacteraemia (12 months) Above target	3.70

PERFORMANCE BY DOMAIN – KEY METRICS

DOMAIN & METRIC		DEC-25 PUBLISHED	SEP-25 PUBLISHED	JUN-25 PUBLISHED	TREND (vs previous period)	CURRENT RANK
Access to Services	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	2.11	2.27	3.05	↓	49/131
	Difference between planned and actual 18 week performance	1.00	1.00	3.78	↓	36/131
	Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	2.61	2.10	2.55	↑	65/131
	Percentage of patients waiting over 52 weeks for community services	2.35	2.64	3.20	↓	34/77
	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	1.00	1.12	→	4/123
	Annual change in the number of children and young people accessing NHS-funded MH services	2.39	1.96	1.94	↑	9/20
Effectiveness & Experience	Average number of days from discharge ready date to actual discharge date (including zero days)	1.00	1.00	1.00	→	1/127
		1.05	1.05	1.05	→	3/124
Patient Safety	Number of MRSA bacteraemia cases (12 months)	2.28	2.00	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)	3.70	3.68	3.98	↑	n/a
People & Workforce	Sickness absence rate	3.60	3.54	3.25	↑	132/134
	NHS staff survey engagement theme sub-score	1.25	1.25	1.25	→	12/134
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	2.00	→	14/134
	Implied productivity level	1.70	1.32	1.43	↑	32/134

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Compliments, Complaints and PALS report Q4 and Year End 2025/26
Report of:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

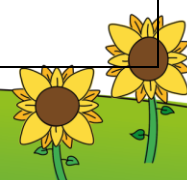
Purpose of Paper:	Decision ☐ Assurance ☒ Information ☐ Regulation ☒
Action/Decision Required:	To note ☐ To approve ☒
Summary / supporting information	To provide update and assurance on the performance against complaints and PALS targets in Q2 2025/26: 3 day acknowledgement of formal complaints: average 90% compliance in Q4; 89% in year 25 working day response to formal complaints: average 90% compliance in Q4; 87% in year 5 working day response to informal PALS concerns: average 97% compliance in Q4; 94% in year The main themes continue to be treatment and procedure, access to appointments and communication. Examples of lessons learned and action taken included
Strategic Context This paper links to the following:	Outstanding care and experience ☐ Collaborate for children & young people ☐ Revolutionise care ☐ Support our people ☐ Pioneering breakthroughs ☐ Strong Foundations ☐
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☒

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

Risk number	Risk description	Score

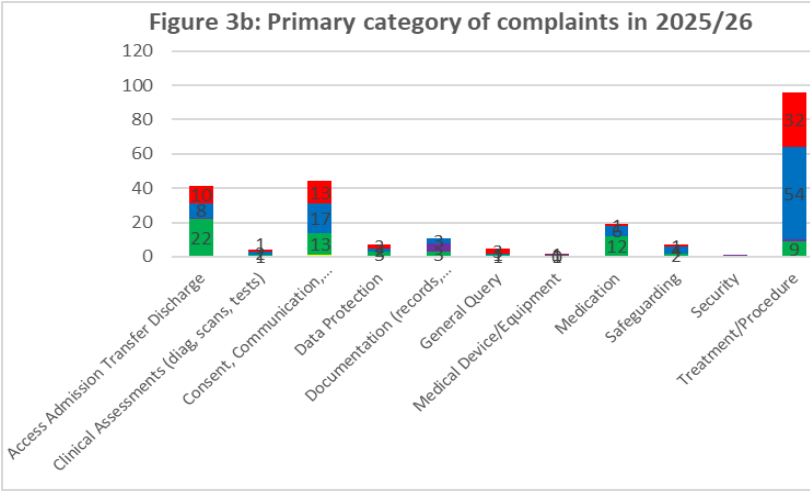
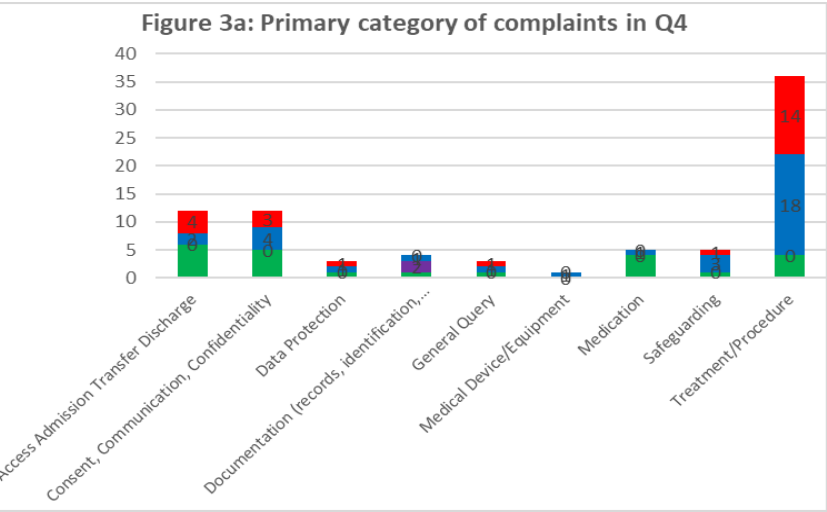
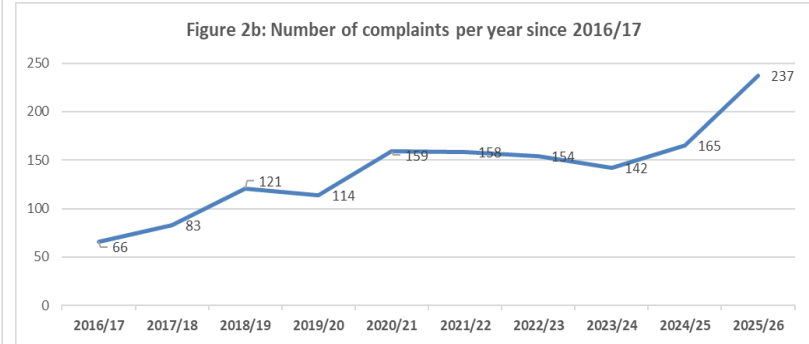
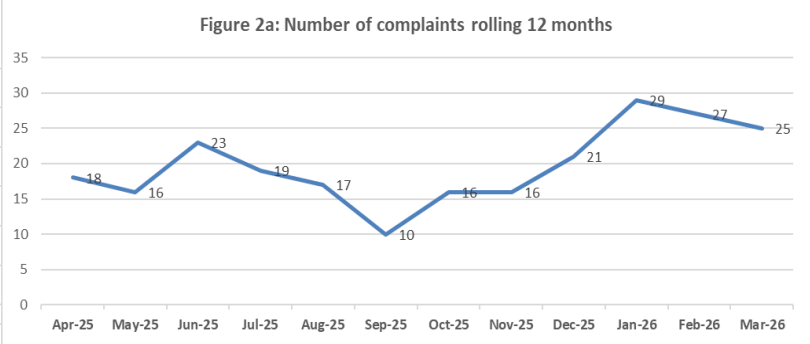
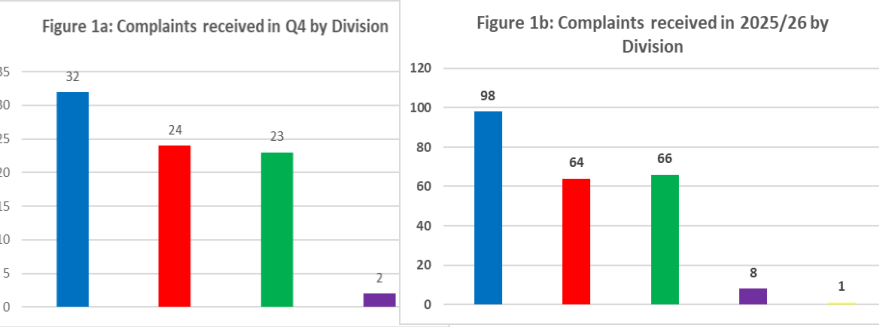
Level of assurance (as defined against the risk in InPhase)	☐ Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ Not Assured Evidence indicates poor effectiveness of controls
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Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q4 2024/25 and the full year of 2024/25 and a thematic analysis of the top reasons for complaints and PALS
Vision and Goals	The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. Where care and treatment does not meet the standard of care expected, the Trust has a duty to listen to their concerns, wherever possible resolve at the first point of contact, investigate concerns, and provide a full, appropriate, and compassionate response.

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



Complaints: In Q4, 81 formal complaints were received which is the highest number recorded. The increase in complaint numbers was seen across three clinical divisions (not Research). Analysis has shown that whilst the main reasons for complaints is the same as previous years (treatment and procedure (44%), ADT (15%) and communication 15%), there has been a significant increase in AI generated complaints. These AI complaints can be more complex and challenging to interpret, however it is recognised that AI may be perceived by patients and families as making raising a concern easier and more accessible by patients and families. In year, there were 237 formal complains raised; a rise due to Q4. Main reasons continue to be treatment and procedure (40%), communication (18%) and ADT (17%).

Compliments, Complaints and PALS Report – Q4 and Year End 2025/26



Figure 4: Trust overall compliance with 3 day acknowledgement of complaints - rolling 12 months

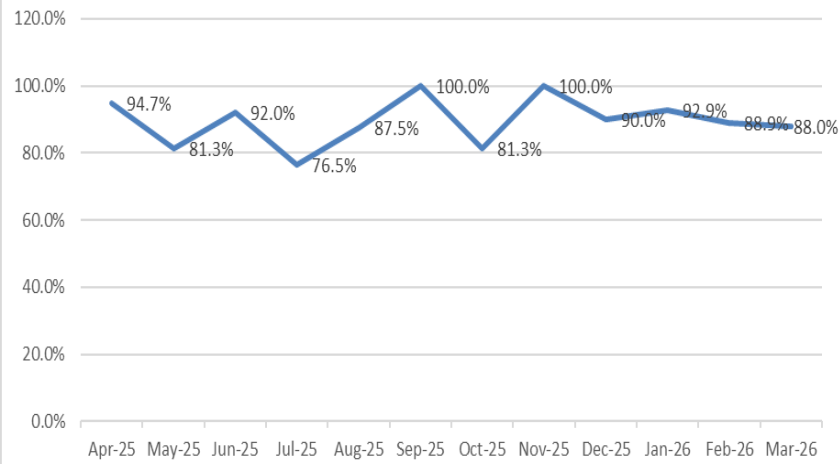
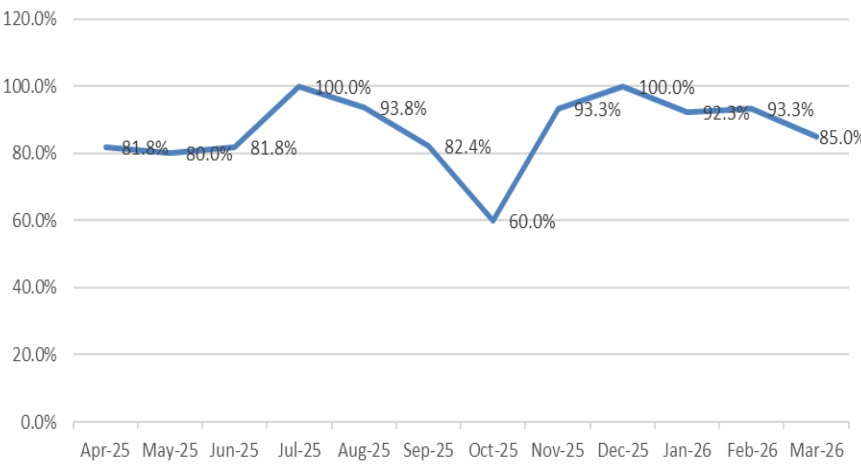


Figure 5: Trust overall compliance with 25 day response to complaints - rolling 12 months



Percentage compliance with 25 day response by Division				
Division	Q1	Q2	Q3	Q4
Medicine	94%	100%	93%	100%
Surgery	69%	87%	80%	80%
Community & Mental Health	76%	78%	100%	82%
Corporate Services	NA	NA	50%	100%
Research and Innovation	NA	NA	100%	NA

Complaints: Trust overall not compliant with the 3 day acknowledgement; average 90% compliance in Q4 and 89% compliance in year. 48 complaints investigated and responded to in Q4 and 193 in year.

Figure 6a: Outcome of complaints responded to in Q4

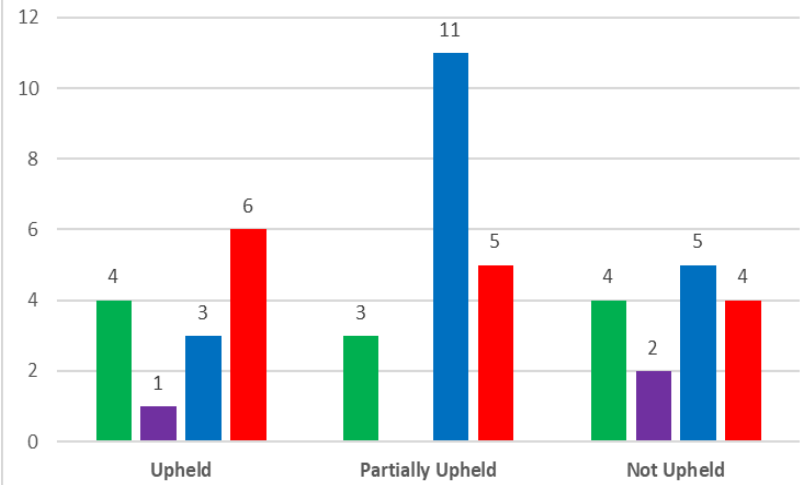
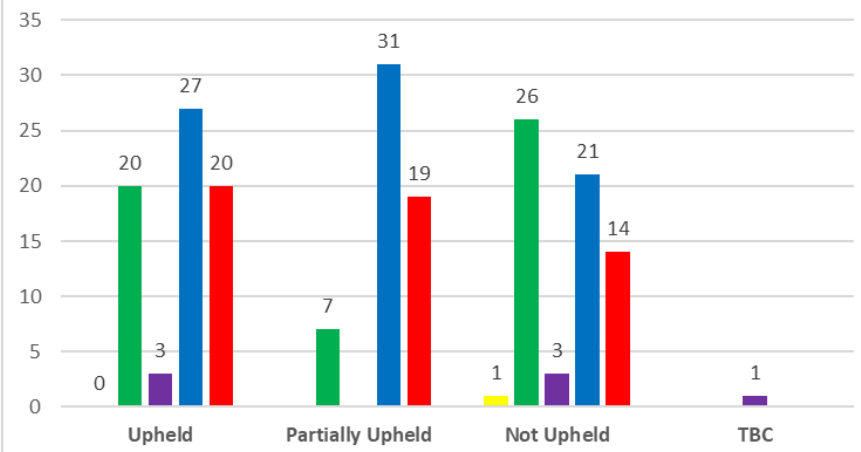


Figure 6b: Outcome of complaints responded to in 2025/26



Trust overall not complaint with the 25 working day response; average 90% compliance in Q4 and 87% compliance in year as shown in Figure 5. The table demonstrates the performance within the Divisions. This is a sustained high performance particularly in view of the high number of complaints received in Q4.

PHSO: Two cases opened in Q4 in the Division of Surgery. PHSO have met with the Trust and PHSO have proposed mediation as an option for consideration in certain cases; one case under consideration in the Division of Medicine



Figure 7a: PALS received in Q4 by Division

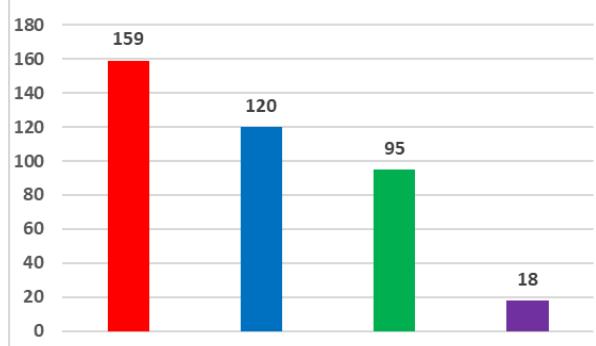


Figure 7b: PALS received in 2025/26 by Division

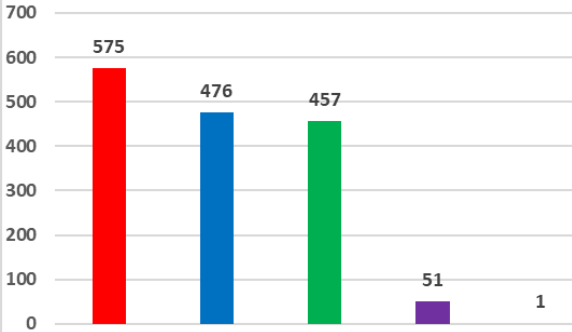


Figure 8a: Total number of PALS - rolling 12 months

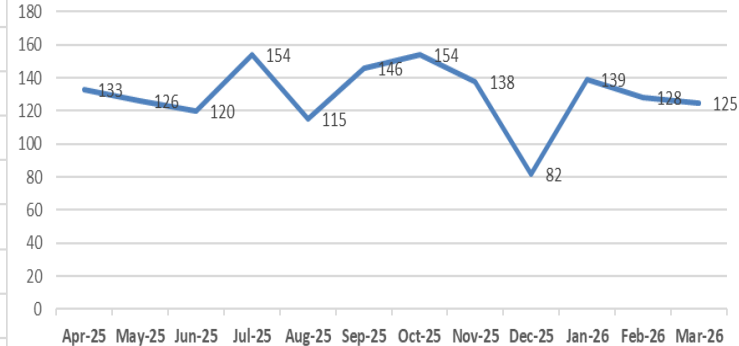


Figure 8b: Total number of PALS per year since 2016/17

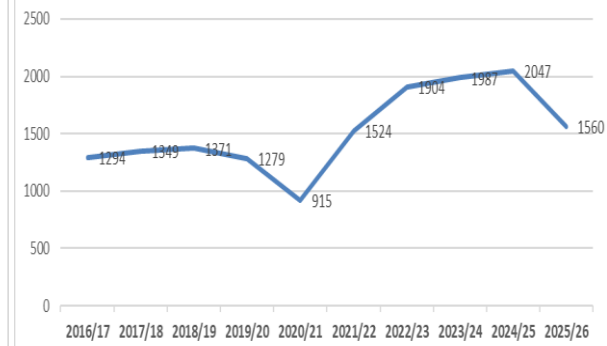


Figure 9a: Category of PALS - Q4

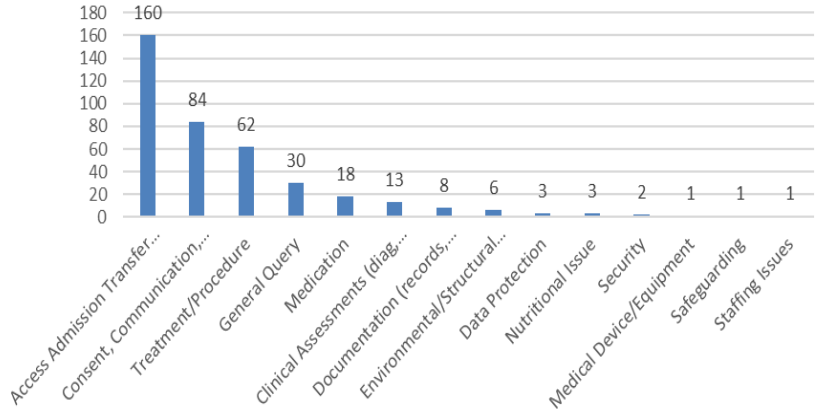


Figure 9b: Category of PALS - 2025/26

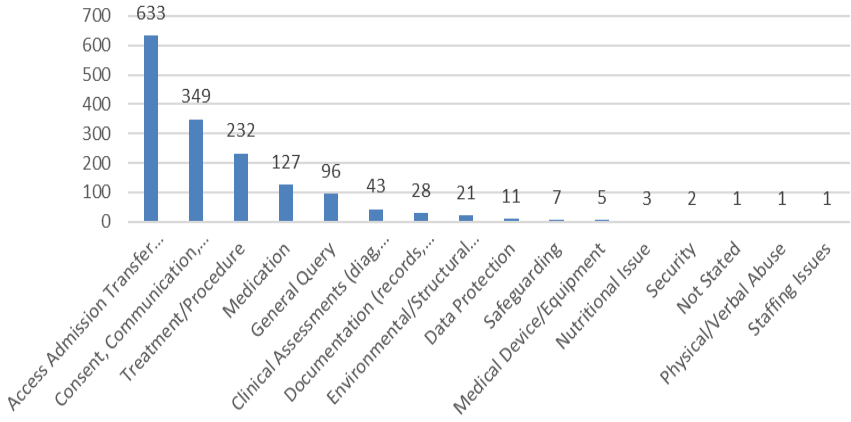
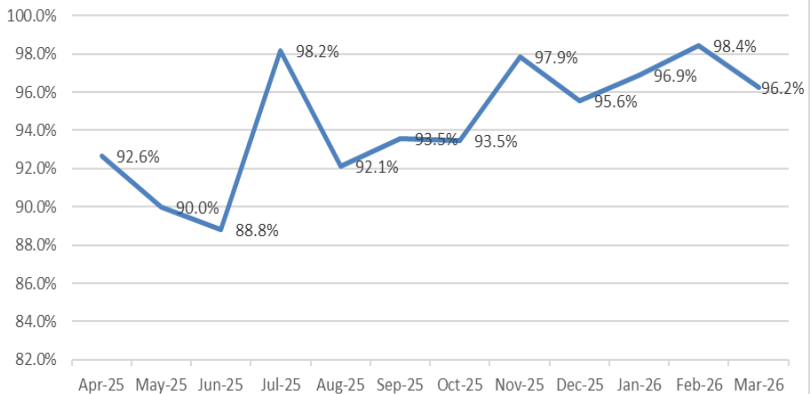


Figure 10: Trust overall compliance with 5 day response to PALS - rolling 12 months



PALs - Percentage compliance with 5 day response by Division

Division	Q1	Q2	Q3	Q4
Medicine	98%	100%	99%	100%
Surgery	98%	99%	98%	99%
Community & Mental Health	76%	89%	92%	93%
Corporate Services	60%	64%	60%	83%

PALS: In Q4, 392 PALS concerns were received which is a significant decrease from Q3 (534). In year, 1560 PALS concerns were received which is a decrease on the previous 4 years though as seen, formal complaints have risen. Sustained improvement in compliance with the 5 working day response; average 97% compliance in Q4 and 94% in year. Corporate services compliance is reviewed on a monthly basis by the Corporate Collaborative. The main themes continue to be access to appointments, medication delays in Community and communication. Medication delays have been actioned by the new Cleo system regular medication reviews and releasing prescriptions. The Community Division have implemented Customer Service Training for staff

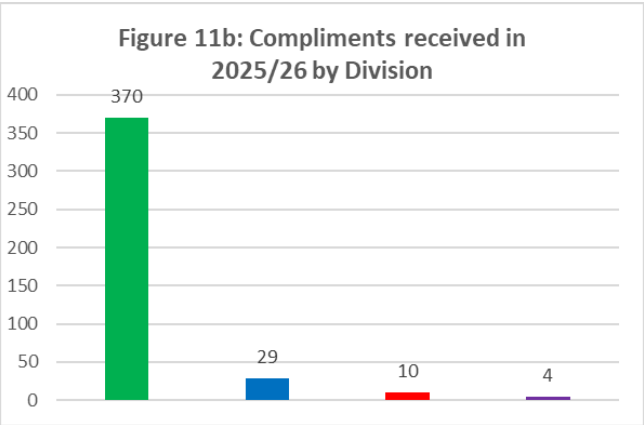
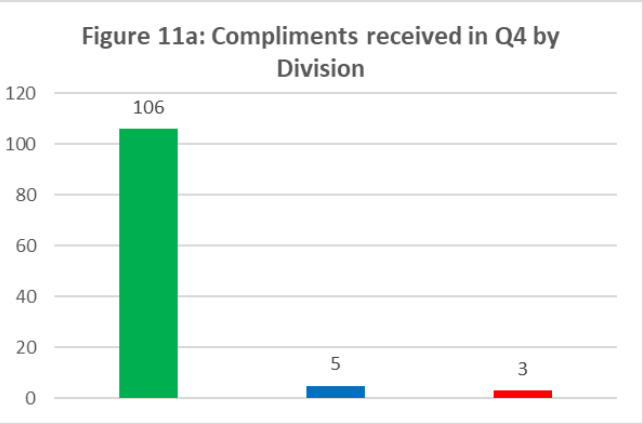


Learning from complaints and PALS: Alder Hey is a learning organisation and uses complaints as a mechanism for taking forward improvements and changes in practice.

Lessons learned and actions taken in Q4 include the following:

Lessons Learned and Actions

- Parental concern is a key factor to be considered and communicated at the time of discharge. The importance of listening to and responding to parental concerns discussed at clinical team meeting. Martha's rule training has been completed by staff on PAU and the unit is promoting this
- Importance of consistent messaging across medical and nursing teams to ensure families receive clear and unified information. Monitoring of the type of dressing that was used to ensure this would not happen again. The nursing team reminded at safety huddle regarding the importance of communication with parents. Ensure Nurses and HCAs work together and delegate tasks to each other if they are aware they are likely to be delayed attending to basic care needs
- Following delay in receiving tests results following a video fluoroscopy study learned that clear and timely documentation should be completed after each assessment. **Action:** A review has taken place for the period between December 2024 – March 2025 which highlighted 3 cases where reports had not been generated. Discussed at the SALT operational meeting.
- It is important to clearly communicate any safeguarding concerns or referrals to families to help reduce additional anxiety. The patient's health record has been updated
- Ensure PCO's are aware of correct process for clinical sign off for letters and disclosure process via automated workflow.
- Ensure recipient email addresses and attachments are validated prior to sending to ensure correct data attached.
- Improving communication and coordination between administrative and clinical staff to ensure that all necessary updates are completed and clearly documented before listing patients.
- Reviewing and updating our patient-tracking processes to ensure that any patient who has not been reviewed within the last 12 months is identified before being listed for GA.
- Information leaflet to be created, detailing NHS support services.
- Exploration of Alder Hey's Infant Feeding team supporting Outpatients as well as Inpatients.
- ENT specialist nursing team to re-visit and refresh knowledge of NHS provision and support for infant feeding.
- Lead for Tissue Viability and Lead of Orthotics finalising a risk assessment checklist for all orthotic patients. This will be completed by the Orthotist at every appointment where an orthotic good is being delivered. This checklist will allow us to identify at risk patients going forward. Patients who are identified as high risk are to be fitted with prophylactic dressings prior to fitting of their orthotic device. Medium risk patients will be offered prophylactic dressings to have on standby in case of any redness whilst waiting for feedback or review by Orthotics or Ponseti Team. As an interim measure while waiting for this checklist to be finalised, all new babies requiring boots and bar will be treated as high risk and will be fitted with their new device with DuoDerm dressings in situ. If at any stage marking is present despite DuoDerm, we will get input at this stage from Tissue Viability and can also progress to Mepilex dressings.
- Written information outlining report-writing standards and oversight processes will be shared with Tier 4 team; the service will ensure documentation is monitored to comply with Trust and regulatory standards for factual and balanced clinical documentation.
- Clarification of processes and pathways between Crisis Care and Mersey Care NHS Foundation Trust
- Cascaded with the HDU Nursing and Medical team about the importance of documentation in relation to any interruptions of intravenous medications inclusive of blood transfusions.
- Clear responsibility for follow up actions – ensuring all requested investigations are confirmed and tracked
- Proactive communication with Families – providing updates when plans change or results updates are delayed.
- Consider how we communicated the discharge discussions and confirmation that the parent/carer is happy to take the child home following their discharge
- Ensure all discharge information is provided before the patient leaves the hospital. SDC Ward manager to complete snapshot audit of the electronic patient record to ensure staff are completing that the discharge information is provided prior to discharge.
- The importance of good communication between staff and parents.
- When completing a clinical session with a child, young person and/or family, it is important to minimise any distractions. Mobile phones should be silenced or left with a colleague if needed.
- To maintain confidentiality and abide by Trust Data Protection policies, all computers should be locked if left unattended.



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

Success Highlights	90% of formal complaints responded to within 25 working days in Q4 and 87% in year however there is potential room for improvement to ensure families receive a response in a timely manner 97% of informal PALS concerns responded to within 5 working days in Q4 and 94% in year which is excellent performance and compliance
Feedback and lessons learnt	Divisions capturing actions and sharing learning at the Patient Experience and Engagement Group
Escalations and Risks	Significant increase in complaints associated with increase in AI generated complaints. Workshops held and strategies to address concerns through increased local resolution explored and identified. Digital team supporting and review of Trust systems, process and policy underway. The Trust welcomes and encourages families to feedback and recognise that AI can act as an enabler. Trust working with Healthwatch to promote and increase advocacy.

BOARD OF DIRECTORS

Thursday, 4th June 2026

Report of:	Nathan Askew Chief Nurse
Paper Prepared By:	• Pauline Brown Director of Nursing • Colm Mac Eoin AHP Workforce and Education Lead • Vikki Hughes Head of Nurse Education and Support Worker Development • Lisa Westley Lead Nurse for Retention The following staff are acknowledged and thanked for their support in compiling this paper: • Debbie Hughes Head of Nursing and AHP's Medical Division • Jayne Guy Head of Nursing & AHP's for Diagnostics & Clinical Services • Cathy Wardell Associate Chief Nurse Medicine • Liz Grady Practice Education Facilitator
Subject/Title:	Nursing Workforce Report 2025/2026
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Quality Network for Community CAMHS Standards for Services: Royal College of Psychiatrists, 2020 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018

	- NHS Long Term Workforce Plan, June 2023 10 Year Health Plan for England: Fit for the Future: Gov.UK; July 2025		
Purpose of Paper:	This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing in accordance with NQB guidance To inform the Board of Directors of nursing workforce activity and progress in 2025/26 and proposed workforce improvements in 2026/27.		
Action/Decision Required:	The Board of Directors are asked to approve the following: The content of the report and assurance that appropriate information is being provided to meet national and local requirements. - The information on safe staffing and the impact on quality of care - Proposed workforce developments		
Summary/Supporting Information	Annual staffing report		
Link to: ➤ Trust's Strategic Direction ➤ Strategic Objectives	- Provider of 1st choice - Deliver clinical excellence		
Resource Impact:	none		
Does this relate to a risk? Yes ☐ x 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	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	☐ 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

The aim of this paper is to provide assurance to the Trust Board of Directors 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.

Recruitment activity in 2025/26 was more targeted than in previous years, reflecting the Trust's low vacancy position and wider financial pressures. During the year, 69 Band 5 Registered Nurses were recruited by headcount, and the March 2026 ESR summary showed the NMC registered workforce above budgeted FTE at year end.

The 2025 establishment review provides assurance that ward staffing requirements have been reviewed through a robust, evidence-based and professionally led process. The Registered Nurse funded establishment is aligned to assessed requirement, with a minimal over-establishment of 5.61 WTE across the wards and departments reviewed, excluding Ward 1C Neonatal. The review highlights continued pressure in relation to HCA capacity, Band 6 skill mix and staff availability.

In 2025/26, a funded NHSP line was created for Band 5 and Band 3 nurses across wards / departments by realigning 5% of the 23% uplift. This did not incur any reduction or change to the approved funded establishment for that area.

Monthly safer staffing data shows that Registered Nurse fill rates remained broadly stable and generally above the 80% threshold. HCA fill rates were 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.

The main workforce pressure during 2025/26 was staff availability rather than Registered Nurse establishment alone. Sickness absence, maternity/adoption leave, enhanced care demand, acuity and specialist skill requirements all affected availability and contributed to temporary staffing need. NHSP spend totalled £2.94m. In 2025/26, a funded NHSP line for Band 5 and Band 3 nursing staff was created by realigning 5% of the 23% uplift meaning that only bank usage above the 5% is additional temporary bank spend. NHSP uptake remained variable, particularly for HCA shifts, demonstrating that bank staffing does not create additional workforce capacity in isolation.

The overall 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. However, Band 5 retention remains an area of concern when compared with paediatric peers.

Staff survey results show positive indicators for professional purpose, safety culture and staff voice, but continued pressure in relation to wellbeing, burnout, recognition, flexible working, work-life balance, appraisal quality and career development.

Overall, the report provides assurance that safe staffing continued to be actively monitored and managed. Continued focus is required on HCA capacity, staff availability, sickness absence, maternity/adoption leave, temporary staffing resilience and Band 5 retention.

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care delivered by the right staff, in the right place, with the right skills, and to ensure we have a resilient, resourced, well trained nursing and HCSW workforce to deliver this.

This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing.

This report will outline the key national guidance and regulatory requirements related to nurse staffing, a summary of achievements in 2025/26, compliance with workforce standards, and provide assurance on safer staffing requirements as set out in the National Quality Board (NQB) guidance; meeting NQB guidance is key to compliance with the CQC fundamental standards on staffing.

The report details proposed workforce improvements in 2026/27 which include implementation of the new Target Operating Model.

2. National context and regulation

Trusts are expected to comply with the CQC fundamental standards on staffing; key to compliance is meeting NQB guidance including *Developing Workforce Safeguards* (NHSI, 2018).

There are a number of tools available to support in determining safe staffing levels. The Trust is in Year 3 of implementing the NHSE Children and Young People Safer Nursing Care Tool (SNCT) and Year 2 of implementing the Emergency Department SNCT and the Mental Health Optimal Staffing Tool (MHOST) on Sunflower House. The SNCTs support Trust's to determine optimal nurse staffing levels by measuring patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.

The tools currently used at Alder Hey are Royal College of Nursing standards nurse to patient ratio, skill mix review, patient acuity and dependency assessment using SNCT data, professional judgement, and triangulation with nurse sensitive indicators.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine lay out standards for care of neonates (BAPM, 2011). The Royal College of Psychiatrists set out CAMHS standards (RCP, 2020).

The National Quality Board (NQB, 2017) set out improvement tools specifically for the care of children and neonates based on their expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time.

A specific workforce statement is provided in the annual governance statement which is monitored by NHSE. Implementing the recommendations and strong, effective governance, provides Trust Board assurance that workforce decisions promote patient safety and comply

with the Care Quality Commission's (CQC) fundamental standards, NHSI compliance and the Board's statutory duties.

In June 2023, the NHS Long Term Workforce Plan was published, setting out an ambition to grow and reform the NHS workforce through the three priorities of train, retain and reform. The plan included an ambition for up to 170,000 more nurses by 2036/37, supported by increased education and training, improved retention and reform of roles and ways of working.

In July 2025, the Government published the 10 Year Health Plan for England: Fit for the Future, setting out three major shifts for the NHS: hospital to community, analogue to digital, and sickness to prevention. For nursing, this reinforces the need to maintain safe staffing in current services while also preparing the workforce for changing models of care, increased use of digital technology, care closer to home, and a greater focus on prevention.

3. Workforce developments and achievements in 2025/26

The overall impact of the success of the nursing workforce strategy, including a reduction in vacancies, development opportunities, retention strategy and other initiatives to support safe nurse staffing are as follows:

3.1 Recruitment

- i. Recruitment activity in 2025/26 was more targeted than in previous years, reflecting the Trust's low vacancy position during the year and the need to manage recruitment in the context of wider financial pressures. The March 2026 ESR summary showed the NMC registered workforce above budgeted FTE at year end, supporting the overall position that vacancies were not the primary workforce pressure
- ii. During 2025/26, 69 Band 5 registered nurses were recruited by headcount.
- iii. The Trust has maintained a responsive recruitment approach, supported by strong partnership working between senior nursing teams, divisional nursing teams, Human Resources and the organisational recruitment team. This includes national recruitment days, a comprehensive induction offer and the continued preceptorship programme for new nursing staff.
- iv. The Trust continued to use a "one-stop" recruitment model during 2025/26, with candidates interviewed on the same day. In line with workforce requirements, successful candidates were placed either directly into available vacancies or onto a reserve list to be aligned to posts as vacancies became available. Through this process, 27 candidates were recruited; 18 were placed directly into vacancies and 9 were placed onto the reserve list. Of those placed on the reserve list, 5 subsequently withdrew and 4 remained on the reserve list until it expired.
- v. Recruitment activity continues to be supported by partnership working with Higher Education Institutes to attract student nurses from diverse backgrounds and to engage with the student workforce. This supports a clear offer to encourage students to identify Alder Hey as their preferred employer.
- vii. The Trust is also developing a new Health Care Assistant 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.

- viii. The Trust continues to attend regional Health and Social Care recruitment events, extending the reach of recruitment activity to potential candidates who may already hold the Care Certificate qualification.

3.2 Strong and effective leadership

- i. The Lead for Nurse Retention role has now transitioned to a substantive post. The role continues to support the Trust wellbeing offer, in conjunction with Thriving Teams, and contributes to Trust 2030 vision initiatives. The Lead for Nurse Retention also links with regional and national workstreams and contributes to internal and external reporting requirements. Role now has a focus on supporting all nursing staff rather than newly qualified staff majoritively
- ii. Secondment opportunities to AHP Workforce and Education Lead, and Head of Nurse Education and Support Worker Development posts to ensure strategic approach to workforce and education for nurses and AHPs underpinning commitment to work across the nursing and AHP workforces
- iii. Opportunities for staff to develop, grow and progress in the organisation.
- iv. Developed and commenced implementation of a clear structure for advanced and enhanced practice
- v. Internal promotion to Band 7 Ward Manager positions and Band 6 Ward Sister/Charge Nurse positions, Matron secondment and Heads of Nursing.
- vi. Continued implementation of relevant Safer Nursing Care Tools with senior leadership and validation of data collection

3.4: Educational developments

- i. Further implementation of the national Band 5 children and young people nursing competencies continues. This supports the embedding the organisational Band 5 development framework, which offers clear guidance through the initial first 2 years post recruitment, identifying the range of learning available and expected. The introduction has provided a 24-month progression framework for all Band 5 nurses within the organisation. The existing Band 5 framework can be used to further support this in addition to local progression pathways to meet each areas patient and family needs to support a standardised baseline of knowledge and skills to our Band 5 nursing workforce.
- ii. Band 6 Development programme: The Trust is reviewing the current regional and organisational resources to create a single flexible development programme to support Band 6 nurses.
- iii. A new leadership development programme has been launched for our international nurses which provides mentorship from senior staff and progression through key knowledge and skills sections.
- iv. Ongoing partnership working with our HEI partners to ensure full utilisation of existing placement capacity, and the opening of new placement opportunities as they arise.
- v. All nursing students are provided with organisational induction led by the PEF team. In 2025/26 a total of 516 students have received induction.
- vi. Delivery of a fully structured student engagement programme, with annual engagement days delivered for all nursing students, focusing on key skill development and enhanced knowledge building. 460 learners have attended student engagement days across 2025/26.

- vii. Implementation of a multiprofessional learner forum, which provides a learning hour and listening hour for all learners within the organisation to come together. Across 2025/26 155 learners have attended
- viii. Ongoing delivery of the Supportive Coaching in Practice (SCiP) model, to support our learners onsite utilising coaching skills.
- ix. Completion of Phase 2 of an IV pilot project, enabling final placement nursing students the opportunity to administer IV medication under direct supervision.
- x. Continuation of the Practice Education Recognition Certificate (PERC), which enables those student nurses who demonstrate exceptional practice, to be identified. 8 PERC's have been issued across 2025/26.
- xi. We continue to deliver a full day SSSA training programme, in line with NMC requirements to suitably prepare nursing staff to support and assess students. This training day enables supervisors to progress to the assessor role and introduces the preceptor role and coaching skills.
- xii. Practice Education Facilitators and Clinical Practice Educators continue to ensure required internal and external placement quality standards are met, address organisational education requirements, and provide a streamlined approach to a wide variety of staff development opportunities. There have been 1056 student placements provided 2025/2026.

3.5: Quality metrics

- i. Continued monitoring of different aspects of practice using the InPhase audit tool across all the wards.
- ii. The Ward / Departmental Accreditation programme has assessed all 25 wards and departments included in the programme.
- iii. E-roster system fully in place and monitored across wards, with KPI's reviewed updated and performance monitored.
- iv. Local challenge boards continue to monitor staffing at Divisional level providing information for recruitment events. They also provide assurance around key performance indicators reporting into Trust wide committees.
- v. Patient Safety Meetings continue to provide assurance around our safety culture.
- vi. Quality Ward Rounds undertaken with a range of quality topics reviewed. Involvement from the CYP Forum, young volunteers and Patient Safety Partners (PSPs) adds significant value to the process. Associated action plans are monitored via Divisional Governance committees. The quality rounds are undertaken by the senior nursing / AHP team and provide visibility and drive improvement work across all areas.
- vii. CNIO supporting digitally enabled quality improvements and solutions.
- viii. Monthly Safer Staffing report provides an update on quality metrics.

3.6: Retention

In 2025/26, there was a significant reduction in total Registered Nurse leavers, decreasing from 94.7 WTE in 2024/25 to 69.5 WTE in 2025/26. This improvement is also reflected within the Band 5 nursing workforce, where leavers reduced from 53.16 WTE in 2024/25 to 37.9 WTE in 2025/26. This can be attributed to the package of support available within early careers, particularly during the first one to two years in post. A reduction in leaver data can also be seen across all bands, as detailed in Appendix 3.

Retention data specific to Alder Hey continues to be tracked and compared with regional and national data, enabling targeted interventions and demonstrating improvement. Recent data

shows a reduction in leaver rates, particularly within the preceptorship period, covering the first 12 months in post.

The Professional Nurse Advocacy programme, led by the Lead for Nurse Retention, continues to grow. There are now 34 Professional Nurse Advocates delivering Restorative Clinical Supervision and wider aspects of the A-EQUIP model across the nursing workforce. A further 3 learners are currently undertaking training, which will further expand the PNA workforce.

Professional Nurse Advocates are now providing support across all divisions, with a specific focus within the Community Division as requested as part of the quality schedule.

All nurses are supported to complete the organisational Standards for Student Supervision and Assessment training, enabling them to meet Nursing and Midwifery Council requirements to support and assess student nurses. As part of this training, education is also provided in relation to the preceptor role and an introduction to coaching.

The Clinical Supervision for Nursing Policy has recently been ratified and incorporates the role of the Professional Nurse Advocate and the delivery of Restorative Clinical Supervision. As the role of the clinical supervisor and PNA continues to expand across the Trust, this provides further assurance that support is available to the nursing workforce.

The Support for Our People Toolkit is now available for all staff groups to access. This provides a signposting resource to support staff in receiving the right support, from the right person, at the right time.

Work also continues to support internationally educated nurses, in conjunction with the Head of Equality, Diversity and Inclusion, and through the Grow to Lead Sponsorship programme.

4. Nurse staffing model

4.1: Ward establishments

The staffing model is based on achieving compliance with national requirements, local patient acuity and dependency, professional judgement, benchmarking, and review of key quality, safety and workforce metrics as core components of safe staffing principles.

A full nursing establishment review was undertaken between 28 July and 22 August 2025. The review considered the current bed base, including the recent reduction in HDU beds, and included a forward look to the proposed bed base in 2026. The review followed a systematic and triangulated approach, incorporating national staffing guidance, use of valid and reliable acuity and dependency tools, professional judgement to meet local needs, and review of quality metrics including feedback from children, young people and families.

The following national standards and Safer Nursing Care Tools continue to be used to support establishment setting and workforce planning:

Table 1	
Ward / Department:	SNCT:
Ward 1C Cardiac	CYP (Children and Young People)
Ward 3A	CYP
Ward 3B	CYP
Ward 3C	CYP

Ward 4A	CYP
Ward 4B	CYP
Ward 4C	CYP
Sunflower House	MHOST (Mental Health Optimal Staffing Tool)
ED	ED (Emergency Department)

The following wards and departments continue to follow the relevant national staffing standards as there is not an SNCT applicable (the tools cannot be adapted for use):

Table 2	
Ward / Department:	SNCT:
Ward 1C Neonatal	BAPM (British Association of Perinatal Medicine)
PICU	PICS (Paediatric Intensive Care Society)
HDU	PICS
Burns Unit	RCN (Royal College of Nursing)
Renal Unit	RCN
EDU / PAU	RCN
SDCU	RCN
MDU	RCN
OPD	RCN

Patient acuity data was collected twice during 2025, in February and June, for 28 days across inpatient wards within scope of the Children and Young People Safer Nursing Care Tool. Ward 1C Cardiac and Ward 4A completed shorter periods of data collection in one or both periods and further data collection was therefore undertaken to strengthen the evidence base. Sunflower House and ED completed their first data collection periods in February and June 2025; following discussion with the NHSE Safer Staffing Faculty, Sunflower House are repeating MHOST data collection to ensure the data is sufficiently robust to inform future establishment planning.

The CYP Safer Nursing Care Tool (SNCT) Ward Multipliers have now been used as part of the establishment-setting process. There were significant variances between the output of the SNCT multipliers and the funded or recommended establishments identified through the Trust's traditional methodology. The SNCT multipliers generally produced a lower suggested establishment, largely because the tool is affected by actual occupancy at the time of data collection and the number of patients scored at higher acuity levels. Professional judgement has therefore remained essential when interpreting the outputs.

It has been agreed with the Chief Nurse that wards and departments will continue to be profiled based on actual bed base rather than bed occupancy alone. Professional judgement has been applied to empty beds and Level 0 beds within the multiplier tool for transparency. Additional professional judgement has also been applied to reflect the impact of the high number of cubicles across the majority of wards, which has implications for safe staffing and visibility.

The establishment reviews were facilitated by the Director of Nursing to ensure a consistent approach. Ward Managers, Matrons, Heads of Nursing and Associate Chief Nurses were involved in the reviews, with input from HR and Finance Business Partners. The roster team also attended to support alignment between agreed staffing requirements and roster templates.

In 2025/26, a funded NHSP line was created for Band 5 and Band 3 nurses across wards / departments by realigning 5% of the 23% uplift. This did not incur any reduction or change to the approved funded establishment for that area.

The review concluded that the current funded Registered Nurse establishment across the wards and departments reviewed, excluding Ward 1C Neonatal, is 724.26 WTE, compared with an actual required profile of 718.65 WTE. This equates to a minimal over-establishment of 5.61 WTE. The current funded establishment for Band 4 staff is 18.98 WTE, compared with an actual required profile of 8.86 WTE, creating an opportunity to convert Band 4 funding to support Band 3 HCA roles. The current funded HCA establishment is 212.87 WTE, compared with an actual required profile of 219.44 WTE, indicating an under-establishment of 6.57 WTE. The key findings from the establishment review are summarised below:

Table 3: Summary of 2025 Nursing Establishment Review Findings				
Workforce group	Funded establishment	Required profile	Variance	Implication for safe staffing
Registered Nurses	724.26 WTE	718.65 WTE	+5.61 WTE	Aligned to assessed requirement
Band 4 staff	18.98 WTE	8.86 WTE	+10.12 WTE	Opportunity to convert funding to support Band 3 HCA roles
Health Care Assistants	212.87 WTE	219.44 WTE	-6.57 WTE	Under-established; requires targeted workforce action

Overall, the establishment review provides assurance that ward staffing requirements have been reviewed through a robust, evidence-based and professionally led process. The Registered Nurse funded establishment is aligned to assessed requirement; however, the review also highlights the need for ongoing focus on HCA workforce capacity, Band 6 skill mix, and the impact of staff availability to work on daily safe staffing.

In 2026/27 the new CYP SNCT tool will be implemented following the launch in May 2026. Whilst the existing tool is no longer considered valid it has been agreed with NHSE that acuity data collection scheduled for June 2026 will use the existing tool as training for the new tool, plus the requirement for repeated inter-rater reliability assessments, are planned for June and July 2026. Therefore establishment reviews planned for July 2026 will be based on the existing tool and the new tool will be used for data collection from February 2027.

4.2: Safer staffing levels

Trusts are mandated to provide nurse staffing information on a monthly return via the Strategic Data Collection Service and publish this data at ward level. The Trust remains compliant with this requirement.

The Trust produces a monthly Safe Staffing and Patient Quality Indicator Report to provide a summary of Registered Nurse and Health Care Assistant staffing fill rates, Care Hours per Patient Day (CHPPD), staffing status and associated workforce indicators. Fill rates are calculated by comparing the planned number of Registered Nurse and Health Care Assistant hours across day and night shifts with the actual hours worked over the month. Planned hours are set through the electronic roster and captured daily. The monthly percentage fill rate includes hours worked by both substantive and bank staff.

Areas where staffing fill rates fall below 80% are reviewed to understand any potential impact on patient safety, outcomes and experience. Across April 2025 to March 2026, Registered Nurse day and night fill rates remained broadly stable and generally above the 80% threshold. Health Care Assistant fill rates were more variable, with HCA day fill consistently lower than Registered Nurse fill rates and below 80% throughout the year. HCA night fill was more variable, remaining above 80% in most months but falling below 80% in August and December 2025. This supports the wider workforce position that HCA capacity and staff availability remained key operational pressures during 2025/26.

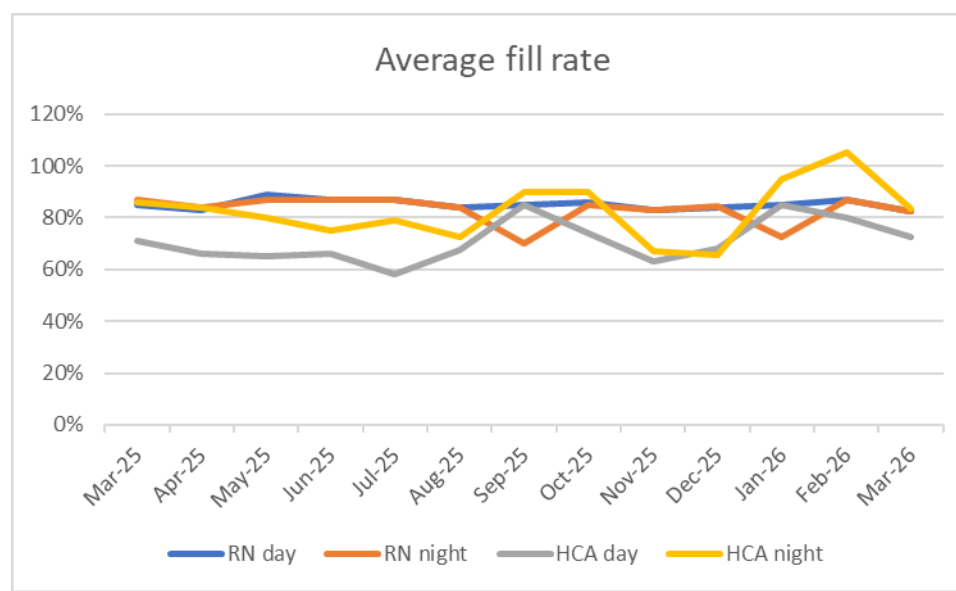


Figure 1: Average RN and HCA Fill Rates, April 2025 to March 2026

The year-end position in March 2026 showed a reduction in Registered Nurse fill rates compared with February 2026, with Registered Nurse day fill at 82.85% and Registered Nurse night fill at 80.39%. HCA day fill also reduced to 68.06%, while HCA night fill was 89.99%. This supports the wider workforce position that HCA capacity and staff availability remained key operational pressures during 2025/26.

CHPPD data should be interpreted alongside professional judgement, patient acuity, occupancy and activity. CHPPD is reviewed against the latest available Model Hospital benchmark data at the time of reporting. Benchmark data is not refreshed every month; where no updated benchmark was available, the most recently available benchmark was carried forward, in line with the approach confirmed by the safer staffing lead. Across the year, Alder Hey CHPPD was variable by ward, and month. The year-end position showed a greater number of areas below benchmark, particularly in February and March 2026, as shown in Appendix 2. This coincided with increased workforce pressures related to sickness absence, maternity/adoption leave, annual leave at the end of the leave year, reduced shift fill rates and an increased temporary staffing requirement. These findings reinforce the need to interpret CHPPD alongside fill rates, acuity, occupancy, quality indicators and professional judgement.

Safer Staffing meetings continue to provide daily operational oversight of staffing requirements and deployment. Staffing decisions are made in line with acuity, dependency, activity and risk. The staffing position is reviewed and escalated through the agreed staffing escalation process, including escalation to the Daily Operational Meeting and to the Chief Nurse by exception where required.

Staffing RAG data provides further assurance that staffing risk was actively monitored across the 24-hour period. Most shifts remained green or amber during the reporting period. There were three red-rated shifts in 2025/26: one night shift in October 2025, one day shift in December 2025 and one day shift in January 2026. Staffing pressures continued to be actively managed through daily Safer Staffing meetings, redeployment and escalation processes.



Figure 2: Registered Nurse Staffing Model, Day and Night, March 2025 to March 2026

E-rostering data also demonstrates increased workforce pressure towards year end. In February 2026, sickness remained above KPI at 9.2% and total unavailability increased to 33.6%. In March 2026, total unavailability increased further to 35.8%, unfilled roster shifts increased from 17.3% to 19.2%, temporary staffing hours increased to 9,207, and the percentage of shifts filled by temporary staff increased from 5.6% to 7.8%. This reflects the impact of higher levels of staff leave and unavailability, high sickness, maternity leave and increased operational pressure.

Overall, the monthly safer staffing data provides assurance that safe staffing continued to be actively reviewed and managed through established daily processes. Registered Nurse fill rates remained broadly stable and generally above the 80% threshold; however, HCA fill rates, sickness absence, maternity leave, total unavailability, unfilled roster shifts and temporary staffing requirement continued to present operational pressure during the year. These findings are consistent with the establishment review and ESR workforce summaries, which identify staff availability to work and HCA capacity as key workforce challenges.

5. Workforce challenges

5.1: Leavers

Detailed leaver data is supplied in Appendix 3 and demonstrates an improved overall leaver position, with the Trust continuing to compare favourably against the national position.

However, comparison with other paediatric trusts indicates that the Band 5 leaver rate remains an area of concern, as Alder Hey has not seen the same reduction demonstrated by some comparator organisations.

Alder Hey's paediatric Band 5 leaver rate reduced significantly in April 2025 to 3.8%. However, data from March 2025 and May 2025 showed leaver rates of 4.3% and 4.5% respectively, which are more consistent with the March 2026 position of 4.4%. This suggests that the April 2025 position may have been an anomaly. Comparator paediatric trusts have, on average, reduced their leaver rate by 1.6% since April 2025. In comparison, Alder Hey has broadly maintained an average leaver rate of approximately 4.4%, or increased by 0.6% if April 2025 is used as the baseline.

The main reasons for leaving the Trust within the last 12 months were voluntary resignation, with 48 leavers, predominantly due to relocation and promotion outside the Trust, and retirement or end of contract, with 23 leavers. Promotion has previously been highlighted as a reason for leaving in the 2023/24 and 2024/25 data and is again evident within the 2025/26 data. This continues to suggest a potential lack of opportunity for internal progression. This has primarily been highlighted within Band 5 and Band 6 staffing groups, although this is now also evident across all band groups.

Leaver rates for internationally educated nurses show a slight decrease compared with 2024/25. However, a high proportion of internationally educated nurse leavers, 67%, cited voluntary resignation for relocation or promotion as their reason for leaving.

Focused support has continued and expanded within preceptee cohorts, resulting in a continued decline in preceptee leaver rates. However, as the recruitment strategy shifts towards a more bespoke process and the lack of vacancies continues to impact on staff choice, preceptee tracking and preceptee experience have become more challenging. Early 2026 data demonstrates a slight increase in preceptee leavers compared with the same point in 2025.

The Internal Transfer Process, which previously offered existing Alder Hey Band 5 nurses the opportunity to relocate within the organisation, has been paused due to lack of vacancies. This creates further restrictions in relation to choice and internal movement, which is contributing to some staff leaving the Trust.

5.2 Staff Experience and Wellbeing

Staff survey results for the Registered Nursing workforce show a mixed picture. There are strong indicators of professional purpose, safety culture and staff voice, with nursing staff scoring above the organisation average for feeling that their role makes a difference to patients, confidence in reporting incidents, feedback following incidents, and feeling secure to raise concerns about unsafe clinical practice.

However, the results also highlight continued workforce pressure. Registered nursing staff scored below the organisation average for health and wellbeing, burnout, recognition and reward, flexible working, work-life balance and aspects of line management. These findings triangulate with operational workforce pressures relating to staff availability, sickness absence, maternity leave, temporary staffing and HCA vacancies.

Table 4: Staff Survey Results: Key Nursing Workforce Strengths and Areas for Focus			
Indicator	Nursing and Midwifery Registered	Organisation average	Interpretation
My role makes a difference to patients / service users	93.0%	89.1%	Strong professional purpose
Organisation encourages us to report errors, near misses or incidents	94.6%	92.0%	Positive safety reporting culture
I would feel secure raising concerns about unsafe clinical practice	84.7%	77.3%	Strong staff voice and speak-up culture
We are given feedback about changes made in response to reported errors, near misses and incidents	75.5%	68.5%	Positive feedback loop following incident reporting
Burnout sub-score	4.59	5.05	Area of concern for staff wellbeing
Enough staff at this organisation for me to do my job properly	31.1%	32.6%	Continued staffing pressure
Recognition I get for good work	50.4%	55.6%	Area for retention and engagement focus
Organisation is committed to helping me balance work and home life	47.7%	53.6%	Work-life balance remains an area for improvement
Appraisal helped me improve how I do my job	19.9%	22.6%	Appraisal quality and impact require further focus

The staff survey findings also provide useful context for the leaver data. Whilst the overall Registered Nurse leaver position has improved, Band 5 retention remains an area of focus. The survey does not identify reasons for leaving by band; however, the registered nursing and midwifery results highlight factors that may influence retention, including recognition, work-life balance, appraisal quality, line management and career development. Only 51.6% of registered nursing and midwifery respondents were positive that there are opportunities to develop their career in the organisation. These findings support the need to continue strengthening career development, progression, recognition and local support for early career nurses.

Overall, the staff survey findings support the continued focus on retention, health and wellbeing, compassionate leadership, appraisal quality, flexible working, career development and local recognition. These areas will remain important in supporting a resilient nursing workforce and reducing the impact of workforce pressures on staff experience and safe staffing.

5.3: Age profile of RN and Band 5 nursing staff

Age profiling and the potential for retirement is an integral part of effective workforce planning, enabling future workforce requirements to be identified and factored into the Trust's recruitment and retention strategy.

ESR data identifies 1,493 NMC registered staff by headcount, including 705 Band 5 registered nurses. Figure 3 identifies that 41 Band 5 nurses are aged 55 years or over and therefore may

be able to retire. This equates to 5.8% of the Band 5 nursing workforce. Across the full NMC registered workforce, 170 staff are aged 55 years or over, equating to 11.4% of the registered nursing workforce.

The age profile also demonstrates a relatively young, registered nursing workforce. Overall, 894 NMC registered staff are aged 40 or under, representing 59.9% of the registered nursing workforce. This is more pronounced within the Band 5 workforce, where 562 staff are aged 40 or under, representing 79.7% of Band 5 registered nurses.

Figure 3 shows the age profile of the full NMC registered workforce compared with Band 5 registered nurses.

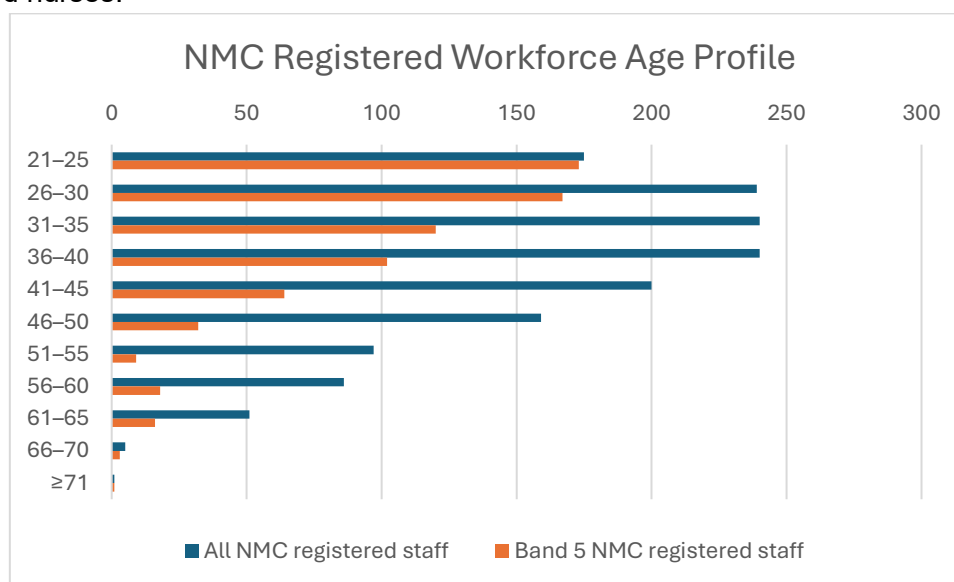


Figure 3: NMC Workforce Overall vs Band 5 Age Profile

Partial retirement options have been introduced and have encouraged a number of nursing staff to take their pensions but return to work.

Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years. This will take the form of 'stay interviews' which can occur anytime but mainly as part of the appraisal process.

5.4: Maternity and adoption leave

Maternity leave cover is not included within the calculated ward establishments. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the overall funded nursing establishment of 40 WTE to improve resilience in providing maternity leave cover.

The 2025 establishment review demonstrates that this provision remains essential. At the time of the review, the Band 5 Registered Nurse position showed an over-establishment of 40.13 WTE, broadly in line with the agreed 40 WTE maternity cover arrangement. However, this was offset by 40.09 WTE staff on maternity leave. Once leavers and new starters were also accounted for, the overall Band 5 position was an over-establishment of only 1.98 WTE.

March 2026 ESR data shows 52.52 FTE NMC registered staff recorded under Maternity & Adoption across the wider NMC workforce. Services in scope of this review accounted for

48.52 FTE of this total. This demonstrates that the 40 WTE maternity cover arrangement remains necessary but provides limited flexibility when maternity/adoption absence is above this level.

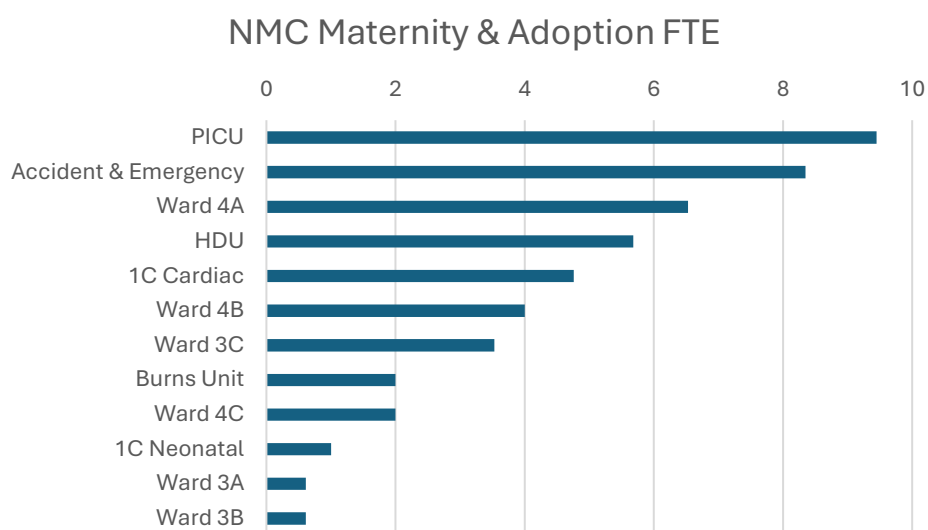


Figure 4: March 2026 Maternity and Adoption Leave

The highest NMC maternity/adoption FTE was recorded in PICU, Accident & Emergency and Ward 4A. This concentration of maternity/adoption leave reduces flexibility in areas already experiencing staffing pressure and reinforces the need for continued oversight through safer staffing review, redeployment and temporary staffing.

As reported previously, 60% of maternity costs are recovered from central government across the duration of a period of maternity leave absence, with the remaining 40% representing an internal Trust financial pressure. Maternity leave therefore remains both a workforce availability and financial consideration.

Overall, the data demonstrates that maternity leave continues to have a material impact on staff availability. Continued monitoring of maternity leave, sickness absence and temporary staffing use will be required to maintain safe staffing and understand whether the current maternity cover provision remains sufficient.

5.5: Sickness

Sickness absence continued to impact staff availability during 2025/26. ESR data shows variation in 12-month rolling sickness rates across the wards and clinical areas in scope for this report. This is important because sickness reduces the number of staff available to work, even where establishment or staff-in-post numbers appear sufficient.

Figures 5 and 6 show 12-month rolling sickness rates by ward, split by short-term, long-term and overall sickness.

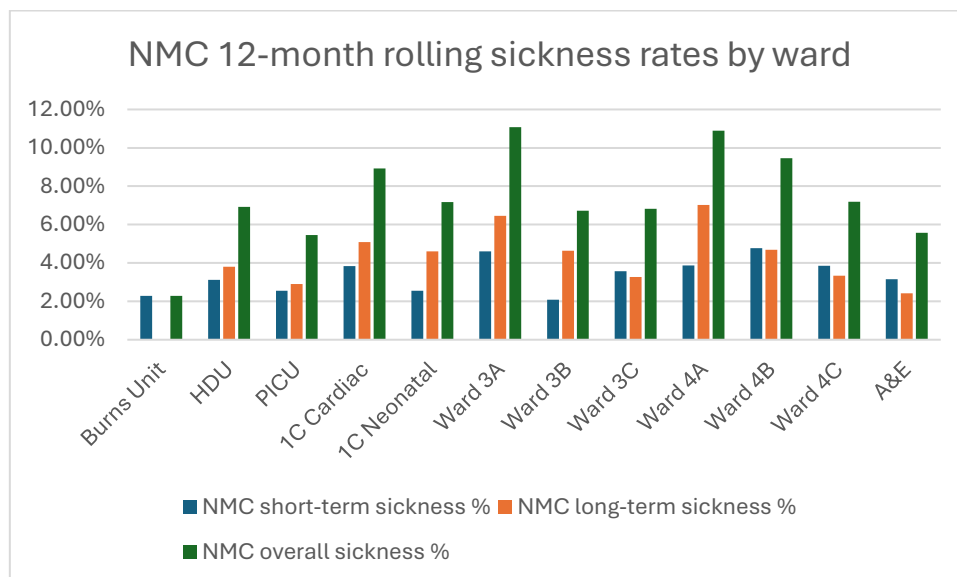


Figure 5: 2025/26 NMC sickness rates by ward

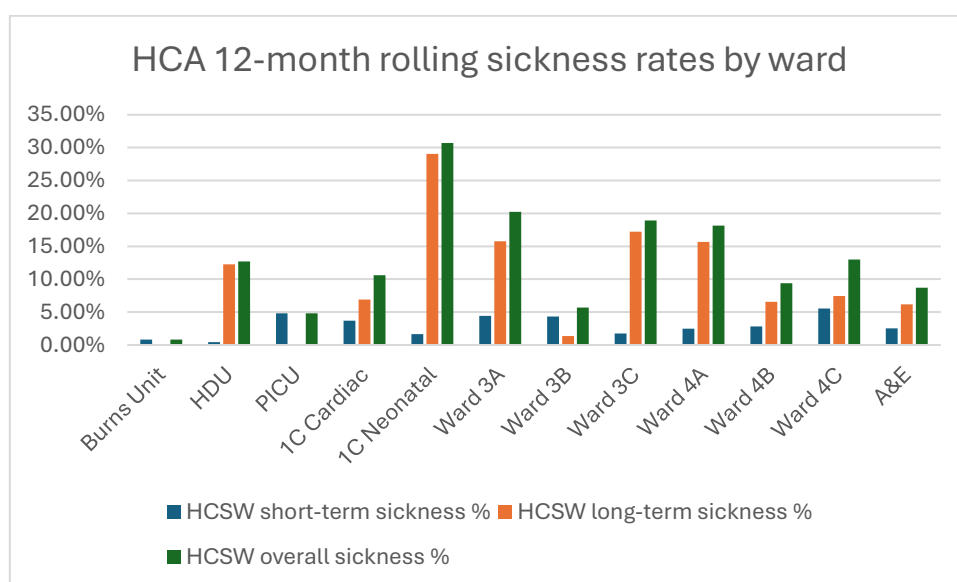


Figure 6: 2025/26 HCA sickness rates by ward

The NMC data shows higher overall sickness rates in Ward 3A, Ward 4A, Ward 4B and 1C Cardiac. HCA sickness rates show particular pressure in 1C Neonatal, Ward 3A, Ward 3C, Ward 4A, HDU and Ward 4C. Long-term sickness is a significant issue in a number of areas, particularly within the HCA workforce.

There is overlap between areas with higher sickness rates and areas with higher NHSP use. Ward 3A, Ward 4A and Ward 4B are identified in the sickness data and also feature in the NHSP spend data. This supports the wider workforce narrative that sickness absence contributed to reduced availability and increased reliance on temporary staffing during the year, however a funded NHSP line has now been created within existing ward / departmental funded establishments.

Overall, sickness absence remained a material contributor to reduced staff availability during 2025/26. Continued focus on sickness management, wellbeing support, return-to-work

planning and retention will remain important in supporting safe staffing and reducing reliance on temporary staffing.

5.6: Enhanced Therapeutic Observations and Care

The Trust continues to care for a significant number of patients who require 1:1 nurse to patient ratio of care outside of PICU and HDU areas. Oversight on a daily basis is provided through the Safer Staffing Meeting in line with the Standard Operating Procedure for one-to-one care (Developing Workforce Safeguards, NHSI 2018).

NHSE recognise 1:1 care as Enhanced Therapeutic Observation and Care (ETOC), and in August 2024 they launched the ETOC programme to support Trusts to make local, clinically led, and patient centred approaches that improve their care provision based on the following four pillars:

1. Effective leadership and oversight – including governance, data, local assurance, clinical policy making.
2. Effective person-centred and safe therapeutic care – including identifying the need for ETOC, monitoring and stepdown.
3. Effective education and training – ensuring that that staff are trained in reviewing, providing and overseeing ETOC.
4. Effective workforce planning and deployment – planning for levels of ETOC, ensuring that ETOC is considered during safe staffing establishment setting processes.

The Trust is part of the Cheshire and Mersey ETOC working group and has reviewed and aligned our policies and procedures to meet the standards. In support of the national programme to understand the demand for ETOC, monthly data was submitted via the PWR in 2025/26.

5.7: Temporary staffing: NHSP and agency

The Chief Nursing, AHP and Experience Officer has continued to lead a sustained drive to reduce bank and agency use. Temporary staffing remains under close scrutiny through the divisional reviews and daily oversight through the Safer Staffing Meeting. Strengthened controls remain in place for NHSP and overtime approval.

However, in 2025/26, to support Ward Managers to manage their budget more effectively, ward / departmental establishments were realigned across substantive and bank lines, to reflect that some bank shifts are required to cover sickness and other short term absences. By setting a more realistic budget, ward managers are now in a better position to manage financial resources appropriately. 5% of the 23% uplift was aligned from the substantive budget to an NHSP budget for each ward across Band 5 and Band 3 lines. On ED and PICU where the establishment for clinical Band 6 nurses is higher, Band 6 was also included. This strategy did not lead to any reduction in total allocated budget but supported a reduction in expenditure run rate and reduced the level of over- spending against agreed budget.

NHSP spend for April 2025 to March 2026 is outlined in Table 5 below.

Table 5: NHSP Spend 2025/2026	
Staff group	NHSP spend
Registered Nurses	£1,594,616
HCA / unregistered staff	£1,344,813
Total	£2,939,429

Overall NHSP spend reduced in the second half of the year, from £1.52m in April to September 2025 to £1.42m in October 2025 to March 2026. This was driven by lower HCA / unregistered spend. Registered Nurse spend increased in the second half of the year, peaking in February and March 2026. This reflected reduced staff availability due to sickness absence, maternity leave and annual leave at the end of the annual leave year, alongside increased operational demand.

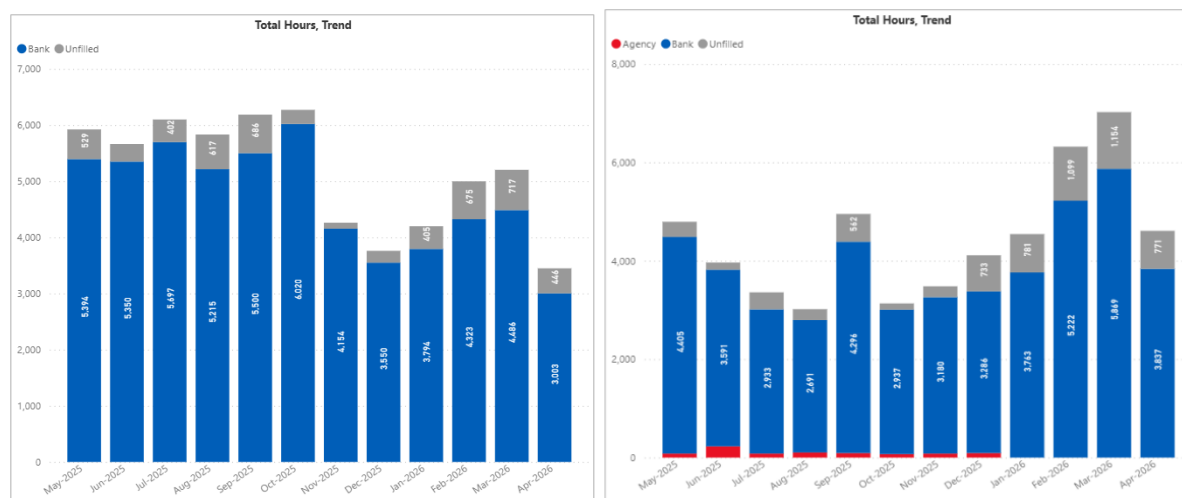


Figure 7: HCA (left) and Registered Nurses (right) total hours NHSP 2025/26

The highest areas of Registered Nurse NHSP spend were PICU, HDU, Ward 3A, Crisis Care Team and Sunflower House. The highest areas of HCA / unregistered spend were Sunflower House, Ward 4B, Ward 4A and Ward 3A.

The temporary staffing position should be interpreted alongside sickness and maternity/adoption data. Ward 3A, Ward 4A and Ward 4B feature in both the sickness and NHSP spend data, while PICU, Accident & Emergency and Ward 4A had the highest NMC maternity/adoption FTE. This demonstrates that NHSP use was driven by overlapping availability pressures, alongside acuity, enhanced care demand and specialist skill requirements.

No agency has been used on in patient wards and departments.

Substantive HCA recruitment has supported reduced HCA temporary staffing requirement. Ward 3C and Ward 4B have recruited to substantive posts, and 12 NHSP trainees completed competencies and were appointed to permanent HCA roles.

5.8: Staffing risks and incidents reported

There were 180 nursing staffing-related incidents and near misses reported through the Trust incident management system between April 2025 and March 2026. Of these, 172 were recorded as causing no harm and 6 were recorded as near misses where the incident was prevented. 2 records did not have a recorded outcome.

The main reported theme related to a lack of suitably trained or skilled nursing staff, followed by lack of suitably trained or skilled Health Care Assistants. The highest number of staffing-related reports were from Ward 1C Cardiac, Ward 3A, Ward 4B, HDU and Sunflower House. These areas align with wider workforce pressures described elsewhere in this report, including

staff availability, sickness absence, temporary staffing requirement, patient acuity and HCA workforce gaps.

Table 6: Nursing staffing-related incidents and near misses, April 2025 to March 2026	
Total nursing staffing-related incidents and near misses	180
Recorded as no harm	172
Near miss / incident prevented	6
Outcome not recorded	2

This represents an increase compared with previous annual reports, where 79 staffing-related incidents and near misses were reported in 2024/25, 76 in 2023/24 and 145 in 2022/23. The increase in reported incidents will be reviewed to confirm whether this reflects a true increase in staffing-related events, increased reporting, or differences in reporting scope and categorisation.

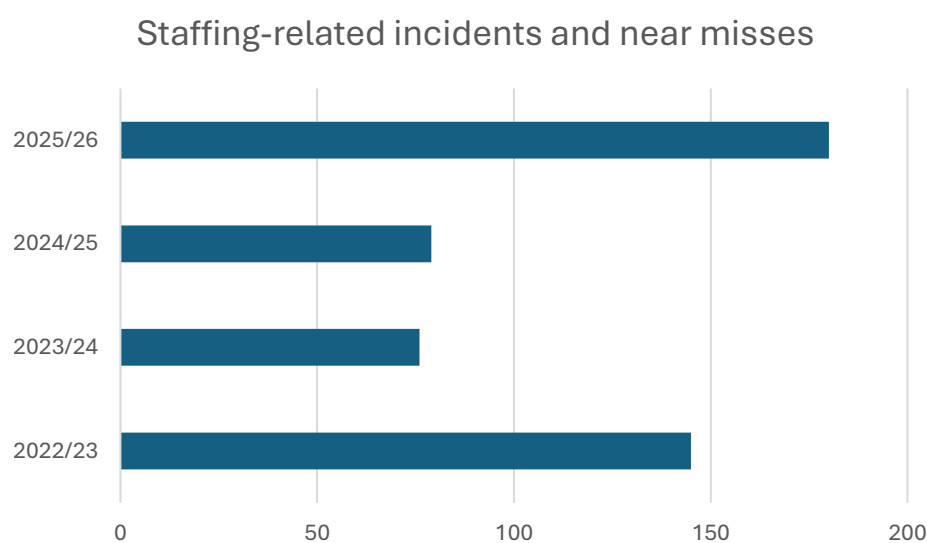


Figure 8: Incidents by year



Figure 9: 2025/6 Incidents by Area

There are currently 11 open risks on the Risk Register relating to staffing in Wards and Departments (does not include specialist nursing teams) with risk scores ranging from 6 to 15. All have appropriate control measures and associated actions. 7 staffing risks relating to

Wards and Departments were closed on the Risk Register in 2025/26. An overview of the risks is shown in Appendix 4.

6. Proposed workforce developments for 2026-2030

6.1. Support a thriving workforce with a shared sense of value and belonging by:

- a. Continuing to maximise high quality practice learning capacity to support a pipeline of newly qualified nurses with paediatric skills and interest.
- b. Ensuring we have HCAs and nurses with the right skills to care for our increasingly complex children and young people by exploring and developing innovative models of recruitment and working to ensure we attract and retain talented people.
- c. Continuing to access relevant apprenticeship opportunities to help support a sustainable future paediatric HCA and nursing workforce to access careers and widening participation of our local population.
- d. Continuing to broaden and strengthen our retention focus to grow and improve our preceptorship offer, enhance support for those at early career, new to role and transitioning.
- e. Continuing to review ways of reducing the use of temporary staffing, including workforce reviews
- f. Reviewing Job Descriptions in line with the national nursing profiles
- g. Undertaking job planning together with Specialist Nurses

6.2. Develop and strengthen compassionate and inclusive leadership by:

- h. Developing and empower our nursing workforce by providing training, support and resources to build confidence in EDI and Allyship, including a tailored development plan for our internationally recruited colleagues.
- i. Continuing to develop and expand restorative clinical supervision offer to nurses.
- j. Continuing to develop and improve the diversity of our nurses, ensuring we have an effective training and education plan and succession planning.

6.3. Design and develop our future workforce, ready to embrace new ways of working within the new systems by:

- k. Continuing to build our advanced practice workforce, and grow the enhanced practice offer for our nurses, supporting work across the 4 pillars of practice.
- l. Supporting career pathways, enabling every nurse to reach their full potential and talent
- m. Ensuring compliance with regulatory guidance and safer staffing, including continued use of the relevant Safer Nursing Care Tools and safe and effective implementation of new tools.

6.4. Inspire excellence in research, innovation, digital and education by:

- n. Continue to support our nurses to be research literate, informed and to facilitate evidence-based practice within their services through access to relevant training, advice and opportunities.
- o. Continued partnership with local HEIs to explore options to grow clinical research and academic careers, strengthen and grow continuing professional

development opportunities, and ensure positive learner experiences for all our nursing workforce.

- p. Developing intuitive dashboards to accurately capture staffing and quality metrics

7. Conclusion

This report provides assurance that safe staffing has continued to be actively monitored, managed and maintained during 2025/26 through established governance processes, including monthly safer staffing reporting, daily Safer Staffing meetings and escalation processes and continued focus on recruitment, retention, education, wellbeing and workforce development.

The report demonstrates that the Registered Nurse establishment is aligned to assessed requirement through the approved establishment review process. A funded NHSP line has been created by realigning 5% of the 23% uplift to assist Ward Managers to manage their budgets and reduce local overspend relating to staff availability to work; this does not lead to a reduction in total allocated budget but supports a reduction in expenditure run rate. In line with the financial landscape, recruitment of Band 5 Registered Nurses in 2025/26 has been undertaken in line with vacancies rather than the group recruitment approach utilised in previous years.

The Trust Board of Directors is asked to note and approve the contents of this report.

Appendix 1: Staffing availability report 2025/26

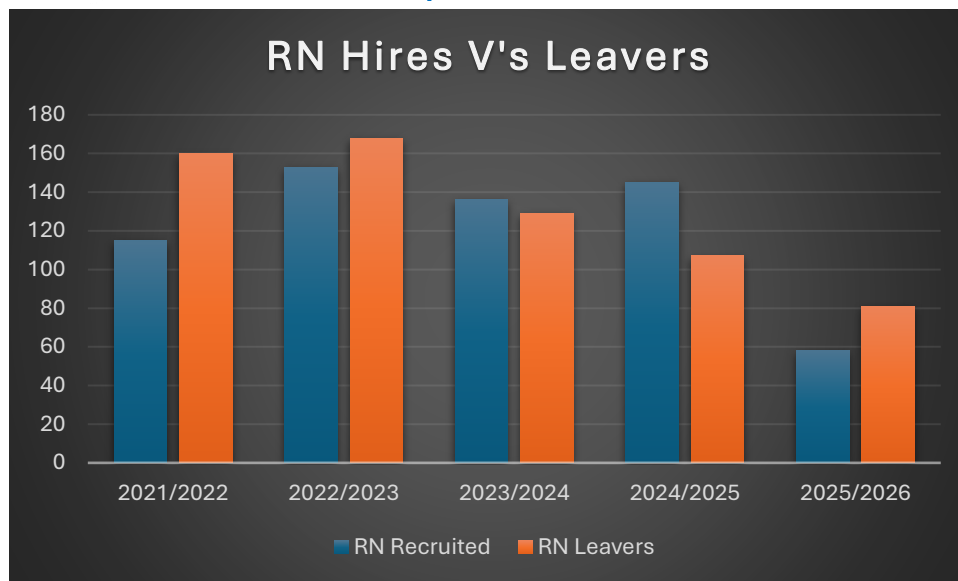
Ward Safer Staffing 2025/26	Day RN	Day HCA	Night RN	Night HCA	Overall Staffing		
					Average RN	Average HCA	Overall
April 25	82.97%	74.81%	81.79%	101.73%	82.38%	88.27%	85.33%
May 25	88.56%	77.01%	87.30%	101.01%	87.93%	89.01%	88.47%
June 25	86.45%	74.45%	84.89%	86.39%	85.67%	80.42%	83.05%
July 25	86.00%	70.59%	85.12%	90.81%	85.56%	80.70%	83.13%
August 25	83.00%	69.59%	80.40%	79.12%	81.70%	74.36%	78.03%
September 25	84.20%	72.37%	82.85%	87.49%	83.53%	79.93%	81.73%
October 25	83.95%	71.56%	80.98%	96.80%	82.47%	84.18%	83.32%
November 25	81.45%	70.88%	79.51%	85.13%	80.48%	78.01%	79.24%
December 25	83.38%	67.08%	82.27%	77.95%	82.83%	72.52%	77.67%
January 26	83.88%	69.47%	82.05%	87.72%	82.97%	78.60%	80.78%
February 26	87.43%	76.32%	85.61%	92.12%	86.52%	84.22%	85.37%
March 26	82.85%	68.06%	80.39%	89.99%	81.62%	79.03%	80.32%
Total compliance 2025/26	84.51%	71.85%	82.76%	89.69%	83.64%	80.77%	82.20%

*the above does not reflect ward occupancy and is a measure of % fill rate against roster template.

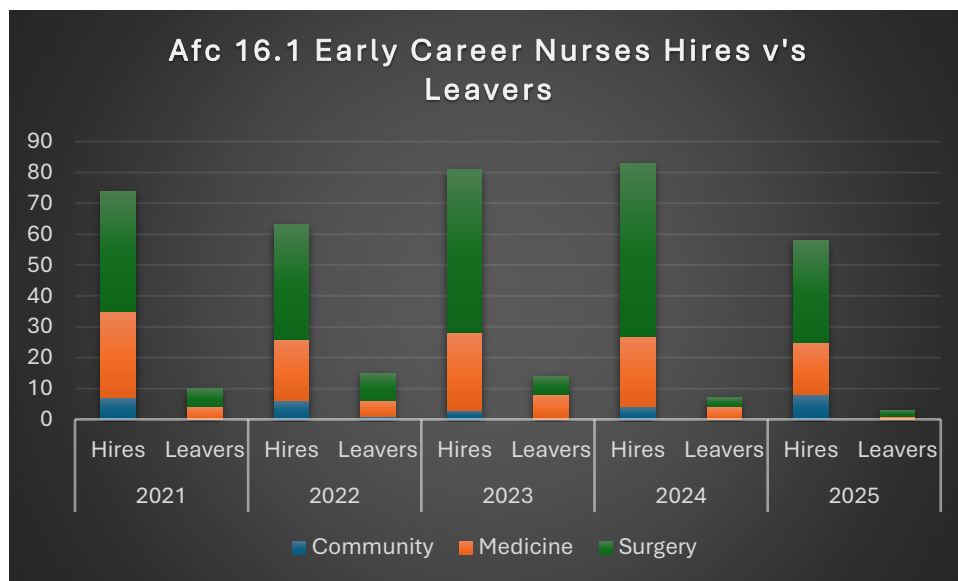
Appendix 2: Care Hours per Patient Day (CHPPD) report April 2025 to March 2026

Ward / area	Apr AH	Apr BM	May AH	May BM	Jun AH	Jun BM	Jul AH	Jul BM	Aug AH	Aug BM	Sep AH	Sep BM	Oct AH	Oct BM	Nov AH	Nov BM	Dec AH	Dec BM	Jan AH	Jan BM	Feb AH	Feb BM	Mar AH	Mar BM
Burns Unit	24.67	12.30	28.07	12.30	20.46	12.30	22.06	22.06	18.81	18.80	18.87	18.90	25.75	18.90	21.08	18.90	18.94	18.90	20.60	18.90	17.40	18.90	21.80	18.90
HDU	35.21	28.50	27.41	28.50	25.49	28.50	54.89	52.30	34.26	32.06	27.48	26.08	70.36	26.08	29.32	26.08	26.76	26.80	29.90	26.80	24.50	26.80	21.30	26.80
ICU	42.33	37.80	35.24	37.80	40.64	37.80	42.86	41.70	44.95	43.50	37.05	36.10	19.15	36.10	40.09	36.10	36.58	36.60	36.20	36.60	33.80	36.60	33.60	36.60
1C Cardiac	12.69	12.50	13.95	12.50	11.29	12.50	11.88	11.04	11.92	11.20	12.36	11.50	13.45	11.50	13.07	11.50	13.45	13.50	13.30	13.50	12.00	13.50	10.00	13.50
1C Neonatal	17.48	19.20	22.11	19.20	19.52	19.20	19.53	19.50	16.72	16.50	18.12	18.10	17.63	18.10	18.51	18.10	16.43	16.40	16.80	16.40	15.20	16.40	13.30	16.40
Ward 3A	11.92	10.40	10.45	10.40	10.65	10.40	10.33	7.90	10.33	8.00	10.66	8.40	11.73	8.40	11.12	8.40	11.23	11.20	11.00	11.20	10.00	11.20	9.80	11.20
Ward 3B	15.19	16.00	15.45	16.00	14.64	16.00	15.86	14.30	15.54	12.70	16.54	13.80	14.54	13.80	14.19	13.80	13.06	13.00	13.70	13.00	13.80	13.00	12.60	13.00
Ward 3C	11.24	10.90	12.03	10.90	12.66	10.90	13.57	11.40	12.40	10.40	11.69	9.90	13.81	9.90	12.31	9.90	10.25	10.30	11.20	10.30	9.20	10.30	8.50	10.30
Ward 4A	10.57	10.70	10.92	10.70	11.76	10.70	10.51	9.40	11.19	9.90	11.38	9.30	12.11	9.30	10.64	9.30	12.13	12.10	11.20	12.10	11.10	12.10	9.90	12.10
Ward 4B	14.96	11.80	16.10	11.80	11.97	11.80	14.18	5.20	14.34	5.40	13.52	4.70	16.86	4.70	15.41	4.70	17.73	17.70	15.00	17.70	12.90	17.70	13.80	17.70
Ward 4C	12.24	10.70	13.12	10.70	11.16	10.70	11.80	10.00	10.51	9.10	10.95	9.30	13.03	9.30	10.44	9.30	10.29	10.30	11.00	10.30	10.10	10.30	9.60	10.30

AH = Alder Hey BM = Benchmark. Red cells indicate where Alder Hey CHPPD was below the benchmark value for that ward/month. Benchmark values are based on the latest available Model Hospital data at the time of reporting. Where benchmark data was not refreshed in-month, the most recently available benchmark value has been carried forward, in line with the approach confirmed by the nursing safer staffing lead.

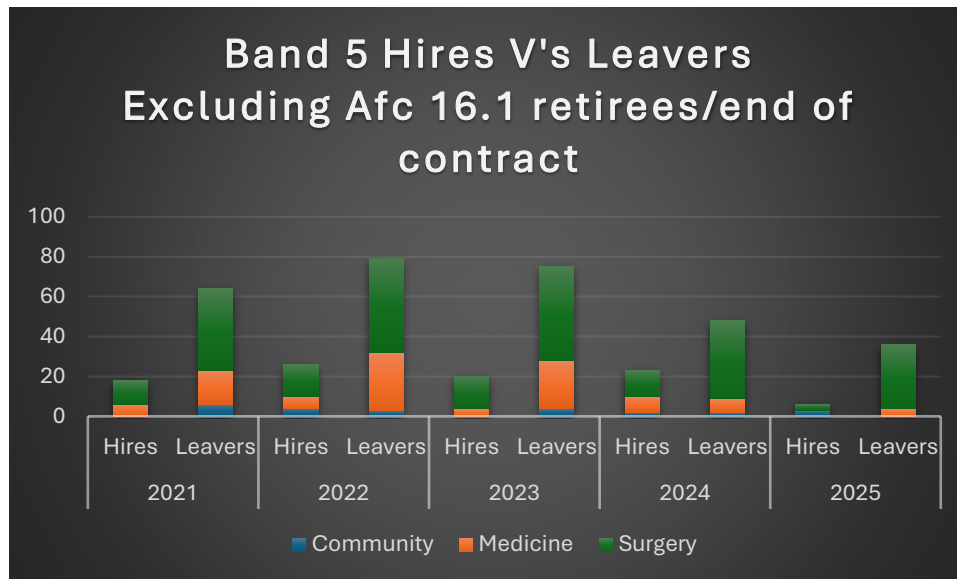


A3.2: Early Career Hires v's leavers including preceptees 2021 to 2025



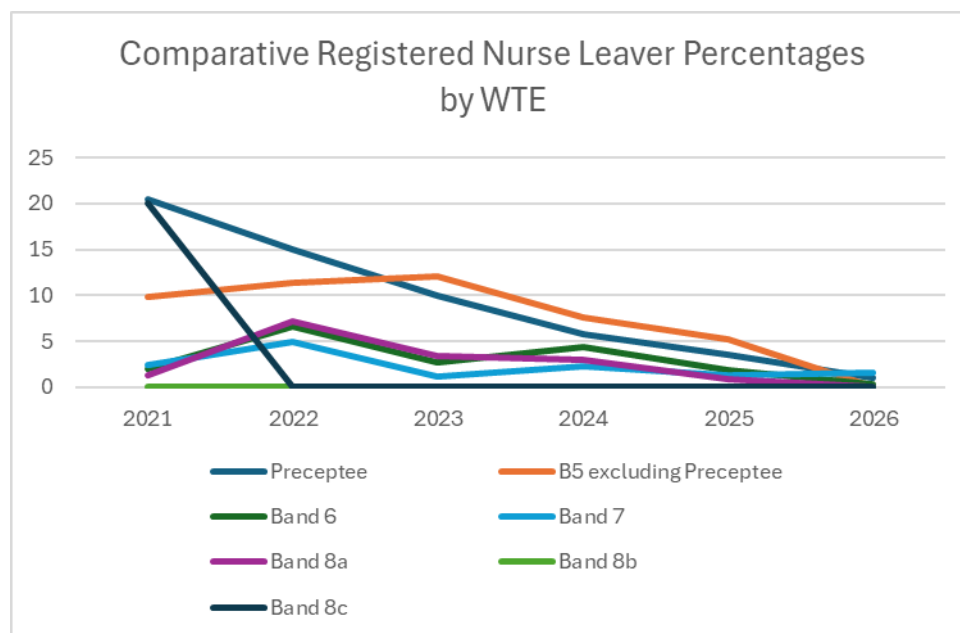
Afc 16.1 (Early Career Nurses)										
	2021		2022		2023		2024		2025	
	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers
Community	7	0	6	1	3	0	4	0	8	0
Medicine	28	4	20	5	25	8	23	4	17	1
Surgery	39	6	37	9	53	6	56	3	33	2

A3.3 Band 5 leavers excluding preceptees/ retirees



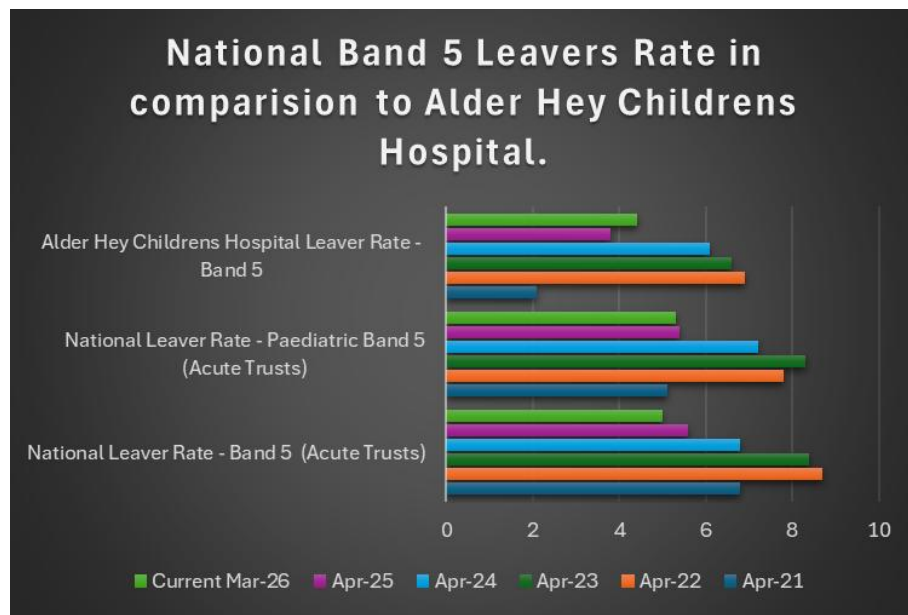
Band 5 positions excluding AfC 16.1 and Retirees/End of contract										
	2021		2022		2023		2024		2025	
	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers
Community	0	6	4	3	0	4	2	2	3	0
Medicine	6	17	6	29	4	24	8	7	0	4
Surgery	12	41	16	47	16	47	13	39	3	32

A3.4 Comparative RN Leaver Percentages by WTE Alder Hey Children's Hospital



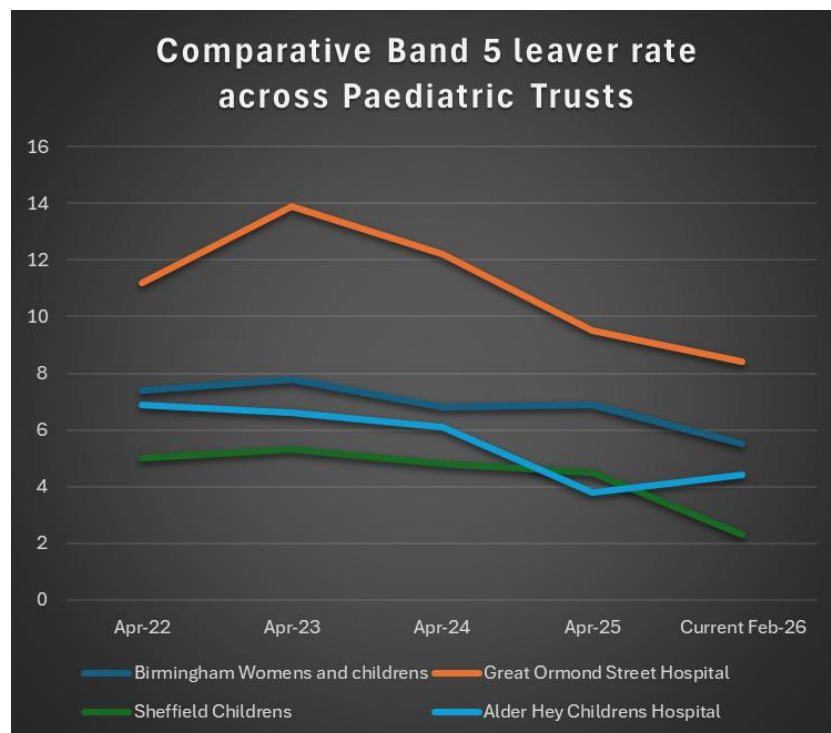
	2021	2022	2023	2024	2025	2026
Preceptee	20.41	14.94	10.02	5.8	3.5	1.03
B5 excluding Preceptee	9.85	11.36	12.08	7.65	5.17	0.11
Band 6	1.94	6.55	2.69	4.41	1.8	0.3
Band 7	2.41	5	1.17	2.25	1.35	1.58
Band 8a	1.28	7.23	3.45	2.97	0.9	0
Band 8b	0	0	0	0	0	0
Band 8c	20	0	0	0	0	0

A3.5 National Band 5 Comparator leaver data



	Apr-21	Apr-22	Apr-23	Apr-24	Apr-25	Current Mar-26
National Leaver Rate - Band 5 (Acute Trusts)	6.8	8.7	8.4	6.8	5.6	5
National Leaver Rate - Paediatric Band 5 (Acute Trusts)	5.1	7.8	8.3	7.2	5.4	5.3
Alder Hey Childrens Hospital Leaver Rate - Band 5	2.1	6.9	6.6	6.1	3.8	4.4

A3.6 National Comparative Band 5 Comparator leaver rate across Paediatric Trusts



	Apr-22	Apr-23	Apr-24	Apr-25	Current Mar-26
Birmingham Womens and Childrens	7.4	7.8	6.8	6.9	5.5
Great Ormond Street Hospital	11.2	13.9	12.2	9.5	8.4
Sheffield Childrens	5	5.3	4.8	4.5	2.3
Alder Hey Childrens Hospital	6.9	6.6	6.1	3.8	4.4

A4 1: Open risks 2025/26

Reference	Risk Title	Department	Opened	Current Rating
Risk 00000046	Shortfall in HDU ACP cover	High Dependency Unit	10 Jul2023	8
Risk 00000122	lack of nursing staff within the allergy service	Allergy	19 Dec2023	9
Risk 00000268	Lack of senior nursing staff who are APLS trained.	3B	19 Sep2024	6
Risk 00000271	Risk 271 - Safeguarding Nursing Team Capacity	Rainbow - Safeguarding	07 Oct2024	15
Risk 00000312	Lack of Nurse Resource and adequate succession planning	ENT	16 Jan2025	6
Risk 00000328	Epilepsy Nursing Capacity	Epilepsy	28 Feb2025	10
Risk 00000355	Lack of Nursing staff within the Gastroenterology service	Gastroenterology	30 Apr2025	9
Risk 00000374	Junior Nursing Workforce on PAU/EDU	PAU	02 Jun2025	9
Risk 00000413	Haematology Specialty Nursing Team	Haematology	22 Jul2025	15
Risk 00000419	Lack of adequately trained Nursing Staff/HCA in Ophthalmology OPD	Ophthalmology	25 Jul2025	9
Risk 00000506	HDU Staffing	High Dependency Unit	02 Dec2025	9

A4 2: Closed risks 2025/26

Ref	Department	Risk title	Risk score	Closed date
Risk 00000326	Ward 4B	Unable to fully implement a new workforce model on 4B	6	24 Feb 2026
Risk 00000296	Tier 4 Inpatient Unit	Sunflower House Nursing Establishment	6	09 May 2025
Risk 00000112	Ward 3C	Inadequate Staff Nurse skill mix on 3C	3	05 Jun 2025
Legacy Risk 00002703	Dewi Jones Unit	Risk of not meeting required safe staffing numbers on Sunflower House for all shifts	12	21 Oct 2025
Legacy Risk 00002581	Oncology	If the Paediatric Oncology Outreach Nurses don't have an adequate number of nurses then the families we support will not receive the best quality care	9	20 Oct 2025
Legacy Risk 00002029	Ward 3A	Patient safety and delivery of care on ward 3A associated with funded establishment	3	25 Jun 2025
Legacy Risk 00002416	Ward 3B - Inpatient	Then there will be increased pressure on staff wellbeing and ability to provide requirements for safe and effective patient care	6	28 Oct 2025

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Infection Prevention & Control Report Q4
Report of:	Director of Infection Prevention & Control (January – March 26)
Paper Prepared by:	Dr Beatriz Larru (DIPC)

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

Does this relate to a risk? Yes ☐ No ☒
If “No”, is a new risk required? Yes ☐ No ☒

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

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

The purpose of this report is to provide oversight of Infection Prevention Control (IPC) activity and reporting for the Q4 period (1st January – 31st March 2026) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

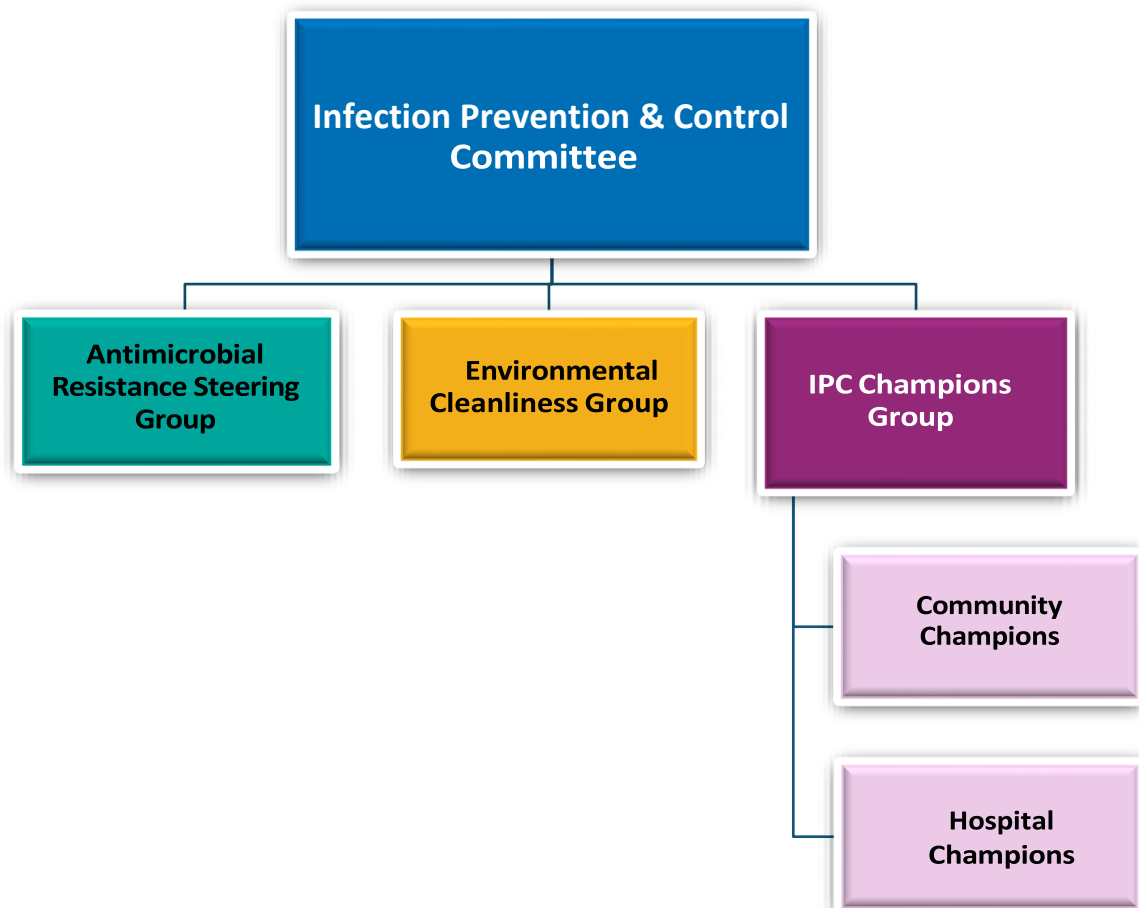
The Trust recognises that the effective prevention and control of healthcare-associated infections (HAIs) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently by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

2. Background and current state

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

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

During Q4, the IPC committee received reports from the following subgroups:



INFECTION PREVENTION & CONTROL COMMITTEE

Antimicrobial Resistance Steering Group

The ongoing workstreams focus on:

- 1) De-labelling penicillin allergies
- 2) Promote IV to PO administration of antimicrobial
- 3) Promote nursing role in AMS
- 4) Understand health inequities and antimicrobial resistance
- 5) Promote diagnostic stewardship by limiting unnecessary blood cultures in ICU
- 6) Understand behavioral change science in antibiotic prescribing
- 7) Surgical prophylaxis

Environmental Cleanliness Group

During Q4 the group met on 16.01.26, 03.02.26 and 17.03.26

Work continues on the below actions:

- **NEW Trust cleaning products**
- **NEW Trust cleaning training package – Nurses & Domestics**
- How to best implement the Hospital Cleaning policy RM49 across the Trust
- New electronic auditing system being procured
- SharePoint page developed with instructions for cleaning and decontamination of items, in accordance with the National Standards of Healthcare Cleanliness 2021
- Reviewing terminal cleaning processes

IPC Champions Group

The groups continue to meet monthly - attendance has improved across all divisions, reflecting better engagement with the sessions. Educational sessions continue to be fully aligned with the NHSE IPC Educational Framework, ensuring consistency with national standards and best practice.

These sessions not only provide structured learning opportunities but also serve as a dynamic platform through which all relevant updates, guidance, and policy changes can be communicated to staff.

By maintaining this alignment, the programme supports staff in staying informed, confident, and competent in applying IPC principles, ultimately strengthening patient safety and quality of care across the organisation.

The groups are currently exploring:

- A new Hand Disinfection Audit tool
- New hand hygiene audit strategies that will include families and visitors

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

3.1 Bacteraemia Surveillance

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

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

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

3.2 Healthcare-associated Gram-negative Bloodstream Infections

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

Note: Healthcare-associated infections include:

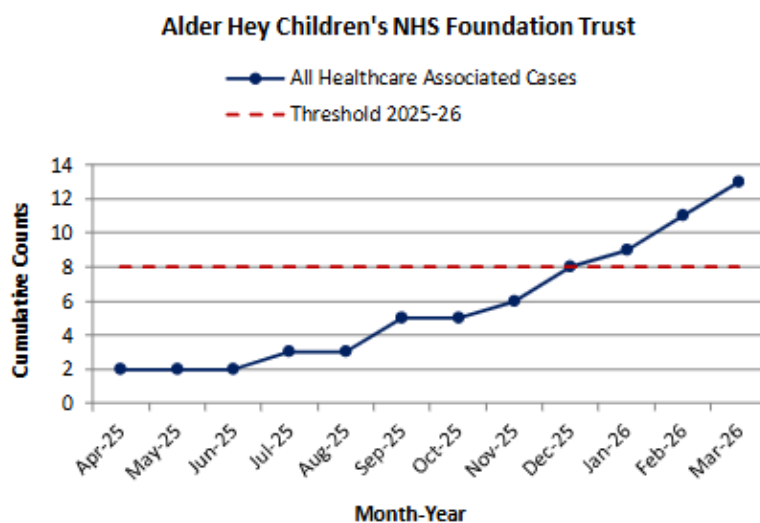
- 1) *Hospital Onset-Healthcare acquired (HOHA) (i.e., occurs in patients admitted >48Hr)*
- 2) *Community Onset-Healthcare acquired (COHA) (i.e., occurred in patients who have received healthcare in either the community or hospital in the previous 28 days).*

Healthcare-associated Gram-negative blood stream infections Quarter 4	
13 patients had healthcare-associated Gram-negative blood stream infections	
Specialist Medical	1
Oncology	7
Cardiology	2
Surgical	2
Neonatal	1

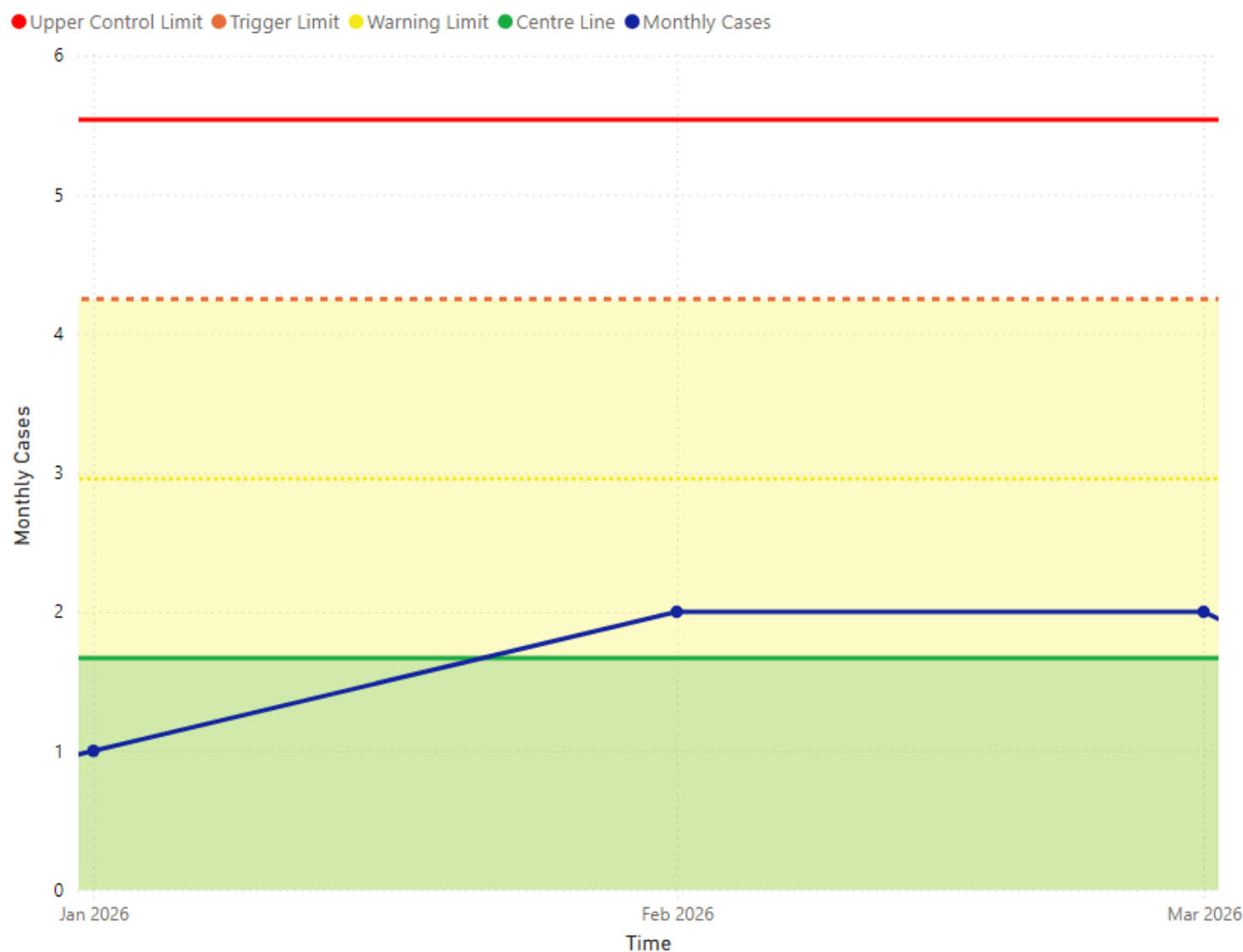
The post-infection reviews (PIRs) of these cases identified:

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

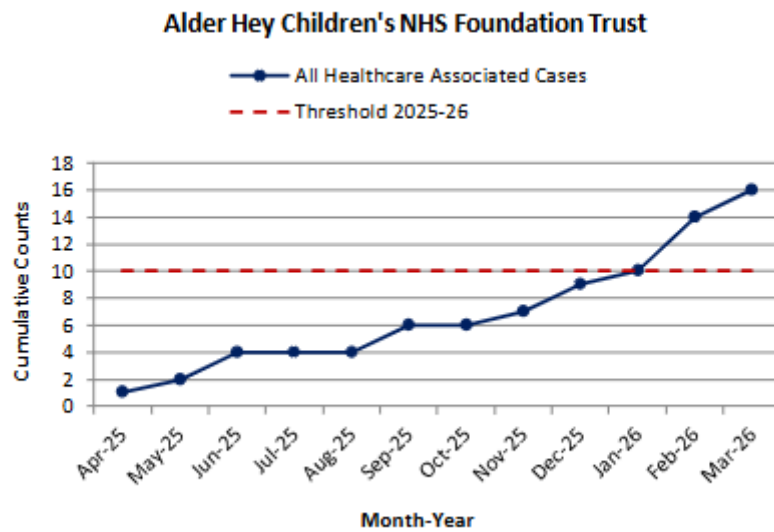
E. coli Bloodstream Infections



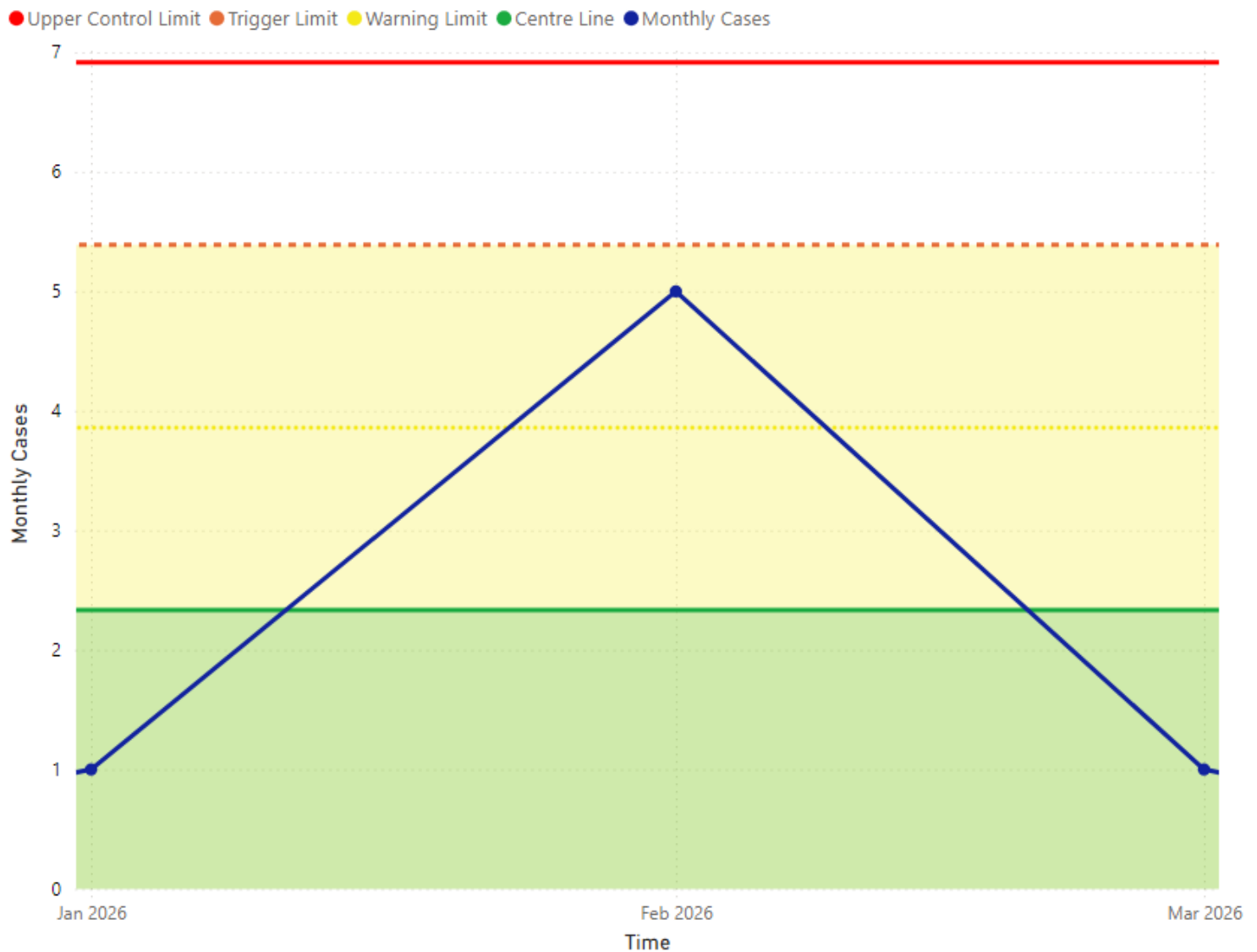
IPC E. coli SPC Charts



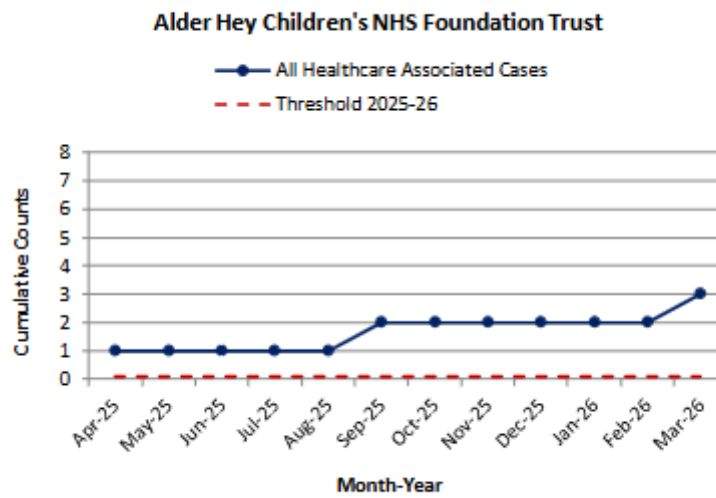
Klebsiella spp. bloodstream infections



IPC Klebsiella SPC Charts

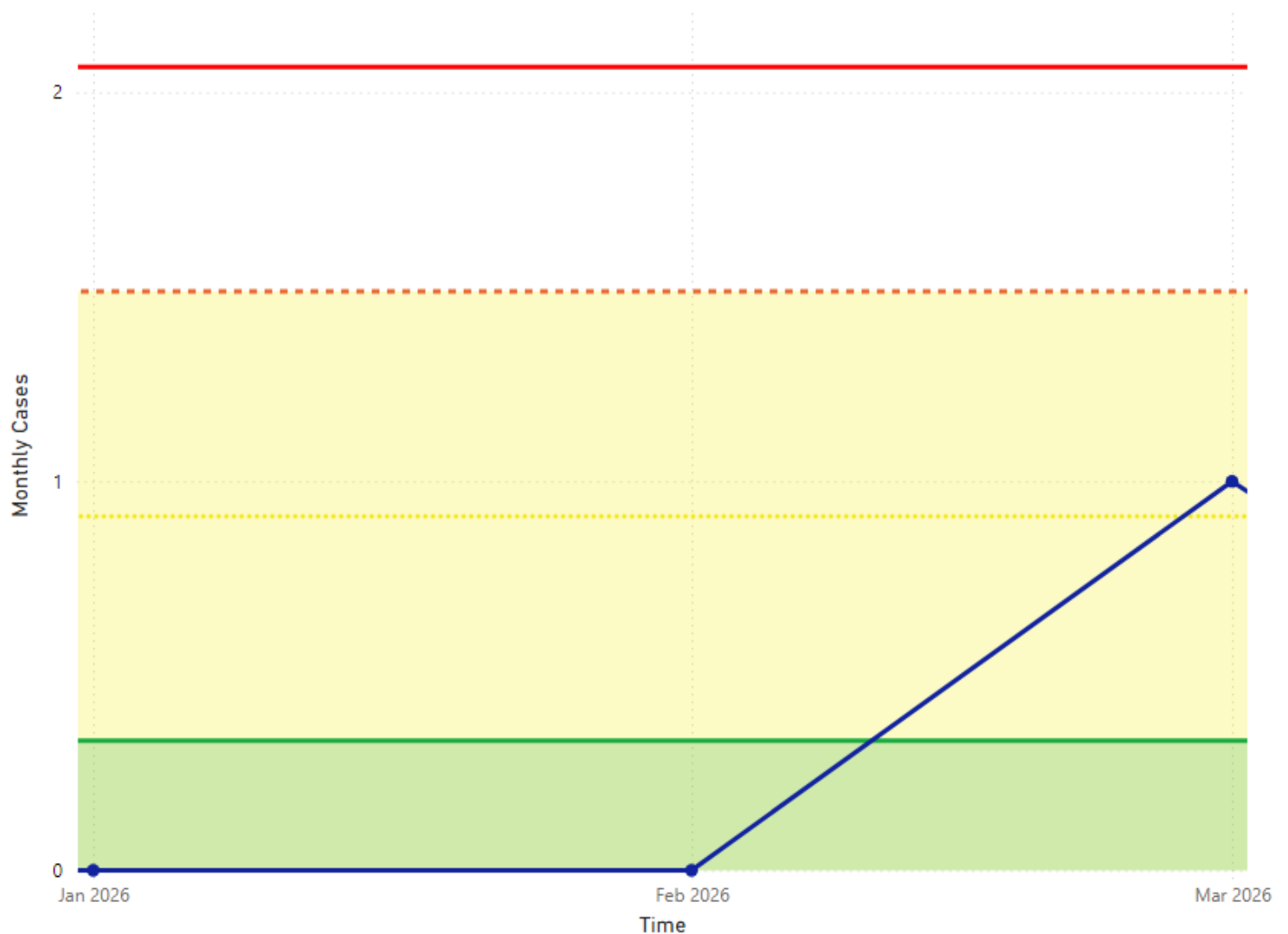


P. aeruginosa bloodstream infections



P. aeruginosa SPC Charts

● Upper Control Limit ● Trigger Limit ● Warning Limit ● Centre Line ● Monthly Cases



3.3 Healthcare-associated *Staphylococcus aureus* bloodstream infections

Healthcare associated MSSA blood stream Infections Quarter 4	
2 patients had healthcare associated MSSA blood stream Infections	
Specialist Medical	1
Critical care	1

The post-infection review (PIR) learning:

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

Key actions:

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

Healthcare associated methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infections Quarter 4	
6 patients had healthcare associated methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infections	
Oncology	1
Surgical	2
Neuro Surgical	2
Neuro Medical	1

The post-infection review (PIR) learning:

- MRSA bloodstream infection (BSI) is secondary to an infected abscess at a Portacath site colonised with MRSA.
- Consistent use of aseptic non-touch technique (ANTT) during access, dressing changes, and flushing is critical

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

The workplan to reduce Central Line Related Line Infections across the Trust has continued during Q4 with a closer collaboration between IPC and the Microbiology laboratory to include in PIRs *all significant blood stream infections and to engage with all stakeholders in the development of the CLABSI steering group.

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

4. *Clostridioides difficile* infections

<i>Clostridioides difficile</i> infections Quarter 4	
0 patients had healthcare associated <i>Clostridioides difficile</i> infections	
N/A	N/A

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

A summary report detailing their visit and recommendations below:

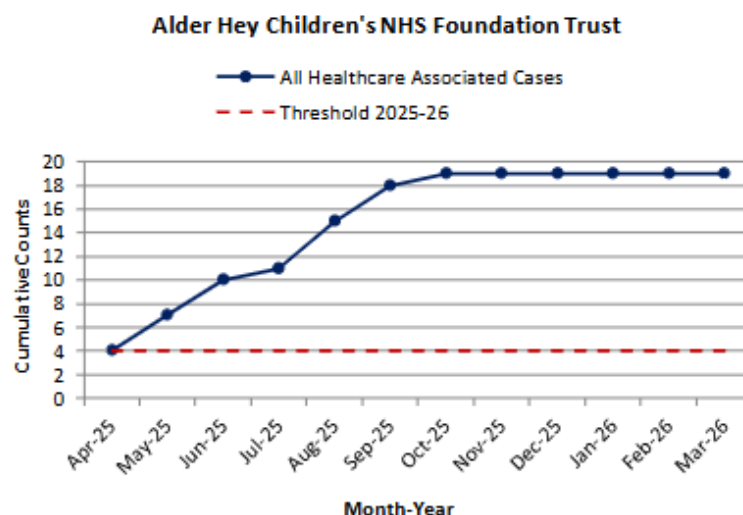


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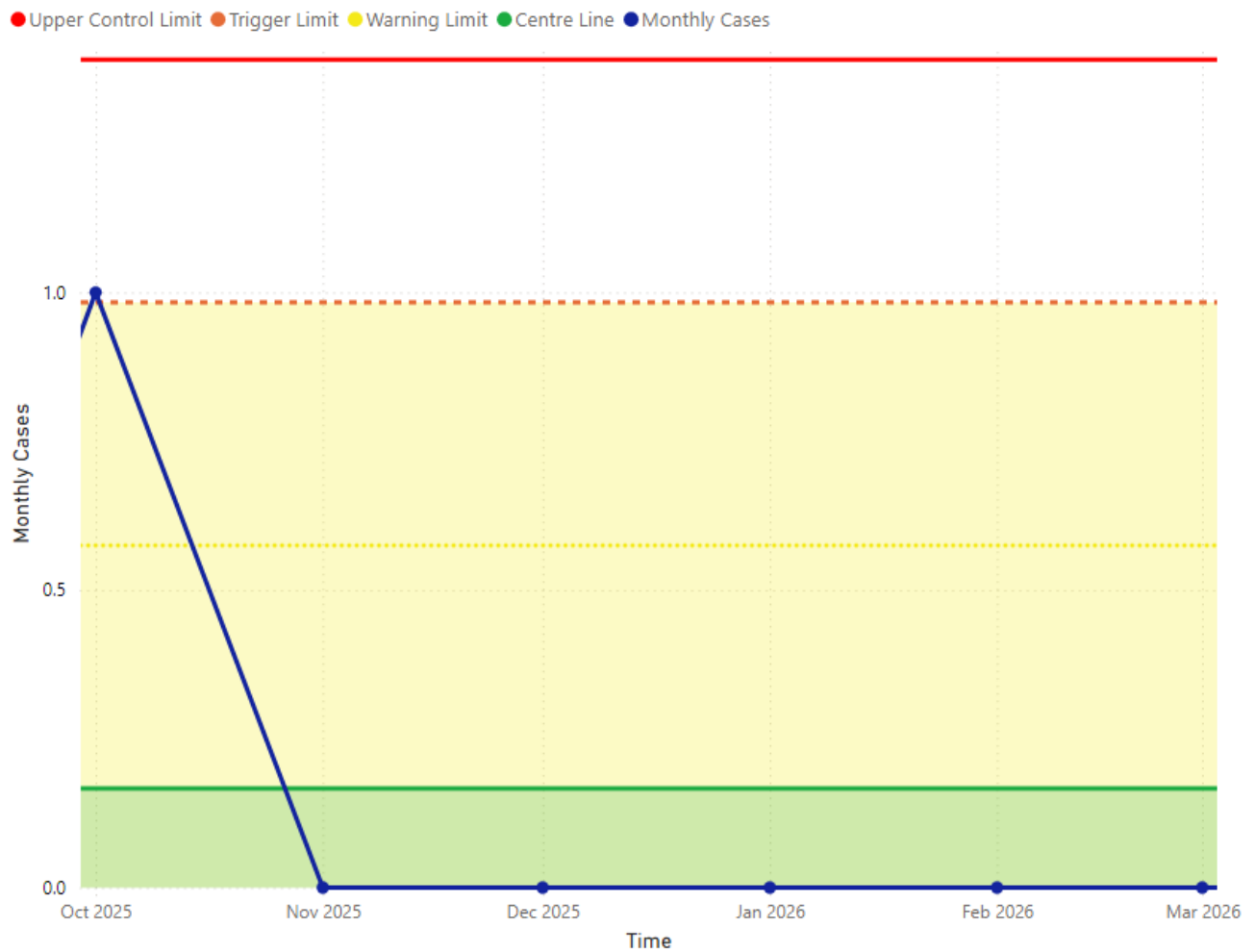
UKHSA reportable HCAs are currently entered via a manual process, a UKHSA audit identified that a number of *C. difficile* cases had not been reported. When this was investigated, a significant number were related to postmortem findings and therefore excluded.

The remaining unreported data were attributed to human entry errors by staff no longer in post but have been rectified. The implementation of ICNET will remove any chance of human error in the future as the system reports directly through to UKHSA.

C. difficile Infection



IPC C. difficile SPC Charts



5. Healthcare acquired viral infections

5.1 Respiratory viral infections

During Q4 the IPC team continued to review instances of inappropriate viral respiratory testing in the ED team to promote the effective use of diagnostic resources across the Trust.

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

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

6. Daily isolation walks

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



ISOLATION POSTERS

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



CONTACT PLUS PRECAUTIONS	AIRBORNE PRECAUTIONS	CONTACT & DROPLET PRECAUTIONS	DROPLET PRECAUTIONS	CONTACT PRECAUTIONS	HELP US TO PROTECT OUR PATIENTS
- If your child has diarrhoea and/or vomiting - it is important to wash your hands with soap & water - Please ask staff before using communal areas on the ward - Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward	- If your child has Chicken pox or Measles - staff will wear a special mask & a gown - Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward	- If your child has a cough, cold or a runny nose - staff will wear a face mask - Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward	- If your child has a cough, cold or a runny nose - staff will wear a face mask - Ensure door is kept closed after entering and leaving the cubicle to protect other patients on the ward	- If your child has an infection identified on admission swabs or on previous admissions - Please follow good hand hygiene	- If your child is known to be immunosuppressed - Ensure door is kept closed after entering and leaving the cubicle

PLEASE SCAN BELOW FOR VIDEO



6.1 Newsletter Example

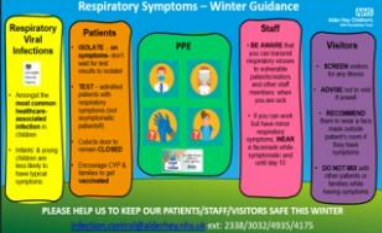
The IPC team distributes monthly newsletters featuring key messages and updates and delivers tailored education sessions to specific areas.



Healthcare without avoidable infections

IPC NEWSLETTER 2025



UKHSA Alerts & Other Infectious Diseases	Hand Disinfection	Announcements
SARS-CoV-2: Regional weekly cases are higher than national levels Influenza: Regional positivity remains elevated Parainfluenza: cases reported remain lower than observed 2024/25 season Norovirus: activity remains low regionally	Please remember to complete a minimum of 20 hand disinfection audits  We are currently exploring an alternative platform for audits – we will keep you updated – will be discussed at the next champion meeting	Well done to the IPC Teams of the month Ward 4B HDU  Welcome to Emma IPC Clinical Nurse Specialist joined the team
Respiratory Symptoms – Winter Guidance 	HAND DISINFECTION Prevention... is in your hands 	Infection Prevention and Control guidance for families during your stay at Alder Hey 

6.2 Guidance and key messages

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



Help us to keep our patients, visitors and staff safe



Alder Hey Children's
NHS Foundation Trust

You can HELP stop the spread of Infection

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

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



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





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



Alder Hey Children's
NHS Foundation Trust

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

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

What we know works

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

What to expect from staff during your hospital stay:

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

Monitoring

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

Environment

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

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

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

Wash your hands

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

Visiting

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

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

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

Environment

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

**GET
GONE
GERMS**





7. Gastrointestinal viral infections

Healthcare associated Norovirus Quarter 4	
21 patients had healthcare associated Norovirus	
Oncology	4
Surgical specialties	3
Medical specialties	2
Neurosurgical	2
Neurology	5
General Paediatrics	5

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

Efforts included: enhanced infection control protocols, such as:

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

Healthcare associated (HOHA) Group A <i>Streptococcus</i> Quarter 4	
1 patient had a healthcare associated (HOHA) Group A <i>Streptococcus</i>	
1	COHA

8. Other Notable Infections

Positive measles cases reported during Q4		
Jan 2026	Feb 2026	March 2026
0	0	3

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

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

Outbreak / Exposure cases Q4						
DATE	AREA	INFECTION	PATIENTS EXPOSED	Prophylaxis?	STAFF EXPOSED	Prophylaxis?
Jan-26	EDU	Influenza A	10	0	0	0
	4B	NOROVIRUS	6	0	0	0
	EDU	Influenza A	1	0	0	0
	EDU	Influenza A	8	1	0	0
	EDU	Influenza A	5	1	0	0
	EDU	Influenza A	4	0	0	0
Feb-26	EDU	Influenza A	5	1	0	0
	EDU	NOROVIRUS	3	0	0	0
	EDU	Influenza A	0	0	0	0
	EDU	Influenza A	1	0	0	0
	EDU	Influenza A	3	3	0	0
	EDU	Influenza A	3	2	0	0
	SAL	CHICKENPOX	5	0	0	0
	EDU	SARS CoV-2	4	0	0	0

Mar-26	EDU	Influenza A	10	0	0	0
	EDU	<i>C. Difficile</i>	3	0	0	0
	W3C	<i>C. Difficile</i>	0	0	0	0
	PAU/EDU	MEALSES	0	0	2	0
	ED	MEALSES	0	0	4	0
	Theatre	Influenza B	0	0	0	0
	EDU	SARS CoV-2	8	0	0	0
	OPD	TB	17	0	7	0
	W3A	CHICKENPOX	12	0	0	0
	ED	MEALSES	0	0	0	0
	W4C	CHICKENPOX	0	0	0	0
	W3A	NOROVIRUS	0	0	2	0

9. Conclusion

Throughout Q4, the Infection Prevention and Control (IPC) department has consistently raised a heightened level of visibility across the Trust.

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

9.1 Relaunch of the Alder Hey Clinical Water Safety Group

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

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

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



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

9.2 IPC Team

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

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

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

10. Recommendations & proposed next steps

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

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Mental Health Act Annual Report 2025/2026
Report of:	Lisa Cooper, Director of Community & Mental Health Services
Paper Prepared by:	Dr Barry Mullan, Consultant Psychiatrist, MHA Lead

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

Does this relate to a risk? Yes ☐ No ☒

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

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



1. Report Purpose

The purpose of this paper is to present the Trust Board with an annual report on the use of the Mental Health Act (MHA) for the reporting period 01 April 2025 – 31 March 2026.

2. Background

There are several different legal frameworks under which Alder Hey treats children and young people aged 0-18 years, which have been determined by Statute and Case Law.

Most children with physical disorders are treated under their own consent if they are Gillick Competent, that is if they have enough intelligence and understanding of the decision to be made; or under Parental Consent if the decision is within the Scope of Parental Responsibility and if parents are believed to be acting in the best interests of the child.

The Scope of Parental Responsibility has some limitations clarified by the Mental Health Act Code of Practice and some limitations clarified by Case Law. Otherwise, there must be a decision made over whether the consent is 'a decision that a parent should reasonably be expected to make' in relation to medical care of their child.

In practice children and young people are detained under the Mental Health Act if they have a mental disorder and require hospital treatment and:

1. Require deprivation of their liberty significantly beyond age-appropriate levels of parental supervision such as the use of a seclusion room or restraint to prevent absconsion.
2. Require deprivation of their liberty and the local authority has acquired 'parental responsibility', as the local authority cannot consent to a deprivation of liberty.
3. Refuse admission and/or treatment and are Gillick competent or aged 16+.
4. Require repeated intrusive treatments such as restraint for intramuscular injections if they are extremely agitated and putting themselves and others at risk and after all alternative interventions have failed or such as requiring restraint for nasogastric feeding if they have an eating disorder.

Children and young people are detained for a period of assessment and treatment (Section 2: up to 28 days) or for a period of treatment (Section 3: up to 6 months then can be extended for up to a further 6 months, and yearly thereafter). Children and young people can challenge any of these decisions by appealing to a Mental Health Tribunal or to the Independent Associate Hospital Managers. Children and young people have access to the support of an Independent Advocate who will assist them to appeal.

Children and young people may be brought to the Emergency Department by Police under Section 136 of the Mental Health Act. The Emergency Department is a

designated place of safety for those children and young people who appear, to a police officer, to be suffering from a mental disorder and to be in immediate need of care or control. Once in the Emergency Department these children and young people will receive a mental health assessment which may result in detention under Section 2 or 3 of the Mental Health Act.

Children and young people may be detained to Alder Hey or from Alder Hey to another hospital on the recommendations of two doctors and an Approved Mental Health Practitioner (AMHP). If children and young people are being sectioned to another hospital, then the detention starts on arrival at that hospital, and they are recorded in the destination hospital's figures and not the Trust's.

Children and young people may be discharged from hospital on a Community Treatment Order (CTO) These are children and young people who have been detained on a Section 3 and the Section is put aside to allow discharge with some conditions. If those conditions are not complied with the section can be reinstated (recall for a period of assessment up to 72 hours and then revoked if deemed appropriate).

The Mental Health Act (1983, 2007 & 2025) authorises the Trust to deprive children and young people of their liberty to assess and treat a mental disorder. The Mental Capacity Act (2005, amended 2019) authorises the Trust to deprive adults (>18) of their liberty to manage a physical disorder. A Family Court or Court of Protection deprivation of liberty order authorises the Trust to deprive children and young people (<18) of their liberty to manage a physical disorder or to keep them safe. All qualifying children and young people have access to Independent Mental Health Advocacy (IMHA) in line with the Mental Health Act. The provider, "Real Advocacy" is a specialist Tier 4 Mental Health Advocacy Service that works in close liaison with the Tier 4 and Paediatric Wards when children and young people are detained under the Mental Health Act.

To support both the increase in young people detained under the Mental Health Act and ensure that the legal and statutory administrative processes related to the use of the Mental Health Act are followed correctly, a service level agreement with Mersey Care NHS Foundation Trust is in place. This service level agreement supports the complex administration of the Mental Health Act, facilitates the review of appropriate Trust policies, and promotes effective staff training in relation to the Mental Health Act.

3. Detentions under the Mental Health Act

For the reporting period 01 April 2025 – 31 March 2026, the Trust had **5** children and young people detained under a section of the Mental Health Act. This is a decrease compared to 2024/2025.

Table 1 shows the breakdown of children and young people detained under the Mental Health Act for the reporting period compared with previous years.

Table 1: Annual detentions under Mental Health Act

Location	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
Tier 4 Inpatient Unit	2	2	4	6	4
Paediatric Ward	3	7	2	6	*1
CTO	2	1 (Tier 4)	0	0	0
CTO recall	0	1	0	0	0
Section 136	5	6	4	3	4
Total	12	17	10	15	9

Please note * Acute paediatric ward had a child on a section 5.2 which did not result in detention

The five children within an inpatient setting identified as:

- 4 x white British females
- 1 x black African male

Ethnicity information was not documented for children brought to Alder Hey under Section 136. Improving this is an action for 2026/2027.

4. Deprivation of Liberty Order Safeguards

In relation to those aged 18 years or over, the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009, as part of the implementation of the Mental Capacity Act 2005, to ensure better legal and administrative protection for all those who may, for whatever reason, lack capacity to consent to the care they are receiving, including where they live and how they are cared for on a day to day basis.

Prior to the Mental Capacity Act, there was a lack of clarity about how the liberty and human rights of those lacking capacity to consent to their care arrangements, including where these restricted their movement and choices, should be protected. The bulk of people whom the Act was intended to help had serious disabilities including those arising from dementia, learning disabilities and serious mental health problems.

The DoLS regime only applies to hospitals (NHS or private) and care homes (registered with CQC). In any other type of placement, deprivation of liberty can only be authorised by an order from the Court of Protection. If there is no authorisation in place, then a deprivation of liberty is unlawful.

Three factors determine deprivation of liberty under Article 5 of the European Convention on Human Rights:

1. The objective element: i.e. that the person is confined to a particular restricted place for a non-negligible period of time
2. The subjective element, i.e. that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement

3. State imputability: i.e. that the deprivation of liberty can be said to be one for which the State is responsible.

The statutory framework of the Deprivation of Liberty Safeguards (DoLS) does not apply to those under 18 years of age. For under-18s, a legal framework must be placed around the arrangement to ensure that the deprivation of liberty is lawful.

A deprivation of liberty will be lawful if warranted under statute, for example, under

- Section 25 of the Children Act 1989 (placement in secure accommodation)
- Mental Health Act 1983
- Youth remand provisions of the Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Custodial sentencing provisions of the Power of Criminal Courts (Sentencing) Act 2000

Where the deprivation of liberty is not authorised by statute, then the appropriate consent must be obtained, either from the Court of Protection or from the High Court exercising its inherent jurisdiction:

- Children/Young People Under the Age of 16 - the Mental Capacity Act 2005 does not apply to those under 16 years; therefore, application must be made for authorisation under the inherent jurisdiction of the High Court.
- Children/Young People Aged 16 and 17 - the Mental Capacity Act 2005 applies. An application must be made to the Court of Protection.

Table 2 below shows the number of Deprivation of Liberty Order Safeguards applications made for the reporting period compared to previous years.

Table 2: Applications for Deprivation of Liberty Order Safeguards

Applications	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
Urgent DoLS applications	11	4	1	6	0
Standard DoLS applications	2	11	6	4	2
Court of Protection	1	0	0	1	0
Total	14	15	7	11	2

The two children for whom applications were made identified as white British females

5. Mental Health Act Training

Mental Health Act training is required for the following areas on an annual basis: Specialist Mental Health Services, Ward 4C and Emergency Department. Training compliance for these identified areas within the Trust is shown in **Table 3** for the reporting period.

Table 3: Mental Health Act Training Compliance

Service/Ward	Mental Health Act Training Compliance
Specialist Mental Health Services	96%
Ward 4C	97%
Emergency Department	90%

In addition, to annual Mental Health Act training, Mersey Care NHS Foundation Trust provides training regarding Mental Health Act paperwork and administration to appropriate staff across the Trust as part of the service level agreement. During the reporting period specific training was provided to Sunflower House and Ward 4C.

6. Incidents

For the reporting period, **8** incidents were reported in relation to use of the Mental Health Act which is the same as 2024/2025 and predominantly related to the used of MHA paperwork. The incidents occurred at the following locations: Ward 4C (2), Sunflower House (5), and Merseyside Police (1).

Learning from incidents resulted in additional training being provided to staff regarding the requirement for accurate completion of MHA paperwork including Section 17 leave processes.

7. Independent Mental Health Advocacy Service

An Independent Mental Health Advocate (IMHA) is a specialist advocate. The right to an IMHA was introduced in 2007 under amendments to the 1983 Mental Health Act. This gave legal rights to IMHAs which are not available to other advocates. These rights mean that IMHAs may:

- Meet qualifying children and young people in private.
- Consult with professionals concerned with the child or young person's care and treatment.
- See any records relating to the child or young person's detention, treatment, or after-care, for the purpose of providing help to the child or young person and where the child or young person consents.
- Request access to records where the child or young person lacks capacity to consent, if accessing the records is necessary to carry out the functions as an IMHA.

IMHA services are independent, confidential, and free of charge to the child or young person and whilst they do not have to accept help from an IMHA they can change their mind at any time, as such this service should be promoted to children and young people detained under the Mental Health Act. Alder Hey commissions "Real Advocacy" to provide advocacy support to children and young people detained under

the Mental Health Act within the Tier 4 Childrens Inpatient Unit and acute paediatric wards.

For the reporting period all children formal and informal in acute paediatric wards and Tier 4 service (Sunflower House) were referred for IMHA services the 5 children and young people identified under section were referred to and availed of advocacy support.

Issues discussed with children and young people who required advocacy support included:

- Clarification of community team
- Identification of RC and MHA rights
- Implementation of traffic light system to support young person to feel safe on ward
- Discharge request
- Device plan review request
- IMAR representation
- Home leave discussion and request
- Supporting young person to request clarification on potential ASC diagnosis
- Ascertaining young person's views in relation to MHA renewal hearing
- Section 17 leave request
- Information about medications
- Move to day-patient status
- Best interest meeting called on behalf of young person detained under MHA
- Access to faith needs
- Discharge planning and views
- CETR

The Advocacy service continues to meet monthly with Sunflower House staff. Staff learning sessions continue to be delivered Sunflower House and on Ward 4C. The Advocacy service has published a "Easy read guide to the Mental Health Act" this was co-produced with young people and copies of this have been provided to Sunflower House.

There were no safeguarding incidents requiring involvement from the Advocacy Service during the reporting period and no formal complaints or concerns raised from the children and young people referred to the service. There were no complaints regarding the Advocacy provider during the reporting period.

8. Implementation of Thalamos

A key priority for 2025/2026, following incidents in 2024/2025 was the implementation of Thalamos eMHA system enabling clinicians to complete Mental Health Act documentation digitally. This system replaced the previous process using paper forms, ensuring a safer, more reliable service for children and staff.

Thalamos' eMHA, part of Alder Hey's 2030 Futures Strategy under the "Transform" pillar for digital innovation, supports the NHS Long Term Plan by digitising outdated

paper processes. A multi-disciplinary team including clinical leads, information governance, and digital systems teams oversaw the project from the start. The project's main objectives were to:

- Streamline clinical workflows and standardise care by digitising the sectioning process for MDT teams at Alder Hey and Mersey Care, replacing paper procedures.
- Enhance quality and safety by ensuring all sectioning forms are fully completed, reducing errors and legal risks.
- Prevent delays or incomplete sections by eliminating the risk of lost or misfiled papers.
- Increase efficiency and collaboration with Mersey Care through improved workflows and shared best practices.

The system launched in November 2025 to positive feedback, delivering several key benefits:

- Clinical workflows have become more efficient, improving staff experience and reducing time spent correcting paperwork errors.
- Patient safety has increased, as Thalamos' eMHA system ensures all mandatory fields are completed for a safe and legal sectioning process.
- The risk of legal claims due to incorrectly conducted sections has been eliminated.
- Clinicians now save significant time by no longer filling out paper forms or searching for hospital details; medical recommendations that previously took 45 minutes are expected to take at least 20 minutes less.
- The system's reliability and safety have improved, removing the chance of losing paper forms.

9. CQC Mental Health Act Compliance

An unannounced Care Quality Commission (CQC) Mental Health Act monitoring visit took place at Sunflower House on the 16 April 2025. The purpose of the visit was to monitor the use of the Mental Health Act 1983 (MHA) for detained children and young people to ensure their needs are safeguarded.

An action was identified by CQC, in relation to the provision of an IMHA service to children detained under the MHA. Whilst the current service provider of IMHA support is an independent service provider, as the service is funded via Alder Hey, CQC advised that this did not meet the requirements of Section 130A (MHA) which requires that independent mental health advocacy services are commissioned by the local authority. It should be noted that Alder Hey had provided the IMHA service for many years and this had not been highlighted in previous CQC inspections/reviews.

The Director of Community Mental Health Services subsequently met with Liverpool Local Authority who agreed to fund and commission an IMHA service for children detained under the Mental Health Act at Alder Hey. This new service commenced on 01 August 2025.

10. Priorities for 2026/27

The following priorities have been agreed for 2026/27 in relation to the Mental Health Act across the Trust:

- Continue delivering Mental Health Act training to relevant Alder Hey staff through Mersey Care and Thalamos.
- Further develop the Thalamos system to improve paperwork accuracy and embed Mental Health Act training across Cheshire and Merseyside NHS and local authority providers.
- Strengthen how Mental Health Act incidents are recorded.
- Improve recording of Mental Health Act assessments and outcomes, including non-detention cases and ethnicity and gender data.

11. Next Steps

Trust Board is asked to approve this report and be assured that robust arrangements are in place to meet the requirements of the Mental Health Act and respond to the needs of children and young people to whom it applies.

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Use of Restrictive Practice Annual Report 2025/2026
Report of:	Lisa Cooper, Director Community & Mental Health Services
Paper Prepared by:	Jacqui Pointon, Associate Chief Nurse, Andrea O'Donnell, Consultant Nurse Mental Health Tony Maguire, Acute Liaison Team Lead

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
*2800	A child may be harmed in the process of holding them to complete an intervention across the Trust.	9

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

The purpose of this report is to provide assurance to Trust Board of activity in relation to the use of restrictive physical interventions across the Trust for the reporting period 01 April 2025 – 31 March 2026. This includes identifying areas for improvement and actions for the Trust to take to support children and young people to access care safely in line with additional guidance from NHS England and Restraint Reduction Network.

2. Background

Children and young people using Trust services, including acute, community and specialist mental health services, may present with behaviours that challenge because of distress, unmet need, or underlying learning difficulties, neurodevelopmental conditions, or mental health needs. In some cases, this can lead to the use of restrictive interventions to maintain safety and support care and treatment.

Where this occurs, restrictive physical intervention, including clinical holding, may be needed as a last resort to prevent harm. The Trust remains committed to ensuring that any restrictive intervention is necessary, proportionate, and used for the shortest possible time within a human rights-based, trauma-informed framework, whether the child or young person is informal or detained under the Mental Health Act 1983 (as amended), pending reforms under the Mental Health Act 2025.

Whilst the Trust has in place a policy framework, this will be strengthened further through the newly established Restrictive Practice Forum during 2026/27, including development of an overarching framework.

National expectations for reducing restrictive practice have strengthened. While the Restraint Reduction Network Training Standards remain the main benchmark for staff training, recent guidance from NHS England broadens the focus from training compliance to a whole-system, culture-led approach to reducing restriction, which should be reflected in future reporting.

The Trust recognises growing national concern about variation in how clinical holding is interpreted and reported. Work is underway through the Restrictive Practice Forum and Parity of Esteem Programme Board to improve consistency in definitions, thresholds, and reporting across all divisions.

The Trust continues to strengthen compliance with the Mental Health Units (Use of Force) Act 2018, including requirements for governance, transparency, and oversight of restrictive interventions. Further work is also needed to improve reporting on protected characteristics so that any disproportionality can be identified and monitored.

Relevant guidance, including NICE Quality Statement 10, RCN guidance, and DHSC guidance, continues to emphasise the need for a proactive approach to reducing restrictive interventions, supported by appropriate staff training and a positive, transparent, and collaborative reporting culture for both restrictive physical interventions and clinical holding.

The Trust's identified Executive Lead is the Chief Nurse, supported in discharging these responsibilities by the Director of Community and Mental Health Services.

3. Data regarding restrictive physical interventions

For the reporting period 01 April 2025 – 31 March 2026, the Trust reported a total of **355** incidents relating to **25** children and young people (9 x Tier 4 Inpatients, 16 x acute Trust), regarding the use of restrictive physical interventions of children and young people accessing services at Alder Hey. This is a decrease in the number (419) reported in 2024-2025. All incidents relate to children and young people who were accessing care from the Trust.

All incidents must be reported within 24 hours, and both staff and young people should receive a debrief after restrictive interventions. The Restraint Reduction Network's debrief model is included in the Trust's Restrictive Interventions policy.

Tables 1 & 2 show the recorded incidents involving restraint and clinical holding reported across the Trust per division for 2025/2026 compared with previous years.

Table 1: Recorded incidents involving restraint

Division	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
Medicine	30	76	16	15	5
Surgery	23	19	6	3	0
Community & Mental Health	88	68	261	322	323
Total	141	163	284	340	328

Table 2: Recorded incidents involving clinical holding

Division	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
Medicine	4	14	14	70	20
Surgery	4	9	3	6	2
Community & Mental Health	3	13	2	3	5
Total	11	36	18	79	27

Clinical holding incidents remain under reported and requires further review, as there is still no effective mechanism for capturing them consistently.

Restraint reporting remains high in Community and Mental Health services, specifically in the Tier 4 Children's Inpatient Unit, reflecting rising clinical acuity, more complex presentations, and longer lengths of stay in line with national trends. Reporting of factors contributing to restraint has improved in the Tier 4 unit, including rapid tranquillisation, increased observation, searching procedures, restrictive escort, and nursing in isolation, segregation, or seclusion.

Reporting on restrictive interventions continues to highlight challenges across the Trust in achieving consistent and accurate recording. Further work will be undertaken during 2026/2027, to improve data quality therefore enabling meaningful analysis of trends, contributory factors, and variation in the use of restrictive interventions across different cohorts of children and young people.

4. Data regarding restrictive intervention incidents reporting harm

The Trust recognises that harm arising from restrictive interventions extends beyond physical injury and may include psychological distress and cumulative effects. Work is underway to improve understanding and reporting of these impacts, which includes consistent recording and analysis of near misses and repeat incidents to support a more proactive approach to risk reduction.

For the reporting period 01 April 2025 – 31 March 2026, **272** incidents were reported as no harm. There was **1** reported moderate harm incident regarding the use of restrictive physical intervention and clinical holding in relation to children, young people, staff, or others (parent/carer/visitor). On review, this was changed to low harm.

A total of **83** incidents, involving low harm were reported (Table 3) which is a decrease from 2024/25 (132) and highlights improvements to safe management/reducing risks. Of the low harms reported, **15** related to staff being hit during the incident of restraint. The remaining **64** related to children/young people through self-harm acts or through fighting against holds during incidents.

Table 3: Incidents reporting harm physical harm 2025/2026

Division	Total Incidents low harm
Medicine	1
Surgery	0
Community & Mental Health	82
Total	83

* 1 x moderate harm incident was reviewed and reduced to low harm.

The Trust continues to provide support to children, young people, and staff affected by restrictive physical intervention or clinical holding. This includes reflective practice, debrief sessions, and access to psychological support. The Acute Liaison Team (learning disability/autism/mental health) also continues to strengthen the clinical pathway through reasonable adjustment training and support. Meeting the needs of children, young people, and staff remains essential to ensuring effective and transparent responses.

5. Staff Training

Training remains essential to driving change. Staff who may use positive behaviour support, restrictive interventions, physical interventions, or clinical holding including bank staff and security personnel must receive specialist training. This focuses on

reasonable adjustments and preventing restrictive physical interventions through trauma-informed care.

Since 2015, Alder Hey has provided Positive Behaviour Support (PBS) training for clinical staff and formally integrated it into the Trust's Conflict Resolution training program in January 2019. In addition, Oliver McGowan phase 1 training was rolled out from 2024. This continues to be reported monthly to line managers as part of the Trust's mandatory training matrix and is >90% across the organisation. There is work underway with the learning and development team on phase 2 training to make this more paediatric focused and meaningful to the Trust.

During 2025/26, basic reasonable adjustment training continued across acute wards on request and is now included in the Trust's twice-yearly student induction. The Community and Mental Health Division have embedded it in local induction and there is a plan to introduce monthly Trust-wide sessions to make available across the Trust as part of a wider paediatric training programme (under development) which also includes incorporating trauma-informed care, autism-informed approaches, and communication strategies in line with updated national expectations to reduce restrictive practices.

For restrictive physical intervention training, the Trust secured an alternative provider, PAMOVA, in April 2024. PAMOVA is BILD/RRN-compliant, has received positive evaluations, and has worked with the Trust to develop training for inpatient mental health services and paediatric ward and department clinical holding, including breakaway techniques.

Based on training needs analysis with wards and departments, **75** staff have completed the one-day clinical holding course (new or refresher), **73** have completed the higher level three/four-day course (new or refresher), and **216** staff across the organisation have received breakaway training. A further review will be undertaken with theatres, the outpatient department, and Ward 4C to ensure current provision meets their needs following feedback around increasing techniques requirements.

All training delivered by PAMOVA is aligned with standards set by the Restraint Reduction Network, ensuring a consistent, high-quality approach to prevention and safe intervention. The Nurse Specialist and Nurse Consultant within the Acute Liaison Team continue to review and build upon the training model and a sustainable Trust model for the future.

6. Restraint Reduction Programme

The Trust's Acute Liaison Team (LD/ASD/MH), train staff on reasonable adjustments across the organisation to reduce restrictive interventions. This includes using communication profiles for children/young people. Ongoing work emphasises the importance of following these profiles to create a positive experience and reduce the use of restrictive physical interventions.

In addition, the Children's Tier 4 inpatient service continues to develop preventative approaches within the service, that reflect national priorities to reduce reliance on restrictive practices through environmental, relational, and therapeutic interventions.

7. Priorities for 2026/27

The following priorities have been agreed for 2026/27, in relation to the use of restrictive physical interventions across the Trust:

- Continue annual PAMOVA and Acute Liaison Team (LD/ASD/MH) training for Alder Hey staff, with Learning and Development to confirm ongoing funding.
- Continue to offer breakaway training to all Trust staff through PAMOVA, including legal frameworks for conflict and basic escape techniques, with clarification on ongoing funding from Learning and Development.
- Develop a formal monthly in-house training offer to complement PAMOVA and mandatory training, covering PBS, conflict resolution, stage 2 Oliver McGowan training, neurodiversity, sensory needs, trauma-informed care, reasonable adjustments, I Support standards, communication, and restrictive practice awareness.
- Improve recording of restrictive intervention incidents, especially clinical holding, and review how this is recorded and reported.
- Audit reported incidents to ensure debriefs are recorded in clinical records and Trust policy is followed.
- Improve tracking of staff harm by reviewing reporting methods and updating the InPhase form for accurate data capture.
- Continue to strengthen the Trust-wide Restrictive Practice Forum for training, policy, and incident oversight.
- Develop stronger reporting to identify and monitor potential inequalities in restrictive interventions, including by ethnicity and disability.
- Strengthen understanding and reduction of non-physical restrictive practices, including environmental and psychological restriction.
- Continue embedding trauma informed, I Support, and person-centred approaches across all services.
- Improve capture and oversight of psychological harm and the cumulative impact of restrictive interventions.

8. Next Steps

The Trust Board is asked to note this report and be assured that robust arrangements are in place for the use of restrictive physical interventions with children and young people accessing Trust services.

The Trust will continue to align with emerging national policy and legislative reforms, minimising restrictive practices and ensuring care remains safe, therapeutic, and rights-based for children and young people.

Appendix 1: Recorded incidents involving restrictive physical interventions per division 2025/2026

Medical Division

Department	Number of incidents	
	Restraint	Clinical holding
Ward 4C	1	6
Ward 4B	0	0
Emergency Department	4	1
Renal (unit)	0	10
Nephrology	0	2
Radiology	0	1
Total	5	20

Surgical Division

Department	Number of incidents	
	Restraint	Clinical holding
Ward 3A	0	0
Anesthetics Department	0	0
Surgical Day Case Ward	0	0
Theatre surgical Day Case & Inpatient general	0	0
Ward 4A	0	1

Burns Unit	0	1
Total	0	2

Community & Mental Health Division

Department	Number of incidents	
	Restraint	Clinical holding
Tier 4 Children's Inpatient Mental Health Unit	323	0
Outpatient Phlebotomy	0	2
Acute Liaison Team (LD/ASD/MH)	0	3
Total	323	5

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Trust Quality Account 2025/26
Report of:	Chief Nursing AHP and Experience Officer
Paper Prepared by:	Associate Director Nursing Risk and Governance

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☒
Summary / supporting information	All NHS Trusts are required to produce an annual Quality Account to provide information on the quality of the services provided to patients and their families. They are an important way for Trusts to demonstrate how well they are performing, considering the views of service users, carers, staff and the public and to identify areas for improvements. The Board are asked to note and Ratify prior to publication via Trust website and NHS Choices no later than 30 June 2026
Strategic Context	
This paper links to the following:	Outstanding care and experience ☒ Collaborate for children & young people ☒ Revolutionise care ☒ Support our people ☒ Pioneering breakthroughs ☒ Strong Foundations ☒
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☒

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

Risk number	Risk description	Score

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

**NHS Cheshire and Merseyside ICB
No1. Lakeside
920 Centre Park Square
Warrington
WA1 1QY**

15th May 2026

Sent by email to:

Nathan Askew, Chief Nursing, AHP and Experience Officer
Nathan.Askew@alderhey.nhs.uk

Re: 2025/26 Quality Account Statement

Dear Nathan

NHS Cheshire and Merseyside Integrated Care Board welcomes the opportunity to provide this statement in response to Alder Hey Children's NHS Foundation Trust's Quality Account for 2025/26.

The Quality Account presents a clear, well-structured and evidence-based overview of the Trust's performance across patient safety, clinical effectiveness, patient and family experience, workforce, and system leadership. It provides a transparent and balanced narrative, with achievements supported by data and benchmarking, alongside appropriate acknowledgement of key challenges. The content is broadly consistent with commissioner and regulatory intelligence and reflects a strong organisational commitment to continuous quality improvement.

NHS Cheshire and Merseyside recognises and commends the Trust's progress and achievements against the 2025/26 quality priorities. Significant achievements include a demonstrable reduction in incidents causing harm and unplanned HDU escalations, improved referral to treatment constitutional standards (RTT) performance with elimination of very long waits, and the continued strengthening of a just and learning culture. It is positive to see learning being shared from Patient Safety Incident Investigations at relevant divisional meetings, we would welcome presentations of any relevant shared learning at the Patient Safety Specialist Community of Practice. The Trust's governance arrangements, including clear Board oversight and the meaningful involvement of Patient Safety Partners, provide assurance that learning from incidents is systematically embedded across the organisation.

The outstanding outcome from the CQC inspection into specialist community mental health services for children and young people demonstrates the excellence the Trust is striving for, and we look forward to the outcome from the surgical services CQC inspection which is due to report shortly. NHS Cheshire and Merseyside will be committed to overseeing any further improvement that is recommended following these findings.

The Trust demonstrates strong patient safety leadership and assurance, evidenced by high Patient Safety Incident Response Framework compliance, a positive reporting culture and sustained zero Category 4 pressure ulcers. Learning from incidents including Never Events is clearly articulated, including use of external review and implementation of the latest National Safety Standards for Invasive Procedures to strengthen surgical safety.



We welcome the Trust's leadership in improving the recognition and management of the deteriorating child, including Trust-wide implementation of Martha's Rule and strengthened escalation pathways. This work makes an important contribution to improving outcomes for children and young people across Cheshire and Merseyside and we look forward to hearing about the progress made with implementation in outpatients, the Emergency Department and community services.

The Trust demonstrates strong clinical effectiveness, with high participation in national audits and performance that is in line with or exceeds comparable specialist paediatric providers. The recommendations described around Juvenile Idiopathic Arthritis, MMBRACE-UK Perinatal mortality and appropriate palliative care discussions for children neurodisability sound positive, we will work closely with the Trust to understand more about the clinical audit findings requiring action during 2026/27 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust's open learning culture is clearly demonstrated within the Account, with particular emphasis on learning from mortality reviews. Key lessons are shared transparently, evidenced by the Trust's commitment to reviewing all inpatient deaths, supporting organisational learning and assurance. We will continue to work closely with the Trust to provide oversight regarding the improvements implemented in response to these learning outcomes.

We welcome the Trust's continued emphasis on patient, family and staff experience. The delivery of Sophie's Legacy is commendable and clearly reflects the Trust's strong commitment to its relationships with patients and families, as well as its determination to honour and fulfil patients' wishes.

The strong results from the national patient survey, alongside the continued development of staff wellbeing, Freedom to Speak Up, and inclusion initiatives, demonstrate a clear commitment to compassion, partnership, and listening. We acknowledge the challenges identified through the staff survey, and is reassured by the Trust's openness, clear understanding of these issues, and the actions in place to address them.

Strong partnership working across the Cheshire and Merseyside Integrated Care System underpins progress on key priorities, including the Beyond Children and Young People Transformation Programme, neighbourhood working, prevention initiatives, and digital innovation. Contributions to research, innovation, and system development support the NHS Cheshire and Merseyside's ambitions to reduce health inequalities, shift care closer to home, and improve population health outcomes for children and young people.

Overall, NHS Cheshire and Merseyside Integrated Care Board is assured that Alder Hey Children's NHS Foundation Trust has robust arrangements in place to maintain and improve the quality and safety of its services. We support the Trust's proposed quality priorities for 2026/27 and look forward to continuing to work in close partnership to deliver high-quality, equitable and sustainable services for children, young people and families across Cheshire and Merseyside.

Yours sincerely



Fiona Lemmens

Executive Clinical Director
NHS Cheshire and Merseyside ICB

cc. Kerry Lloyd, Kerrie France, Tracey Forshaw

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Chair's Report from the Safety and Quality Assurance Committee meeting held on 20th May 2026
Report of:	Fiona Beveridge, Committee Chair
Paper Prepared by:	SQAC Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☐
Summary / supporting information	This paper provides a summary from the Safety Quality Assurance Committee meeting held on 20 th May 2026, along with the approved minutes from the 22 nd April 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	- 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
1.1		
1.2		
1.4		

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
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1. Executive Summary

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

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

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

Minutes of the meeting held on 22.04.26	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Patient Safety update, including Consent and authorising of blood Products report	Report noted
Patient Safety Annual Report	Report noted
Drugs & Therapeutics Quarterly and Annual Report	Report noted
EPRR Quarterly update and Annual Assurance Report	Report noted
HDU PSII Never Event (Medication administered by the wrong route)	Report noted
Compliments, Complaints & PALS report Quarter 4 and Year End 2026/26	Report noted
Patient Experience and Family Feedback Report Quarter 4 2025/26	Report noted
Quarter 4 Children & Young People Engagement Leads Report	Report noted
Patient Experience Annual Report	Report noted
AR Learning Review Action Plan and Southport Inquiry Phase 1 – Actions on recommendations	Report noted
Clinical Effectiveness and Outcomes Board Chairs Highlight report	Report noted
Clinical Effectiveness & Outcomes Board Annual Report	Report noted
Board Assurance Framework	Report noted
Mortality coding update report	Report noted
2025/26 Quality Account	Report noted
Clinical Strategy: 2026-2030	Report noted
Clinical Audit Annual Report 2025/2026	Report noted
Trust wide Clinical Audit Plan for 2026/2027	Report noted
National Confidential Enquiries Report: Quarter 3 2025/26 summary	
Position report and Annual Report 2025/26	Report noted
Children & Young Peoples Gender Service (North) Quarter 4 Report (01 May 2025-31 st March 2026)	Report noted
Assessment against SQAC Terms of Reference – May 2026	Report noted
C5 Child Death and bereavement policy	Ratified
Countermeasures Plan	Ratified
Incident Co-ordination Centre Standard Operating Procedure	Ratified
Mass Casualty Major Incident Plan	Approved
Inspection Accreditation Report	Report noted
Incident Response Plan	Ratified
Management of Suspected meningitis and septicaemia guideline	Ratified

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

None

4. Positive highlights of note

- SQAC received assurance across all three domains of quality – safety, effectiveness and experience, supported by a comprehensive suite of reports and substantive discussions on several key topics. SQAC noted the quality of reporting and scrutiny, the agenda volume remains significant.
- Divisional reports highlighted strong performance in the Medicine Division, including significant recovery in neurology services and a reduction in the associated risk rating.
- SQAC noted the continued improvements in patient flow and service innovation within Surgery
- SQAC noted the increasing complexity and volume of complaints with work underway to strengthen response and resolution processes.
- SQAC received assurance that appropriate governance and oversight arrangements are in place and are effective with regards to Controlled drugs management.
- Positive performance was noted across patient safety metrics: including no reported cases of C Difficile or MRSA in the reporting period. An achievement of a 5% reduction in harm incidents and improved reporting of no-harm incidents.
- SQAC reviewed a Patient Safety Incident Investigation (PSII) relating to medication administered via the wrong route. The investigation was assessed as comprehensive and systems-focussed with clear learning and actions identified, with ongoing focus areas including clinical engagement in safety reviews, compliance with consent processes and timeliness of investigations.
- SQAC welcomed the Patient Safety Strategy Update and the Patient Safety Annual Report, with evidence of embedded processes, continuous improvement and transition of key programmes into business as usual.
- Clinical Effectiveness and audit activity, including 100% compliance with national audit data submissions and strengthened governance through new systems and dashboards.
- Robust discussions took place regarding the Clinical strategy: 2026-2030, which SQAC approved, noting strong clinical engagement and clarity of direction.
- SQAC Ratified the 2025/26 Quality Account, with positive external feedback noted.
- SQAC acknowledged the high standard of reports received, whilst also acknowledging that a couple of report required further improvement.
- SQAC received the Board Assurance Framework update, and noted the continued risk relating to neonatal transfers (LNP), mitigated operationally, but dependent on the opening of the new unit for full resolution.
- SQAC noted the variation in risk scoring across divisions, particularly the absence of high risks in surgery, which would be reviewed through the Risk Management Forum.
- A review of SQAC Terms of Reference demonstrated strong alignment with minor gaps to be addressed through forward planning.

- SQAC acknowledged that it was the Associate Director of Nursing & Governance last SQAC meeting prior to retiring, after 46 years in the NHS. Thanks were expressed for her significant contribution to patient safety and governance over many years.
- SQAC acknowledged that it was the Associate Chief Nurse, Surgery Division final SQAC meeting. Thanks were expressed for ongoing contribution to the Trust.

5. Issues for other committees

None

6. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 22nd April 2026
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director, Community & Mental Health Division	LC
	Gerald Meehan	Non-Executive Director	GM
	Laura Rad	Head of Nursing – Clinical Research	LR
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	JP
	Rachael Pennington	Associate Chief Nurse – Surgical Division	RP
	Jackie Rooney	Associate Director of Nursing & Governance	JR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW

In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Ava Killbride	Governor	AK
(Part meeting)	Sarah Almond	Acting Divisional Director – Surgical Division	SA
26-27-06	Kelly Black	Deputy Head of Neonatal Nursing, LNP	KBL
26-27-09	Kim Hewitson	Sepsis Team	KH
26-27-09	David Porter	Sepsis Lead, Consultant Infection & Immunology	DP
	Jill Preece	Governance Manager	JP

Apologies:	Alfie Bass	Chief Medical Officer	AB
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	ABa
	Veronica Greenwood	Director of Allied Health Professionals (AHP's)	VG
	Jenny Devine	Governor	JD

26/27/01 Welcome and Apologies

The Chair welcomed everyone to the meeting and apologies were **NOTED**.

26/27/02 Declarations of Interest - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

26/27/03 Minutes of the Previous Meeting

The Committee members were content to **APPROVE** the minutes of the meeting held on 25th March 2026

26/27/04 Matters Arising/Review of Action log

The log was reviewed.

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

26/27/05 Divisional Updates

Division of Medicine

CW presented the Medicine Division update and drew attention to a few key points from the report including:-

- Targeted interventions had delivered sustained performance improvements across RTT and diagnostics.
- A marked and notable improvement was NOTED in Neurology RTT performance which had improved significantly from 40% to 91% following workforce redesign and targeted resourcing.
- High-Risk Services: Neurology and metabolic services remain under active review, with significant mitigations in place. A planned reassessment of risk scores is underway, with the intention of reducing current ratings based on demonstrable progress.
- A previously high-scoring risk relating to psychology provision within the Emergency Department has been fully mitigated and closed. The mitigation has already commenced and is demonstrating positive operational impact.

- The Division has achieved a sustained reduction in low-harm incidents.
- Progress continues in improving the timely closure of incidents open for more than 30 days.
- Whilst an increase in formal complaints continues to be observed (consistent with trends discussed at previous meetings), the Division reported: 100% compliance with response timeframes for both complaints and PALS.
- Significant strengthening of Business Continuity Plans (BCPs) had been undertaken across the Division. These improvements were not yet fully reflected in the report due to data lag, however near complete compliance was confirmed verbally.
- ED Sepsis performance - although not included within the report, ED sepsis performance was confirmed at 92%.

FB NOTED an apparent mismatch in colour-coding within the metrics performance data, this was acknowledged by CW.

Division of Surgery

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

Highlights:-

- A new weekly multidisciplinary meeting had been established between Cardiology, ECMO, PICU, and Perfusion teams. The purpose of the meeting is to review incidents and shared learning collaborate, identify and resolve pathway issues more rapidly. The initiative is highly effective, improving joint working and communication across interdependent services, and enabling faster resolution of operational and clinical issues.

Key Challenges:-

- The Division reported a recurrent digital interface issue between Philips monitoring systems and Aldercare, with delays in data transfer to Meditech which can result in delayed or inaccurate PEWS, this creates a risk of delayed escalation in patient deterioration. The issue had been added to the Divisional Risk Register and actively escalated to Digital teams for resolution. RP confirmed the issue is persistent and requires ongoing oversight until fully mitigated.
- Medication Safety – Bedside Medication Verification (BMV) compliance across the Trust is less than 50% in all areas, with the third highest-performing area reporting compliance of approximately 40%. This level of compliance was recognised as indicating a systemic issue, rather than isolated non-compliance. Identified contributory factors include process and workflow challenges, including labelling practices (e.g. labels applied to boxes but not individual vials); time and staffing burden associated with maintaining BMV processes; equipment issues: variation in scanner usability (wired vs wireless devices); availability and suitability of scanning equipment; pharmacy-related issues: product substitutions due to stock changes requiring relabelling; delays and inconsistencies affecting BMV usability at the bedside. RP advised that the BMV issue had been added to the Divisional Risk Register and the Division proposed to undertake a broader evaluation of benefits versus risks, including impact on clinical workflow, contribution to medication safety and opportunity cost and staff burden. The Division reported emerging evidence from research and external studies indicating that: adoption of BMV had not consistently demonstrated a significant improvement in medication safety outcomes, potentially adding complexity and workload without delivering proportional safety benefit.
- The Division recently underwent a CQC safety review, work is ongoing to collate and finalise documentation and responses arising from this review.
- Sepsis compliance for the period was reported at 100%.
- Continued progress was reported in EPRR. Table-top exercises are planned for later in the month, with training compliance slowly improving.
- The Division acknowledged ongoing pressure regarding formal complaints, complaint numbers had reduced from a previous peak of approximately 22 to 7–8 open cases. Confidence was expressed that compliance levels would continue to improve.

FB highlighted that the BMV is a Trust-wide issue, not confined to Surgery, and queried wider oversight.

FB requested that learning from the Division's work on BMV be shared across the Trust.

FB proposed that BMV be presented to Patient Safety Board, specifically under the medication safety workstream and discussed with Pharmacy leadership to ensure Trust-wide learning and alignment.

GM referred to the level of BMV compliance (<50%) which was indicative of a fundamental system failure rather than individual practice issues.

RP advised that the low compliance figures were the primary trigger for escalation, and that the issue is structural and process-driven, with a need to reassess assumptions about BMV effectiveness and usability.

Resolved: SQAC welcomed an update on the current BMV position at the May 2026 SQAC meeting to include an update on progress of discussions with Patient Safety Board and Pharmacy, update on outcomes of the BMV evaluation work and any resulting recommendations or changes to approach.

Clinical Research Division

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

Highlights:-

- The Division made significant progress in community research engagement, enabled through strategic funding from the Research Delivery Network.
- The Mobile Research Unit had delivered over 30 community engagement events across schools and community venues, and had recruited 78 participants into research studies, with extensive public and patient engagement activity, including public health and prevention messaging.
- The EDGE project had been completed, with all study documentation successfully migrated from local drives to the EDGE NHS Research Data Platform, this would enable strengthened document control, version management, and governance assurance, with ongoing oversight by the Quality Assurance Officer.
- No incident concerns were reported.
- The Division is supporting a complex complaint currently overseen by the Division of Medicine. The Committee NOTED strong performance against NIHR patient experience metrics, with the Division exceeding response targets and ranking within the top ten regionally.

Challenges:-

- Due to ongoing capacity issues within aseptic pharmacy team, the Division have been unable to open a number of studies within expected timelines. The Division are working with service leads to find a sustainable model for pharmacy support for clinical trials. The Division are currently training a new member of staff and are also exploring what studies could be undertaken without aseptic services as standard.
- The Division reported increasing pressure associated with the introduction of the national 150-day clinical trial set-up target, noting that while internal processes had improved, wider organisational pressures - particularly within laboratory and pharmacy services are impacting delivery. The cumulative effect of these pressures on staff wellbeing was acknowledged and is being monitored.

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 Division reported significant progress in the ongoing UK Accreditation Service (UKAS) process for the Rainbow Sexual Assault Referral Centre, with the service advancing to the next stage toward becoming a fully accredited paediatric SARC. There are currently no accredited paediatric SARCs nationally, this represents a substantial achievement for the service. The accreditation process is highly rigorous, and SQAC acknowledged the considerable effort and commitment demonstrated by the team in reaching this stage.
- Sunflower House Tier 4 Children's Mental Health Unit had reopened to referrals, supported by NHS England, following a period of review and restorative work. Referrals are currently being accepted on a case-by-case basis, with individual risk assessments, reflecting ongoing environmental and staffing considerations.

Challenges:-

- Three new risks were added to the Divisional risk register during the reporting period.
- A principal risk relates to vacancies within statutory Safeguarding roles, including medical posts, compounded by maternity leave within the team. These vacancies were highlighted as creating vulnerability across the organisation, particularly in terms of timely and consistent Safeguarding support.
- The Division continues to experience an increase in both the number and complexity of formal complaints. JP advised that during discussions with the Parliamentary and Health Service

Ombudsman (PHSO), the PHSO indicated this trend is being seen nationally, and is not unique to this Trust.

GM commended the achievement of the Rainbow SARC team, noting the highly complex and challenging nature of this work, and congratulated the team on their progress.

GM requested clarification on mitigation plans for the Safeguarding vacancies, noting the inherent difficulty of recruitment in this specialist area and the risk associated with prolonged gaps. In response, JP advised that internal options are being explored to address medical gaps, supported by the existing team. The team is relying on workload sharing, specialist nursing support, and prioritisation to maintain statutory functions. Recruitment remains challenging, and mitigating actions must remain compliant with intercollegiate safeguarding guidelines. This remains an active and evolving piece of work.

NA referred to system level support and interim arrangements and provided additional assurance that an internal candidate had been identified for the Children in Care named doctor role, with job descriptions being resubmitted to the Royal College. Following delays since the last recruitment round interim arrangements have been agreed with the ICB, whereby designated doctors will temporarily provide cover for named Safeguarding roles for a six-month period. The ICB has also offered support with advertising and promoting the roles more widely.

Wider system challenges were acknowledged, including inefficiencies created by current requirements for medical-led initial health assessments, which may not always represent optimal use of specialist expertise. GM endorsed this position, agreeing that greater nursing involvement would be beneficial and appropriate if national guidance allowed.

FB welcomed the progress made through ICB engagement, noting the importance of system-wide solutions and commitments to improve resilience in statutory safeguarding provision.

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

26/27/06

Liverpool Neonatal Partnership Monthly update

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

Highlights:-

- KBI advised on the release of 2024 MBRRACE-UK data, noting a significant improvement in neonatal mortality outcomes at Liverpool Women's. For babies born at ≥ 24 weeks gestation without congenital anomalies, mortality rates were reported as the lowest recorded since data collection began in 2013. When benchmarked against comparable trusts, outcomes were reported as approximately 5% lower, representing a material improvement in performance and providing strong clinical assurance.
- Following a previous increase in bloodstream infections, zero infections were reported for March. A detailed IPC action plan is in place, with many actions already completed. A staff IPC roadshow had been delivered, reinforcing "back-to-basics" principles including hand hygiene, ANTT, uniform compliance, and environmental standards. Work commenced initially at Liverpool Women's but is transferable across both LNP sites.
- A strengthened and collaborative LNP IPC working group is now well established. Families are actively supported and educated to help reduce infection risk.
- Ongoing collaborative work was reported to embed safe water management and clinical workflows.

Challenges:-

- KBI advised that the August handover date remains the current working assumption; however, KBI **NOTED** that essential clinical pathway decisions had been missed. KBI stated that unless these issues are resolved promptly, achieving the August opening date may not be possible, with a potential delay extending into October. KBI stated that the delay is increasingly affecting staff morale, especially since the internal environment is largely complete and appears operationally ready, making it challenging for staff to reconcile the lack of visible progress. KBI cited a specific patient example where a baby had been transferred seven times between sites, it was **NOTED** that five of these transfers would have been avoidable had the new unit been open, reinforcing the original safety rationale for the partnership.

Resolved: ES proposed that a risk should be added to the Risk Register to reflect this.

SQAC acknowledged that the continued delay was highlighted as a direct quality and patient experience risk, and not solely an infrastructure issue.

KBI stated that phased implementation and rotation plans are in development but had not yet been finalised due to uncertainty around opening dates. Planned staff engagement sessions are being supported by HR and Psychology, with continued attention to wellbeing.

- Virtual tours and 360-degree imagery of the new unit had been shared with staff and are reported to be positively received.
- Progress continues on the LNP mobilisation plan, which is being finalised for submission to NHS England.
- A new local LNP Operational Board had recently met for the first time and was reported as well attended, with minor agenda refinements planned. Work is progressing on a joint governance framework, supported by MIAA, with weekly meetings now established.
- Culture workshops are being developed and will be rolled out initially with the Senior Leadership Team, followed by clinical leaders, focusing on psychological safety; civility; large-scale organisational change and high-functioning teams
- A visit to Nottingham NICU was confirmed to learn from their integration of Mindray patient monitoring with Badger, including digital workflows and staff experience.
- Feedback will be sought via nursing focus groups in a safe space to maximise learning.
- The LNP have no open Patient Safety Incident Investigations (PSII's)
- There were no formal complaints received in March 2026
- There were no pressure ulcers received in March 2026
- There were no reportable healthcare-associated infections in March 2026
- There are 10 incidents open for review beyond 30 days which are awaiting review
- Swarm huddles had been introduced in response to an increase in unplanned extubations to support real-time learning, immediate multidisciplinary reflection on contributing factors and early identification of avoidable elements, this approach is intended to be transferable to the new unit and could be applied to other frequently recurring incident themes.

FB welcomed the improvements in mortality and IPC outcomes; FB highlighted the importance of sustaining these gains.

FB confirmed that Trust Board is sighted on the build delay and escalation activity.

FB referred to the patient safety cost of delay, particularly unnecessary inter-site transfers.

KB commended the report as comprehensive and well-articulated, recognising the complexity of the programme.

KB raised concerns regarding governance visibility, noting she had been omitted from the LNP Board diary invitations and was unclear on the current LNP Board arrangements and Co-chairing arrangements following leadership changes. KBI confirmed that the next LNP Board is scheduled for 11 May and the meeting invitation would be re-circulated. KBL advised that membership had been refreshed to include new executive leaders across both organisations.

Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership Monthly update and acknowledged the strong clinical and quality progress and the growing delivery and safety risks linked to build delays and its emerging impact on patient safety, staff morale and system flow.

---- Safe ----

26/27/07

Patient Safety Update

JR presented the Patient Safety update and drew attention to a few key points within the report:-
The Patient Safety Programme Board met on 26th February 2026.

Highlights:-

- SQAC NOTED that at year-end the Trust remains on trajectory to achieve a 5% reduction in harms per 1,000 bed days.
- Some discrepancies were identified within the Integrated Performance Report (IPR), specifically relating to PSII initiation and closure metrics, which had now been corrected and will be reflected in the next IPR iteration.
- A reduction in MSSA and C.difficile infections was reported compared with the previous month.
- All agreed milestones for the Patient Safety Partners programme had been achieved.
- This workstream has now transitioned to business as usual, with patient safety partners joining the Patient Safety Programme Board from the current reporting period.
- A structured Restrictive Practice training programme is being rolled out as part of the parity of esteem workstream.

- Continued work is underway to improve the accuracy and consistency of restrictive practice incident reporting, including alignment of terminology with national datasets.
- Restrictive Practice forums are scheduled for the current month.
- The NatSIPPs (National Safety Standards for Invasive Procedures) - group has convened and developed a draft framework, approved for consideration and discussion.
- Monthly reporting into the Patient Safety Programme Board has been established.
- Martha's Rule continues to be overseen within the Trust's deteriorating patient workstream.
- KPI monitoring had transitioned to business as usual, providing ongoing assurance.
- The Patient Safety Programme Board Terms of Reference and Work Plan for 2026/27 had been approved, with the caveat that terminology may be updated following changes associated with new systems implementation.
- My Kit Check compliance had improved from 85% to 93%, with particularly notable improvement in community services.
- The ALTE process had been updated and embedded into care pathways.
- A resuscitation plan had been established with Manchester Children's Hospital to support children receiving chemotherapy treatment off ward.
- >90% compliance was reported for delivery of antibiotics within 60 minutes for children and young people with sepsis in ED and inpatient settings.
- The Sepsis dashboard has been completed and is functional.
- 100% compliance was achieved for completion of AARs and SBARs within 7 days of a decision to proceed to a Patient Safety Learning Response.

Challenges:-

- The volume and complexity of complaints remain high, with extended response times creating additional operational pressure across divisions.
- Mandatory training compliance within the Resus Team remains below 90%.
- A DNA rate of approximately 30% was identified for training bookings between December and February. The Resus Team is actively addressing this issue.
- There are an increasing number of unacknowledged notifications requiring individual team ownership and sign-off was reported. An action had been agreed to develop a Standard Operating Procedure (SOP), which will return to the Patient Safety Programme Board for approval and oversight.

KB queried whether there is an external deadline for NatSIPPs implementation and queried whether auto-completion/exception reporting functionality (available in Meditech 6) could be implemented in Meditech Expanse. JR confirmed that there is no national implementation deadline for NatSIPPs and advised that NatSIPPs is included in the ICB Quality Schedule for 2026/27, with six-monthly progress reporting expected. JR advised that further clarification would be sought regarding Meditech functionality.

RP advised that NatSIPPs 2 builds on an existing embedded framework, with challenges experienced nationally due to variation in application and oversight and Trust-defined timelines and assurance levels would be appropriate.

FB welcomed this feedback (including comments shared via meeting chat) that parity of esteem work is now broader than restrictive practice alone, with increased visibility of mental health training delivered to acute staff.

NA raised concern regarding a proposal in the report to transition Unacknowledged notices to business as usual, stating this would be premature. Clarification was provided that Patient Safety Board had not approved transition to business as usual and confirmed that Unacknowledged notice updates would continue to be shared at SQAC to provide assurance.

FB confirmed reassurance that this position aligned with previous SQAC discussion and expectations.

Resolved: SQAC received and **NOTED** the Patient Safety update

26/27/08

Learning from Patient Safety Incidents Quarter 3 January - March 2026

JR presented the Learning from Patient Safety Incidents Quarter 4 January – March 2026

The report was presented to provide SQAC with a summary of patient safety activity undertaken during Quarter 4, in line with the requirements of PSIRF and national reporting expectations. The report has been provided routinely to Trust Board over the last 18 months and was brought to SQAC at the Committee's request for oversight and assurance.

- The Trust continues to actively report patient safety incidents via: InPhase & LFPSE (Learning from Patient Safety Events – national system).

- Implementation of the Version 6 system upgrade commenced earlier in the year but was subsequently paused due to national technical issues. These issues are being managed nationally by IT system providers (including Ideagen for InPhase) and are outside the Trust's direct control. There are no confirmed national timescales for resolution currently available. The ICB is fully sighted on the delays and implications.
- Patient Safety Incident Investigations (PSIIs) - One PSII had been commissioned during Quarter 4: Related to the death of a seven-day-old neonate who experienced rapid clinical deterioration following hospital attendance (August 2025). There was extensive discussion and challenge regarding the harm classification (fatal vs non-fatal). Due to disagreement at panel level, the case was escalated to Executive leads (Chief Medical Officer and the Chief Nursing Officer) who agreed the incident should be classified as fatal harm, triggering a PSII. Duty of Candour had been fulfilled. The Terms of Reference had been agreed and the investigation is underway.
- Two PSIIs concluded in Quarter 4, both relating to Never Events (retained swabs). Findings from these investigations have been previously presented to SQAC.
- Two Patient Safety Learning Responses were commissioned and concluded during the quarter: both were undertaken as After Action Reviews (AARs).
- An external subject matter expert review was commissioned following two Never Events involving retained swabs. It was initially anticipated that the review would conclude in Quarter 1 2026/27, however this timescale would not be met due to the recent withdrawal of external SME reviewers. The Trust is currently in the process of appointing alternative external subject matter experts, following which a reviewed timeline for completion of the SME review will be confirmed. An update would be provided through Patient Safety Board.
- Patient Safety Training Level 1 (mandatory) - 99% compliance achieved.
- 44 staff had been trained at Level 2 Patient safety syllabus training (not mandated for all staff), and is a requirement for those in oversight, learning response and engagement lead roles. Reported figures under-represent the true position due to misalignment between ESR and E learning for Health (ELfH) data. Names and records are available where assurance is requested.
- 3 staff have completed Level 3-4 training via Loughborough University.

Quarter 4 Assurance and Next Steps

- The Trust continues to embed the Patient Safety Strategy.
- Focus for Quarter 1 of the new financial year includes: Refresh of the Patient Safety Plan for 2026/27; Incorporation of Stakeholder feedback; Emerging themes from patient safety data.
- A communications brief inviting feedback has been issued
- Patient Safety Partners remain actively involved.

GM requested clarification regarding the classification of harm in the neonatal fatality case. GM query specifically addressed whether the determination centre on care-related factors or any underlying congenital conditions. It was clarified that according to the established framework, any paediatric death is initially categorised as fatal harm, thereby requiring a comprehensive investigation. Uncertainty pertains to the cause of harm rather than the outcome itself. The investigative process permits subsequent reclassification of harm if deemed appropriate. The family had been engaged and will contribute to the investigation process.

FB reflected that it is appropriate to err on the side of higher classification to ensure learning and transparency.

SQAC acknowledged the delicate balance between proportionality and the need to investigate thoroughly and that failing to investigate would be unacceptable.

KB raised concern regarding the withdrawal of external Subject Matter Experts from the theatres review, querying whether this reflected concerns following observation of practice.

It was confirmed the withdrawal related to payment conditions (a request for payment prior to completion of work) and not related to any concerns about observed clinical practice.

Resolved: SQAC received and **NOTED** the Learning from Patient Safety Incidents Quarter 4 January – March 2026

26/27/09

Sepsis Quarterly Report

DP presented the Sepsis Quarter Report and drew attention to a few key points from the report including:-

- The sepsis dashboard is nearing completion. Final work is focused on accuracy and presentation of data and final validation checks. The dashboard was originally designed around

inpatient activity; additional work is underway to ensure the dashboard appropriately reflects Emergency Department (ED) workflows; harmonise data flows between ED and inpatient settings. DP advised that the harmonisation process was complex but close to completion. The intention is for the dashboard to support both ED and inpatient sepsis oversight.

Antibiotic Administration Performance -Inpatients

- Quarterly data demonstrates that administration of antibiotics within 60 minutes remains consistently above the 90% target.
- Month-to-month variation exists due to relatively small patient numbers, but overall performance remains strong.
- When measured against the 90-minute standard, performance is consistently above 90% across most months.

Emergency Department

- ED performance is based on larger patient volumes and therefore shows greater stability.
- Quarterly and monthly data demonstrates that ED antibiotic administration is consistently above the 90% target for both the 60-minute and 90-minute standards.
- Sustained improvement over previous years was NOTED, with performance now having stabilised at a high level.

Sepsis training

- Sepsis training compliance had reduced slightly in recent months. Current compliance levels are below the 90% target across staff groups.
- Contributory factors include Imminent changes to staff role assignments, which may initially reduce compliance further as new staff groups are added
Planned mitigation: Transition from annual training to a two-yearly training cycle, this change is expected to: Improve overall compliance figures and bring sepsis training into closer alignment with other training packages. It was acknowledged that annual training requirements can artificially suppress compliance rates compared to longer renewal cycles.

Forward Plan (Next Six Months)

Key priorities for the next reporting period include completion and full operational use of the sepsis dashboard, including ED integration; ongoing focus on training compliance, particularly as workforce changes are implemented and continued monitoring of antibiotic administration performance to maintain current high standards

No new risks or escalation issues were identified.

FB emphasised the importance of maintaining oversight of sepsis performance given its critical patient safety implications and thanked DP and sepsis team for their ongoing support.

Resolved: SQAC received and **NOTED** the Sepsis update

26/27/10

Sunflower House Improvement Plan

JP presented the Sunflower House Improvement Plan and drew attention to a few key points from the report including:-

- Sunflower House had reopened to referrals on a case-by-case basis, subject to individual risk assessment. Some environmental risks remain; therefore, admissions are being carefully staged. The approach is designed to balance access with safety and workforce readiness.

Progress Against the Improvement Action Plan

- There are a total of 22 actions within the improvement plan: 16 actions had been completed, 5 actions are ongoing and 1 action had been paused, this related to Consultant Psychiatry capacity: additional consultant psychiatry time has been paused due to: a short-listed candidate identified and due to be interviewed imminently. If appointed, this will allow: a reassessment of service capacity and capability and potential closure or revision of this action.
- Four actions have had completion dates extended; this relates primarily to the time required to complete training programmes across whole staff groups. Extensions were presented as pragmatic and proportionate.
- Three additional actions have been added to the plan. These relate specifically to: evaluating the impact of earlier completed actions and ensuring that improvement is embedded and sustainable, not just implemented. The focus is not solely on action delivery, but on: workforce resilience; staff wellbeing and ongoing safety and quality of care. Evaluation will inform any required revisions or further mitigations.
- A clinical psychologist had now commenced in post, recruitment to family therapy roles is underway. Interim mitigation is in place: two experienced family therapists from within the Division are providing sessions into the service.

- The nursing establishment is fully staffed. Focus has shifted to consistent training delivery and embedding agreed frameworks to support practice under pressure.
- The service currently has two children in residence, with two further admissions planned over the coming weeks. A staged admission model is in place, ensuring robust preparation prior to admission; clear admission goals and early consideration of discharge planning and specific patient needs are assessed in advance to ensure staff skill-mix and readiness.

GM asked how close the service is to having a stable and resilient team, given the inherent pressure associated with the service. JP confirmed that, subject to successful recruitment: the service is very close to having the required multidisciplinary capability with interim arrangements to ensure coverage and expertise while recruitment is completed.

FB NOTED the importance of ensuring that as occupancy increases, previous practices do not re-emerge and emphasised the challenge of maintaining culture and safety as pressure builds. JP advised that the staged reopening approach was described as a key mitigation, with built-in preparation and evaluation mechanisms are intended to prevent regression and ensure learning is embedded.

Resolved: SQAC received and **NOTED** the Sunflower House Improvement Plan

26/27/11

Update on improvements to Neurodevelopmental Pathways Report

LC presented the Neurodevelopmental Pathways report

- A significant number of children and young people remain open on the ND assessment pathway. As at the most recent data point the average wait to diagnosis was approximately 113–115 weeks.
- It was highlighted that Children with more complex needs typically experience longer waits due to the volume and sequencing of assessments required. The scale of demand and length of waits were acknowledged as a substantial and continuing risk, reflected at Trust Board and consistent with national trends.
- Complex safety huddles are well embedded and are operating effectively, these huddles bring together: ND services, Community Mental Health Services, Crisis services and Safeguarding.
- The huddles focus on children and young people at increased risk particularly those: awaiting ND diagnosis; presenting to crisis services, including out-of-hours. The approach ensures: shared situational awareness, clear escalation routes and joined-up risk management across services.
- Following the CQC review, a significant programme of work commenced in December to ensure all children and young people identified as high-risk have a completed risk assessment. Just over 50% of the required risk assessments for high-risk children have been completed to date. This work is resource-intensive, typically requiring detailed record review; often re-engagement with children and families and takes approximately 1–1.5 hours per case.
- There are approximately 5,000 high-risk children, with a target to complete all assessments by end of May.
- Updates to the electronic patient record had been implemented and welcomed by staff.
- Pathway tracking tools and risk documentation had been strengthened to improve oversight and consistency.
- A Complex Needs Development Pathway has been embedded, focusing on children with: Learning disabilities; broader vulnerability and safeguarding concerns
- An enhanced ND Pathway had been introduced to support children already known to other specialist services, including Eating disorder services; Clinical health psychology; Sexual Assault Referral Centre (SARC) which enables fast-tracking of ND assessments where required, avoidance of parallel or duplicative pathways and better integration with the child's primary treatment service
- ND Pathway Support Workers are fully in post. Early evidence suggests a positive impact on Reducing "Was Not Brought" rates. A formal evaluation of this impact is planned for Quarter 1, with an offer to bring findings back to SQAC.
- Since the paper was prepared, the risk score relating to ADHD medication has increased from 8 to 16. A paper has been submitted for the Executive Team scheduled for 28th April addressing medication initiation processes, size of the waiting list, associated risks, and resource requirements to stabilise and reduce waits.
- Separate engagement with the ICB is ongoing regarding the ambition to achieve a 52-week pathway and the required investment and capacity to support this.

- Transition arrangements to adult ADHD services were highlighted as a significant system-wide challenge. Adult ADHD services currently have waiting lists of 18 months to 2–3 years. Work is underway across Cheshire and Merseyside to explore alternatives to reliance on adult mental health services for medication continuation and greater involvement of primary care in shared-care arrangements
- The ND service continues to receive the highest volume of complaints and PALS contacts within the Division. Primary drivers remain lengthy waiting times for assessment and diagnosis and delays in medication initiation. A slight reduction in volume of complaints had recently been observed.

FB referred to the scale of improvement work undertaken and NOTED that had this work not already been in progress, additional recommendations would likely have resulted from the Southport Inquiry. FB emphasised that ND pathways represent a long-term, high-level Trust risk requiring sustained oversight.

FB requested a shift to more quantitative, trend-based reporting, including waiting list trajectory over time, treatment vs diagnosis waits, impact of medication delays and Complaints and PALS trends. FB suggested that standardised graphs would support consistent reporting across SQAC, Executive Team, and ICB. LC confirmed agreement with the request.

SQAC welcomed a Quarterly Neurodevelopment Pathway update, aligned with other governance forum and welcomed the proposal for enhanced, trend-based reporting for future reports.

Resolved: SQAC received and **NOTED** the Update on improvements to Neurodevelopmental Pathways Report

---- Caring ----

---- Effective ----

26/27/12

Southport Learning review

FB provided the committee with an update following the publication of Part 1 of the Southport Inquiry report. SQAC acknowledged the findings of the Inquiry and the identified shortcomings in service and care provided. FB highlighted the importance of considering the implications for Alder Hey services, Reviewing the status of the existing learning review action plan and the importance of outlining next steps for assurance, governance, and implementation.

FB referred to Recommendation 53, which is directed specifically to Alder Hey. It was NOTED that further recommendations may have been directed to the Trust had significant practice improvements - particularly within mental health services had not been made.

FB expressed her thanks to teams who had responded rapidly and who had implemented changes ahead of the Inquiry's conclusions.

FB acknowledged that: The Inquiry identified good practice alongside areas for improvement; Participation in the Inquiry was challenging for staff.

FB highlighted that the Trust is committed to Reviewing the Inquiry report in its entirety, not solely the health chapter and identifying learning relevant across the organisation, not limited to mental health services.

Key learning themes highlighted included: Safeguarding and risk management; cross-service and cross-agency working; documentation quality and clarity; ensuring clarity around who knows what, who needs to know, and how assurance of knowledge is achieved.

Emphasis was placed on designing systems that account for routine handovers and staff turnover, strengthening records and escalation processes accordingly.

The Trust will work proactively with partner organisations; align responses with emerging national recommendations; use audit, dashboards, data review, and professional oversight to assure implementation.

FB advised that an extraordinary SQAC meeting with limited membership (key executives and non-executives) will be convened to Take stock of Part 1 conclusions and to ensure all relevant Trust workstreams are aligned and are comprehensive.

GM emphasised that the central learning relates to multi-agency working and stated that preventing recurrence relies on fundamental improvement at agency interfaces; clear communication, escalation, and documentation across organisations and NOTED that these lessons apply beyond this single case.

JP highlighted the impact on parents and carers, particularly: anxiety and pressure created by safeguarding decisions; risk that inquiry findings could inadvertently affect trust with families. JP emphasised the importance of meaningful involvement of parents and carers in risk management and planning and careful consideration of how safeguarding decisions are communicated.

FB acknowledged the complexity of working in partnership with parents while balancing risk and reinforced the need for transparent, proportionate, and supportive framed safeguarding practice.

NA advised that outstanding actions within the action plan are summarised within Appendix 2 of the report and confirmed that the Inquiry-specific recommendation directed at Alder Hey will formally be added to the current action plan. This will be reviewed in detail at the extraordinary SQAC in May. The current action plan is required to be completed by October, in line with Inquiry timelines. Further work will involve reviewing whether existing actions need to be broadened to Trust-wide actions.

The Trust is currently awaiting NHSE and Department of Health responses to recommendations.

Thanks, were formally expressed to: JR and NO for leading the learning review and those teams who co-designed and implemented actions.

LC provided an update on Recommendation 53, which requires: A joint audit with the Forensic CAMHS service; focus on children and young people who pose a risk to others. An Initial data extraction is underway a meeting had been arranged with the Director of Forensic CAMHS to scope audit methodology. Proposed approach is to complete audit as early as possible; Implement learning and actions and undertake re-audit to evidence embedding and impact. Plan to share an update at SQAC ahead of presenting at Board in September/October at the latest.

The audit would sit within Divisional audit plans; Trust-level priority audit programme.

JP advised that an additional paper was presented to SQAC to clarify rationale for delays against some actions; provide assurance around sequencing and dependencies (e.g. SOPs, guidelines, Meditech reporting). Actions undertaken since last SQAC included further work to mitigate capacity-related delays; careful review to avoid unintended consequences, particularly in reporting systems. A further meeting is scheduled for late April, with the intention to accelerate delivery; complete remaining actions ahead of original timescales (by June, rather than later).

FB confirmed the additional detail provided assurance, clarifying the complexity and staged nature of delivery.

ES referred to Inquiry Process – Phase 2 and confirmed that the process and criteria for becoming a core participant in Phase 2 of the Inquiry had not yet been published and that updates will be provided to SQAC once the Inquiry team clarifies next steps.

Resolved: SQAC received and **NOTED** the Southport Learning Review update.

26/26/13

Clinical Effectiveness and Outcomes Board Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Board Chairs highlight report and drew attention to a few key points from the report including:-

- Continued improvement was reported in oversight, compliance, and learning from clinical audit activity across the Trust.
- Progress is being made in the development of the Trust Clinical Audit Plan for 2026/27.
- The planned joint audit between Alder Hey and FCAMS, arising from the Southport Inquiry, will be included as a Trust priority audit. This audit will also feature within relevant divisional audit plans.
- The completed Clinical Audit Plan is scheduled to be presented to SQAC at the next meeting.
- Compliance levels for Trust documentation (including policies and guidelines) had significantly improved.

- CEOB continues to maintain active oversight to ensure compliance remains high and sustained over time.
- Positive progress was reported against the action plan arising from the MIAA Clinical Audit review.
- The Trust remains on trajectory to complete all actions by the end of June, as per the agreed timeline.
- The CEOB Terms of Reference and 2026/27 Workplan were reviewed and approved at CEOB. It was NOTED that: some terminology and references will need to be amended once new system structures go live and that the documents will therefore remain iterative and subject to update as required.
- No immediate risks or issues requiring escalation to SQAC were NOTED.

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

26/27/14

Board Assurance Framework

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

- Minor updates were made to Risk 1.1, reflecting improved confidence in controls and assurance mechanisms.
- Gaps in control and assurance previously identified had been removed, where evidence now demonstrates effective and embedded mitigation.
- Sepsis was cited as an example of effective control, with assurance supported by the detailed update provided earlier in the meeting.

ES highlighted that SQAC's work is increasingly reflected in the BAF through stronger articulation of controls, clearer lines of assurance and evidence of sustained improvement.

This was NOTED as testimony to the Committee's role in strengthening the Trust's overall assurance maturity.

ES referred to the issues raised within the Liverpool Neonatal Partnership (LNP) update, specifically: the ongoing build delay; emerging evidence of clinical impact, including multiple patient transfers between sites. Concern was expressed that the original rationale for the partnership was to prevent avoidable transfers following a serious historical incident and a continued delay increases the risk of recurrence of harm. It was highlighted that a single significant incident could have serious consequences for patient safety and organisational assurance.

This issue will require clearer visibility within the BAF and could appropriately align under Risk 1.3 (Quality, Safety and Experience) rather than being viewed solely as a capital or programme issue. The importance of recognising the direct patient safety implications of infrastructure delay was emphasised. ES referred to the wider risk landscape and awareness of: ongoing access pressures across the Trust (Risk 1.2), being actively managed and monitored; significant oversight activity through the Risk Management Forum and other governance routes, including divisional escalation. It was NOTED that divisional risks, particularly within Community and Mental Health Services are receiving appropriate executive and governance attention.

FB agreed that the risks associated with the neonatal build delay are most coherently aligned with Risk 1.3. More appropriately considered as a quality and safety risk, rather than solely an estates or programme risk.

FB emphasised the need for ongoing visibility and oversight at BAF level.

Resolved: ES confirmed agreement and agreed that she would discuss the risk positioning with the Deputy Head of Neonatal Nursing, LNP and ensure appropriate alignment and escalation within the BAF.

SQAC supported the proposed approach and recognised the need to maintain organisational focus on patient-safety implications of programme delay.

26/27/15

Annual plans including Terms of Reference and Workplans:-

Patient Safety Board

SQAC received, **NOTED** and Ratified the Patient Safety Board Terms of Reference

SQAC received, **NOTED** and Ratified the Patient Safety Board Workplan

It was NOTED that: some terminology and references will need to be amended once new system structures go live and that the documents will therefore remain iterative and subject to update as required.

Clinical Effectiveness & Outcomes Board

SQAC received, **NOTED** and Ratified the Clinical Effectiveness & Outcomes Board Terms of Reference

SQAC received, **NOTED** and Ratified the Patient Safety Board Workplan

It was NOTED that: some terminology and references will need to be amended once new system structures go live and that the documents will therefore remain iterative and subject to update as required.

Patient Experience Group

SQAC received, **NOTED** and Ratified the Patient Experience Terms of Reference

SQAC received, **NOTED** and Ratified the Patient Experience Workplan

It was NOTED that: some terminology and references will need to be amended once new system structures go live and that the documents will therefore remain iterative and subject to update as required.

26/27/16

SQAC Terms of Reference

FB presented the SQAC Terms of Reference - It was NOTED that: some terminology and references will need to be amended once new system structures go live and that the documents will therefore remain iterative and subject to update as required.

KB referred to SQAC membership and stated that only the Divisional Director for Community & MH was reflected in the membership. NA explained that the previous SQAC Terms of Reference were intentionally amended to ensure that Associate Chief Nurses attend as core members, to avoid duplication. NA agreed that the membership description could be clarified better to reflect practice.

KB suggested it may be helpful to SQAC to undertake a self-assessment against the responsibilities set out in the Terms of Reference, given the breadth of the remit and suggested a simple mapping exercise to confirm where assurance is currently received and identify any gaps. This was welcomed SQAC.

Resolved: SQAC **NOTED** the suggestions regarding self-assessment and clarity of membership would be taken forward as part of the ongoing refinement.

LR highlighted future potential consideration regarding Innovation governance oversight, recognising that this may need to be reflected in SQAC remit, acknowledging that this was not yet ready for decision and that in the interim this may continue to be addressed through Research & Innovation updates.

SQAC received, **NOTED** and Ratified the Safety Quality Assurance Committee Terms of Reference

26/27/17

SQAC Annual workplan

FB presented the SQAC Annual workplan and advised that it is a dynamic and iterative workplan that would be updated as required in response to emerging risks, external requirements and internal assurance needs.

SQAC received, **NOTED** and Ratified the Safety Quality Assurance Annual workplan.

26/27/18

SQAC Annual Report

FB presented the SQAC Annual Report, and expressed her thanks to Governance Manager for compiling the Annual Report.

SQAC **NOTED** that clinical audit activity was not sufficiently reflected within the report, given that assurance for clinical audit sits with SQAC rather than Audit & Risk Committee. It was agreed that additional wording would be included to reflect SQAC oversight of clinical audit, including delivery, learning and implementation of actions, subject to this amendment SQAC were content to approve the SQAC Annual Report.

Resolved: SQAC received, and **NOTED** the Safety Quality Assurance Committee Annual Report, subject to the amendment detailed above.

26/27/19

Inspection and Accreditation Register 25/26

ES presented the Inspection Accreditation Report and drew attention to a few key points from the report including:-

There had been a gradual improvement in the completeness and quality of information contained within the inspections and accreditations register. Divisions and services are increasingly

notifying the central team of upcoming inspections and reviews and are providing timely updates on outcomes and follow-up actions. ES advised that the register is an important governance tool to ensure Organisational awareness of inspection burden and ensure clear oversight of outcomes, requirements, and assurance activity.

ES advised on a minor data accuracy issue within the register regarding the dates for the CQC inspection and the cardiology assessment had been transposed.

This was highlighted for correction to ensure factual accuracy and reliability of the register.

SQAC welcomed the improving completeness of the register. It was **NOTED** that while not all inspections may yet be captured, the position is improving; The register provides valuable insight into the cumulative inspection burden faced by divisions and services.

GM **NOTED** that there will be an upcoming inspection of children's services in Liverpool during the year. ES confirmed that the forthcoming children's services inspection would be added to the register and advised that any actions arising would also be tracked through the appropriate governance routes

Resolved: SQAC received and **NOTED** the Inspection and Accreditation Register 25/26.

---- *Well led* ----

26/27/20 Incident Response Plan

Resolved: SQAC received, **NOTED** and Ratified the Incident Response Plan

26/27/21 Management of Suspected meningitis and septicaemia guideline

Resolved: SQAC received, **NOTED** and Ratified the Management of Suspected meningitis and septicaemia guideline

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

26/27/22 Any Other Business

None received

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

26/27/23 The key assurances and highlights report was presented to the Board meeting held on 5th March 2026

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Liverpool Neonatal Partnership Chairs Highlight Report
Report of:	Kelly Black, Acting Head of Neonatal Nursing Jill Harrison Clinical Co-Director Rebecca Kettle Clinical Co-Director
Paper Prepared by:	Justine Collins, Risk and Governance Lead

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☐ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☒
Summary / supporting information	To provide assurance of quality and safety monitoring for the Surgery Division.
Strategic Context This paper links to the following:	Outstanding care and experience ☒ Collaborate for children & young ☒ Revolutionise care people ☒ Support our people ☒ Pioneering breakthroughs ☒ Strong Foundations ☒
Resource Implications:	None identified in this reporting period

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

Risk number	Risk description	Score

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

Liverpool Neonatal Partnership (LNP) Operational Board

Date: 19 May 2026

Chair: Kelly Black

Overview

The LNP Operational Board met to review progress across governance, workforce, estates, and operational delivery. Key discussions focused on governance framework development, build delays for the new unit, workforce risks, and quality and safety priorities.

Patient Experience and Safety

A patient story highlighted limited opportunities for kangaroo care, with reports of infants receiving minimal skin-to-skin contact. This raised concerns regarding consistency of practice and potential barriers including staffing, confidence, and operational constraints.

Actions agreed include:

- Further exploration of barriers to delivery
- Consideration of audit and improved documentation
- Increased use of patient feedback to inform improvement

Incidents remain consistently reported, with all cases meeting Duty of Candour requirements. Key recurring themes include medication, equipment, and transfer-related issues.

Immediate focus has been placed on targeted safety reviews (SWARMs) for high-risk areas, including unplanned extubations and feeding errors.

Governance and Quality

Work continues to develop a unified LNP governance framework, with key themes including:

- Standardisation of processes across both organisations
- Clear leadership accountability and reporting structures

- Strengthening of learning, improvement, and innovation systems

There is ongoing work to clarify reporting requirements to the Group Board and ensure alignment with system expectations.

Opportunities have been identified to strengthen reporting through:

- Improved narrative alongside KPI performance
 - Increased use of patient experience data, including PALS and local resolution learning
-

Estates, Equipment and Digital

The neonatal unit build program remains delayed due to service connection issues, with the opening now expected beyond October 2026.

While delays present challenges, they are enabling:

- Additional time for workforce training and preparation
- Further refinement of operational processes

Risks identified include:

- Equipment warranty considerations due to extended timelines
- Ongoing storage and procurement issues affecting digital equipment

Digital developments are progressing, including system integration and early piloting of handheld solutions.

Workforce

The program remains over-established in the context of delayed opening, with workforce models being reviewed to align with reduced capacity.

There are emerging risks relating to:

- Recruitment timelines for key roles, particularly pharmacy and AHP support
- Clarity of non-pay budgets and future financial planning

These risks have been escalated through executive routes, with further discussion planned with commissioners.

Operational Performance

The Integrated Performance Report (IPR) is now largely embedded, with dashboards in place to support oversight.

Further development is required to:

- Improve KPI interpretation (including identification of high performance)
 - Ensure equitable access to reporting tools across both sites
-

Partnership Working and System Integration

Good progress is being made in strengthening partnership working across the network, including:

- Alignment of infection prevention and control approaches
- Development of shared guidelines and clinical pathways
- Engagement with families and MNVP feedback mechanisms

Family feedback remains positive overall; however, response rates remain low, particularly on discharge. Improvement actions are planned, including enhanced engagement through the Family Support Worker role.

Psychological Support and Family Care

A pilot psychology screening program demonstrated:

- Increased identification of families requiring support
- Positive feedback on the neonatal care environment

However, capacity limitations were identified with insufficient resources to support universal screening. A business case is being explored to expand provision.

Key Risks and Escalations

The Board agreed the following key risks requiring ongoing oversight:

- Workforce capacity and recruitment, particularly pharmacy provision
 - Delays to the new neonatal unit build and associated operational impacts
 - Risks relating to governance capacity and organizational change
 - Low levels of family feedback impacting learning opportunities
-

Next Steps

- Progress governance framework and confirm reporting expectations
 - Continue workforce and financial planning aligned to revised timelines
 - Strengthen patient experience reporting and learning
 - Maintain oversight of build program risks and mitigation
-

Liverpool Neonatal Partnership (LNP)

Operational Board

Minutes

Location	MS Teams
Date	Tuesday 21 April 2026
Time	13:00 – 15:00
Chair	Rebecca Kettle
Minutes	Daria Bilkiewicz

Item No	Minutes
26/27_01 Introductions, Apologies, Declaration of Interest	Attendees: Rebecca Kettle, Daria Bilkiewicz, Peter White, Justine Collins, John Glenn, Jo Eccles, Joe Downie, Lindsey Vlasman, Jill Harrison, Deborah Edwards, Adam Bateman, Chloe Lee, Dr Nelson, Rachel Harwood, Varun Hathiramani, Oliver Zuzan, Rachel Lea Apologies: Nathan Askew, Alfie Bass, Kelly Black - Adam Bateman chaired the meeting as Alfie Bass sent apologies. Adam suggested moving the meeting to a day that is more suitable for Alfie. - Oliver Zuzan noted that he will be leaving his post to go on sabbatical leave. - Each member introduced themselves and their job roles. - No declarations of interest noted. - Jo Eccles requested an overview of the LNP as herself and Lindsey Vlasman only began covering the LWH portfolio as of 1st April 2026: - Jill Harrison provided a comprehensive overview of the Liverpool Neonatal Partnership (LNP), explaining that the LNP was established to integrate neonatal surgical intensive care between the two organisations, aiming to minimise transfers, share expertise, and improve patient outcomes by creating a unit at Alder Hey staffed by consultants, nurses, and allied health professionals from both trusts. - Discussion highlighted the complexity of governance with a dual responsibility model being favoured to ensure shared oversight and prevent issues from falling between organisational gaps, supported by a developing governance framework with MIAA. - Adam suggested that day-to-day oversight will be provided by Alder Hey. 68 cots are included in the Partnership across both sites. - Rachel Lea noted that Commissioning requires review; the business case was originally signed off in 2019 and there have been several changes since.

26/27_02 Minutes from Previous Meeting	Nil.
26/27_03 Rolling Action Tracker	Nil.
26/27_04 Update from Clinical Directors a. Chairs Report – LNP Operational Board	• The Chair's Report from the LNP Operational Board Monthly Meeting was shared by Rebecca Kettle. • Rebecca has been chasing the outcome of the AHP & Pharmacy Business Case. Rachel Lea noted that a Commissioner Meeting will take place in June and that they are awaiting a trail of the case. • Commissioners confirmed as Carol Hutchinson. • Action requested to review the business case with finance and clinical leads ahead of the meeting with specialised commissioners. • Rebecca noted that the clinical risk in regard to the arrangement of pharmacy and allied health professionals on site needs to be emphasised. • Mortality rate reduced in year. LWH Neonatal is more than 5% below the average for mortality • Jo Eccles noted there is a suggestion for the NICU team to meet with NHSE to agree on targets and methodology. • Rebecca noted that risks are brought to, and ratified at, the Ops board. • Recruitment is progressing to staff the new unit, and rotation planning is ongoing to integrate staff. Jo questioned who leads on recruitment and contracts; Rebecca noted that it is LWH. Meanwhile operationally, the leadership is shared across the Partnership. • The LNP are working with Jo Pottier on a Culture Plan. • Regarding finance (updated provided at Ops Board by Graeme), the spend is over budget. Rachel Lea noted the extra £1.4m spend is covered by the Commissioners and they agreed to dual running. Rachel suggested reviews need to happen for this year to see how we can utilise staff across the two sites amidst the build delays. • Cot decommissioning is being reviewed. • MNVP have noted positive feedback about the department. • IPR dashboard is a work-in-progress and is being continuously developed. • Jill Harrison will review the metric of transfers and the context around them to present at the next Executive Board Meeting.
26/27_05 MIAA Governance Framework	• Rebecca shared the governance framework is in the form of a spreadsheet, mapping the progress. It includes: the evolving governance framework, escalation routes, organisational reporting lines and safeguarding. • Adam requested visuals / flowcharts for reporting lines.
26/27_06 Build Update	• John Glenn noted that the completion date has shifted from August to a likely October or November handover. The final dates are dependent on service connections and commissioning activities. • High-level timescales requested to be provided by John and Rachel to aid the teams in planning staff, finances and resources. • Jo questioned any seasonal variation in terms of demand for the unit – Jill noted this will not apply to the unit. • Jill noted that the service currently has a lot of flexibility and creative capacity; going forward, the surgical unit at AH will be at fixed capacity. At

	LWH, the cots being decommissioned are the flexible cots. Therefore, capacity is not a concern, though flexibility is. • John confirmed that previously, there was a 4-week commissioning period to prepare the build (risk assessments, equipment installation etc.), followed by a 5-week clinical commissioning period (staff familiarisation, sims etc.). John confirmed that the team are reviewing how to condense and overlap this process to reduce it. • Adam suggested that a move plan should be created and to share our capacity plans with commissioners. • LWH & LNP staff share the same contracts however Alder Hey staff have different contracts – members noted this would require interference from HR. • Rachel Lee shared photos of the new unit and explained the new model, which includes single rooms, parent accommodation and a unique approach to integrated family care. • Jill noted this is a unique and innovative approach in the UK. • The new unit will have 22 cots, including eight intensive care, 13 high dependency, and one special care, with single rooms for babies and parent accommodation to support family-centered care. • Ongoing modelling is occurring to ensure appropriate nurse-to-baby ratios and staffing levels. • Oliver asked from a Procurement perspective whether delivery times have been considered for equipment. Peter confirmed this has all been reviewed and is under control and does not consider it a risk. • Peter noted simulation training has commenced for new systems in preparation for the opening of the new unit.
26/27_07 Finance & Commissioning a. Commissioner Conversations / Contractual Changes	• Commissioning and finance updates were shared within the Build update section above.
26/27_14 Key Messages & Areas of Escalation	• Adam suggested that the next meeting should be focused on planning and discussions around the workforce as we near the opening of the new build. Adam asked for the agenda to be updated to reflect this. A request was also made for the frequency of the meetings to change to every 2 months • Jill noted organisational changes and confusion around lines of reporting. Jo Eccles noted that the exec team are in the process of finalising the Transformation Board within the site, including the strategic development at LWH from a UHLG perspective. Both organisations are undergoing leadership restructuring; an update will be brought to the next meeting.
26/27_15 Any Other Business	
Next Meeting July 2026 13:00 – 15:00 MS Teams	

BOARD OF DIRECTORS

Thursday 4th June 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	Outstanding care and experience
This paper links to the following:	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 continues to progress with ongoing and increasing focus around navigating change and the impact on staff experience and morale, leadership development and support, and new values implementation.

Navigating change & supporting impacted staff

Both SALS and the OD team are prioritising supporting individuals, teams and groups of staff to manage the impact of the current organisational changes. There has been contact from across the whole organisation connected to the impact of the ongoing uncertainty related to organisational restructure and change, and perceived threat of redundancy. Alongside this, there have been contacts from staff facing dilemmas about Voluntary Redundancy or experiencing frustrations where applications are not being supported.

With organisational change now live for operational staff, and change imminent for administrative staff, SALS and OD are receiving increasing numbers of contacts for support in these areas. Support sessions, led by the Director of Culture & OD, have been offered to operational teams (ongoing) with planned support sessions for administrative staff being led by OD and SALS.

Themes are fed back via weekly How We Work in the Future programme meetings and steering group meetings with actions discussed and recommended including: continued focus on providing clarity as soon as possible for all impacted staff; giving clearer rationale for the changes and for senior roles in the new structure and how they contribute to outcomes; acknowledging the impact on staff of change via compassionate communications and messaging; transparency about financial drivers and outcomes; avoidance of engagement activities where outcomes are predetermined; closing the feedback loop with discipline, and ensuring that all staff are regularly signposted to the Change Hub support pages to help them to navigate the change.

Leadership development & support

To support the next phase of the How We Work in the Future programme, the Organisational Development team will focus on the redesign of leadership roles to align with the emerging national Leadership and Management Framework and equip our leaders to deliver against the Vision 2030 strategy. As well as establishing new behaviours and expectations as part of an accountability framework, this work will also include creating new routines, practices and structures as part of a comprehensive induction and ongoing development offer for new system leaders and their associated triumvirates to support them to create and role model an empowered, connected and clinically led leadership team.

As well as the above, our core offer to leadership development and support within the Trust continues to be more important than ever as leaders face increased levels of pressure and uncertainty for themselves and their teams.

Our Strong Foundations Compassionate Leadership Programme continues to be highly valued across the Trust. This month marks the completion of our 48th cohort, bringing the total number of leaders who have participated to over 1,000, with a further eight cohorts scheduled for 2026/27. The programme consistently receives excellent feedback, which continues to drive demand. Workforce analysis also shows a positive correlation between programme

attendance and reduced turnover, alongside encouraging indicators that the programme is supporting staff to progress within the Trust as below:

Year Attended	Turnover Rate of Attendees	Trust Overall Turnover Rate	% Promoted at least 1 band within 12 months of attendance
19/20	3.28%	10.49%	8.20%
20/21	6.25%	8.61%	10.71%
21/22	7.26%	12.71%	8.06%
22/23	4.49%	15.22%	10.11%
23/24	1.98%	10.94%	9.90%
24/25	6.18%	11.30%	10.82%
25/26	No promotion / turnover data available yet due to recency.		

Alongside our Strong Foundations programme, a suite of management essentials courses delivered by key stakeholders including Learning and Development, Human Resources and others continue to be offered to leaders in a variety of topics such as 'Stepping into Management, Crucial Conversations, Appraisals, A3 Thinking and Introductory sessions to EDI'.

Our internal coaching offer, delivered by trained staff alongside their substantive roles, continues to provide valuable support to leaders across Alder Hey. The programme is currently supporting over 35 leaders, with a further 12 due to commence in the coming months following a significant increase in demand since the launch of the HWWWITF programme, as leaders navigate increasing pressure and complexity in their roles.

In response to feedback from leaders seeking additional support, we are also beginning the development of an internal mentoring programme. This initiative will match newer or struggling leaders with experienced, high-performing colleagues from across the Trust to provide structured guidance and support.

Whilst still in its relative infancy, 65 new leaders have completed our Leadership Induction, which consists of a one-to-one session with every individual stepping into a leadership role, whether appointed internally or externally. Feedback has been overwhelmingly positive, with 100% of participants reporting that they learned something new. One participant noted: "The most useful aspect of the Leadership Induction was gaining a clear understanding of leadership expectations and how to effectively navigate the organisation. This provided practical insight that helped me become more confident and effective in my role."

We have also recently introduced a follow-up group session for new leaders approximately 100 days into their role. This provides an opportunity for small-group discussion with a member of the Executive Team, enabling leaders to share their experiences, ask questions, and strengthen their connection to the wider leadership community. The first session took place this month and was very well received.

Equality, Diversity, and Inclusion

The Trust has demonstrated a strong and continued commitment to advancing its Equality, Diversity and Inclusion agenda, delivering a comprehensive programme of work that aligns with strategic priorities and promotes a positive, inclusive culture for both staff and the communities it serves

Northwest BAME Assembly Anti Racist Framework

The Trust is pleased to report that it has successfully achieved Bronze status within the Northwest Race Equity Assembly Anti-Racist Framework, recognising the strength of its submission and the progress made to date. This marks a significant milestone and demonstrates the organisation's clear commitment to embedding anti-racism as a strategic priority. The framework serves as a tool for continuous improvement, operating through a tiered accreditation system (Bronze, Silver and Gold). Achieving Bronze status reflects the establishment of strong organisational foundations and the delivery of tangible actions, which we have successfully met. The feedback from the assembly highlighted several areas of good practice, including strong executive and Board-level sponsorship, meaningful engagement with staff networks and the active involvement of the Youth Forum in ensuring patient voice informs this work. In addition, the Trust's programme of initiatives, such as mutual mentoring, anti-racism training, and system-wide collaboration, were recognised as demonstrating a mature and ambitious approach. While this achievement showcases the foundations already in place, the feedback also reinforces the need to build further on this progress, particularly in evidencing measurable impact as the Trust continues its journey towards higher levels of accreditation.

Alder Hey Stoma Friendly Trust

The Trust is proud to announce the launch of its Stoma Friendly Toilets, an important initiative led by the ACE Disabilities and Long-Term Conditions Staff Network. This significant achievement demonstrates our ongoing commitment to recognising and supporting individuals with unseen disabilities, ensuring that our environments are inclusive and accessible for all. The introduction of these facilities provides enhanced support for staff, children, young people, families and visitors, reinforcing the Trust's dedication to dignity, comfort and equity of access. We are particularly pleased that this work has been formally recognised by Stoma UK, confirming our status as a Stoma Friendly Trust. On Tuesday 26th May the Stoma Friendly toilets will be officially opened by one of our patients, an important milestone that will make a significant difference to staff, patients, and all those who use our services.

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:

Learning at Work

May saw the Trust once again 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 and was once again very well received.

Mandatory Training

As reported previously a review of mandatory training compliance continues as although overall Trust compliance remains over 90% (94.06% as at 27.4.26) there are pockets of non-compliance linked to specific staff groups, teams, individuals and topics. The mandatory training task and finish group meets on a regular basis to discuss a range of factors impacting on compliance and to explore / action solutions, including attendance, delivery method and content review. Divisional reports 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. From a detail perspective:

- Alder Hey welcomed 200 young people from local secondary schools to introduce them to a range of roles and enable them to try out different activities.
- A supported internship graduation is planned for June to celebrate the work and development of our interns.
- A celebration event took place in Medical Needs Education – Alder Centre for Education (ACE) on 14th May to showcase the amazing work of pupils who undertook a photography project with local photographer Michael Kirkham. The subject matter was Alder Hey employees and their careers. The work has now transferred to the Institute in the Park on the main Alder Hey site.
- Plans are underway to hold a national teen tech event for 65 students from Liverpool schools in the autumn. Hosted by Maggie Philbin (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. A programme of work, with key responsibilities has been developed and will be monitored. Responsibility of line management is key to success. A dashboard is in development 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.

Employee Relations & Wellbeing

Sickness Absence

The Trust's sickness absence rate for April 2026 stands at 5.83%. This is a slight increase compared to the previous month's figure of 5.62% (Mar), however is below the rate recorded in previous months of 5.88% (Feb) and 6.69% (Jan). There has been an overall reduction of almost 2% over the last quarter, falling from 7.36% in December 2025. Although these figures indicate a positive trend, the current sickness rate remains over 1% higher than the Trust's target of 4.5%. When examining the breakdown of absence, both long- and short-term absence have increased slightly in April. Long term absence was at 3.58% (compared to

3.42% in March) against a target of 2.5% and short-term was at 2.26% (compared to 2.20% in March), approaching the Trust's 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 April was 29.83 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. Increased acuity and activity resulted in a higher bank position during March. In addition, those areas who have converted overtime spend to bank will be contributing to the increasing bank, alongside the main reason for using bank is now attributed to covering vacancy and not sickness as has been in previous months.
- **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 221 applications were received; with 63 (54.95 WTE) approvals granted to date. Consistency/validation and appeals are ongoing but will be concluded by early 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, 4th June 2026

Paper Title:	Chair's Report from The People Committee meeting held on 13 th May 2026
Report of:	Jo Revill Committee Chair
Paper Prepared by:	Jo Revill

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☒
Summary / supporting information:	This paper provides a summary from the recent People Committee meeting held on 13 th May 2026, along with the approved minutes from the 26 th March 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:	None

Does this relate to a risk? Yes ☒ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks						
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 People Committee (PC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

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

- Terms of Reference/Workplan
- People Committee Annual Report
- Board Assurance Framework – monitoring of strategic workforce risks
- Internal Communications Update
- Strategy People Update – Key People Issues
- Transforming People Services
- Trust/Divisional Metrics Update
- Sickness Update
- How We Work in The Future
- Voluntary Redundancy Update
- Equality, Diversity & Inclusion Update
- Oliver McGowen Decision Documentation
- 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**

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

- **Workforce Performance – PDR Compliance:** PDR compliance remains inconsistent across the Trust particularly below Band 7, with performance not consistently meeting the 90% target and Board expectations. This presents a risk to staff development, performance management and overall organisational assurance. Targeted divisional action plans are in place, with enhanced monitoring, escalation and weekly tracking in underperforming areas. Increased leadership accountability is being reinforced, alongside clear Board expectations that sustained compliance is required.
- **Employee Relations – Timeliness of Appeals and Case Resolution:** Delays in appeal hearings and employee relations processes are resulting in prolonged uncertainty for staff, creating a risk of avoidable employee harm, reduced staff experience and potential reputational impact. Active case monitoring and escalation processes are in place, supported by the avoidable employee harm framework. Work is underway to explore improvements in panel coordination, scheduling and potential process redesign, with a proposed deep dive to identify sustainable solutions. Staff well-being support mechanisms remain in place throughout processes.
- **Sickness Absence – Short-Term Sickness:** Whilst long-term sickness absence is reducing, short-term sickness has seen an increase in month, contributing to a rise in overall Trust sickness levels (March 5.59% to April 5.83%). This presents a risk to workforce capacity, financial performance and service delivery. Targeted interventions are focused on high-impact areas driving absence, with early intervention triggers being piloted, particularly for repeat mental health-related absence. Occupational health support and preventative

approaches have been strengthened, alongside exploration of digital solutions to improve management of short-term absence.

- **Board Assurance Framework – Risk Calibration:** Potential understatement of workforce, culture and EDI risks within the Board Assurance Framework, with reliance on mitigations potentially masking underlying risk exposure, particularly in the context of organisational change and external pressures. 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.
- **Impact of Organisational Change on Staff Experience and Culture:** The cumulative impact of transformation programmes (including “How We Work in the Future”, Transforming People Services and the Voluntary Redundancy scheme) is contributing to increased uncertainty, heightened sensitivity and pressure on staff morale, with evidence of increased behavioral concerns through FTSU. Structured engagement and consultation processes are in place, supported by strengthened internal communications and leadership visibility. Recognition activity is being maintained and enhanced, and staff feedback mechanisms (including FTSU and staff survey activity) are being used to monitor impact and inform response.

4. Positive highlights of note

- The Committee endorsed the People Committee Annual Report, recognising a significant increase in activity and a strong level of assurance provided to the Board over the past year.
- Continued reduction in long-term sickness absence, supported by strengthened processes and proactive occupational health interventions.
- Improvement in return-to-work compliance and evidence of effective cross-divisional learning and sharing of best practice.
- Strong performance in mandatory training compliance and senior PDR completion, reflecting good leadership engagement.
- Positive progress in Equality, Diversity and Inclusion, including active contribution to the Liverpool City Region anti-racism framework and delivery of national high-impact actions.
- Strengthening of Freedom to Speak Up arrangements, including development of new digital reporting mechanisms and refresh of the Champions network.
- Significant progress in major programmes including Transforming People Services and How We Work in the Future, both of which remain on track.

5. Issues for other committees

- **Finance, Performance and Transformation Committee (FPTC):**
Workforce cost pressures, including temporary staffing and delivery of savings through the Voluntary Redundancy scheme. Alignment of workforce planning with financial recovery and transformation programmes.
- **Quality Committee:**
Impact of workforce pressures and organisational change on staff well-being and patient experience. Cultural factors and behavioural concerns are highlighted through FTSU activity.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the People Committee meeting that took place on 13th May 2026.

People Committee
Minutes of the last meeting held on 26th March 2026
Lecture Theatre 1 – Institute Building

Present:

Jo Revill	Non-Executive Director (Chair)	(JR)
Garth Dallas	Non-Executive Director	(GD)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Sarah Leo	Associate Chief Operating Officer	(SL)
Jo Potier	Associate Director of Organisational Development	(JP)
Erica Saunders	Director of Corporate Affairs	(ES)
Melissa Swindell	Chief People Officer	(MS)
Sharon Owen	Deputy Chief People Officer	(SO)

In attendance:	Kathryn Allsopp	Associate Director of People	(KA)
	Audrey Chindiya	Finance Manager	(AC)
	Angela Ditchfield	EDI Lead	(AD)
	Joe Fitzpatrick	Internal Communications Manager	(JF)
	Gill Foden	Head of L&D and Widening Participation	(GF)
	Veronica Greenwood	Director of Allied Health Professionals	(VG)
	Rebecca Murphy	Head of Marketing & Communications	(RM)
	Darren Shaw	Head of Organisational Development	(DS)
	Catherine Wardell	Associate Chief Nurse for Medicine	(CW)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Observing:	Monique Collier	Governor	(MC)
	Su De	Governor	(SD)

Apologies:	Nathan Askew	Chief Nursing Officer	(NA)
	Fiona Beveridge	Non-Executive Director	(FB)
	Adam Bateman	Deputy Chief Executive/COO	(AB)
	Alfie Bass	Chief Medical Officer	(AB)
	Katherine Birch	Director of Alder Hey Academy	(KB)
	Pauline Brown	Deputy Director of Nursing	(PB)
	Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
	Urmi Das	Director, Division of Medicine	(UD)
	Adrian Hughes	Deputy Medical Director	(AH)
	Chloe Lee	Associate COO – Surgery	(CL)
	Julie Worthington	Staff Side Chair	(JW)
	Nikita Prichard	Interim Associate Chief Operating Officer	(NP)
	Jill Preece	Governance Manager	(JP)
	Kerry Turner	FTSU Guardian	(KT)

The Chair welcomed the observers to the meeting, colleagues Monique Collier and Su De, our staff Governors.

25/26/185 **Declarations of Interest**
No declarations were declared.

25/26/186 **Minutes of the previous meeting held on 29th January 2026.**
The minutes of the last meeting were approved as an accurate record.

25/26/187 **Matters Arising and Action Log**
Action log was updated accordingly.

25/26/188 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

- Board Assurance Framework – People Risks (Items 2.1, 2.2 and 2.3)

The Committee received and considered the refreshed Board Assurance Framework people risks, including the proposed reframing of risks:

2.1 (Workforce Sustainability)

2.2 (Organisational Culture)

2.3 (Equity, Diversity and Inclusion)

Members were informed that the revised framework presents a more sophisticated and accurate depiction of the Trust's current risk profile, acknowledging advancements achieved as well as the continuing challenges confronting the organisation.

Workforce Sustainability

The Committee agreed to keep the current risk rating but update the target rating to match a practical risk appetite, considering ongoing workforce issues like sickness, recruitment difficulties, and national constraints.

The Committee noted strengthened controls, including improved workforce planning, inclusive practices and alignment of people services, while agreeing that further action is required to ensure consistency of implementation across the Trust.

Organisational Culture

The Committee discussed the assurance provided around organisational culture, focusing on the established staff wellbeing infrastructure and leadership development initiatives. Members noted that internal communications play a crucial role in fostering a positive culture, while multiple sources of qualitative and quantitative intelligence are used to inform and track progress.

The Committee recognised that, although these controls are in place, further actions have been agreed to enhance real-time monitoring and understanding of cultural shifts within the Trust. This approach aims to ensure that the organisational culture remains responsive to emerging challenges and continues to support staff wellbeing and effective leadership.

Equity, Diversity and Inclusion

The Committee strongly supported the significant broadening of the risk to include patients, families and volunteers alongside the workforce, recognising this as a substantial improvement in the Trust's approach. While acknowledging existing controls, including the Patient Care Race Equality Framework and ongoing work to improve ethnicity data capture, members noted current data gaps and agreed that further work is required to strengthen assurance on likelihood and safety culture impacts. Subject to minor wording corrections and further development of actions, the committee confirmed its collective comfort with the direction of travel and approved the reframed risks for escalation within the Board Assurance Framework, noting that further assurance and refinement will continue as part of routine governance oversight.

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

25/26/189 **Risk Reframe**

The Committee received a detailed presentation on the proposed reframing of the People risks within the Board Assurance Framework and undertook a structured review of the revised risk descriptions, controls, gaps and actions.

The Committee noted that the reframe was intentionally designed to reflect a more realistic and mature assessment of current organisational risk, recognising the Trust's evolving operating context, including workforce pressures, organisational change and increased external challenge. The Committee supported the approach taken to remove or amend legacy wording where risks had moved on, strengthen clarity around remaining gaps in control, and ensure that actions were explicitly aligned to the most material areas of risk. Particular assurance was provided that the reframe better articulated the interaction between people risks and other strategic risks across the Board Assurance Framework, including quality, safety, finance and performance, and that this would support improved coherence and oversight at Board level. Members welcomed the emphasis on setting realistic target risk ratings aligned to the Trust's risk appetite, rather than aspirational targets that could not be credibly achieved and recognised this as an important step in strengthening assurance and transparency.

ES confirmed that the reframed risks accurately captured both progress made and areas requiring further development, agreed that the revised wording and structure provided a clearer line of sight between controls, gaps and actions, and supported the approval of the risk reframe, subject to minor refinements, for inclusion within the Board Assurance Framework and escalation to the Board.

Action: Following People Committee approval in principle of the reframed People risks, ES supported by People Services will finalise minor refinements and bring back to the committee.

Resolved: The Committee noted the contents of the Risk Reframe update.

25/26/190 **Internal Communications Update**

The Committee received an update on internal communications activity and noted the significant focus on supporting the delivery and embedding of the *How We Work in the Future* programme.

The Committee were assured that communications activity over the reporting period had been aligned to the agreed internal communications strategy and had prioritised clarity, engagement and responsiveness during a period of organisational change. RM provided assurance to the committee that a structured communications plan had been implemented, including leadership briefings, staff engagement sessions, intranet updates and drop-in session opportunities, with early feedback indicating improved understanding of both the rationale for change and the approach being taken.

RM informed the committee that initial challenges in how messages landed had been acknowledged and addressed, with subsequent improvements in consistency, visibility and staff engagement. Particular attention was drawn to the proposed approach to awareness and recognition activity, including the development of a prioritised calendar of awareness days agreed with staff networks, intended to balance organisational focus with avoiding communication overload, while continuing to support locally led activity. RM also raised discussion plans on improving intranet functionality and shared conversations, recognising the role this plays in reducing reliance on email communications and strengthening two-way engagement.

The Committee acknowledged the importance of continued emphasis on recognition and celebration, particularly for staff groups reporting feeling undervalued, and agreed that internal communications would remain a key enabler in supporting morale, culture and engagement as the Trust continues through a period of significant transition

Resolved: The Committee noted the contents of the Internal Communications

25/26/191

People Plan Update – Key People Issues

The Committee received the Strategic People Update, which provided a comprehensive overview of current workforce priorities, performance and emerging risks across the Trust.

The Committee noted continued progress against key people metrics, including strong performance on senior staff appraisal completion and improving trends in return-to-work compliance, while acknowledging ongoing challenges in achieving consistent compliance across Bands 5 and 6, particularly in operational and ward-based roles. The Committee recognised the link between these challenges and wider workforce pressures, including high sickness absence, staffing capacity constraints and competing operational demands, and supported further targeted work to understand and address barriers to engagement and completion.

Assurance was provided on sickness absence management, with the Committee noting that although sickness levels remain a significant workforce risk, recent data indicates improving trends, including a reduction in long-term sickness absence, supported by the introduction of a dedicated sickness absence team and strengthened reasonable adjustment processes.

The Committee discussed the impact of sickness absence on wider workforce outcomes, including staff wellbeing, appraisal completion and learning uptake, and acknowledged the complexity of underlying causes, including workforce demographics, deprivation, national pressures and organisational context. Updates were also provided on medical education and the potential impact of forthcoming industrial action, with assurance that mitigating actions were in place to protect student experience and service continuity.

The Committee further noted progress on organisational development activity, including emerging work on refreshed values and leadership development, and agreed that the People Plan continues to provide a coherent framework for addressing current workforce challenges while supporting longer-term cultural and organisational change.

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

25/26/192 **Trust wide Metrics**

The Committee received the Trust Wide Metrics report. (February 2026) data.

- **Sickness Absence** continues to be monitored monthly at Trust level and benchmarked nationally. HRBP continue to support senior leaders.
- **Long-Term Sickness Absence** cases are still tracked on an individual basis, and the new absence management team is delivering encouraging improvements in reported statistics.
- **Short-Term Sickness Absence** identified as a persistent challenge, particularly in ward-based and operational roles, with impact on capacity, morale and delivery of people processes. Senior Leaders continue to manage accordingly.
- **Return to Work Conversations** remains monitored through ESR data collection and management oversight, with assurance of improving compliance in several divisions.
- **PDR Completion** Band 7 and above and Bands 5–6 (identified as a key risk group for lower compliance) continues to be supported in each area to control trust target.
- **Overtime Expenditure** is reviewed alongside agency and bank spend to assess workforce efficiency and financial risk.
- **Mandatory Training Compliance** monitored Trust-wide with hotspot analysis and escalation through People Committee where required.

Resolved: The Committee received and noted the Trust Wide Metric report.

• **Divisional Metrics**

Corporate

The Committee received the corporate metrics report (February 2026) data.

- **Sickness Absence** continues to be monitored monthly and reviewed alongside Trust-wide trends to assess organisational capacity and resilience.
- **Long-term sickness absence** Assurance provided that long-term absence levels are reducing following enhanced sickness management arrangements.
- **Short-term sickness absence** monitored to identify emerging pressure points and support early intervention.

- **Return-to-Work (RTW) compliance** reported as a headline corporate metric, with assurance provided that compliance has improved following clarification of ESR recording requirements and strengthened management oversight.
- **PDR Trajectory and Sprint Activity** used to drive improvement where compliance is below expected levels.
- **Voluntary Redundancy (VR) applications from corporate staff** tracked as part of workforce transformation and financial sustainability.
- **Bank staffing usage** reviewed to assess reliance on temporary staffing and ensure appropriate controls.
- **Mandatory training compliance (Corporate workforce)** reviewed as part of Trust-wide assurance, with escalation of any areas of under-performance.

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

Surgery Division

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

- **Sickness Absence** Reported as improving, with a reduction noted compared to previous reporting periods. This was highlighted as a positive trend and aligned with wider Trust-wide improvements in sickness management.
- **Long-term sickness absence** Implicitly included within the overall reduction, providing assurance that interventions to address sustained absence are having an effect within surgical services.
- **Return-to-Work Compliance** Not escalated as an exception for Surgery during this reporting period, indicating that RTW processes are being applied consistently and are not a current risk requiring additional Committee oversight.
- **Bank staffing usage** Noted as having increased during the reporting period. This was acknowledged as a pressure point and linked to operational demand, including service delivery requirements and capacity management.
- **PDR** Compliance is being managed within acceptable parameters at divisional level.

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

Clinical Research Division

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

- **Sickness Absence** Reported as improving, with both short-term and long-term sickness absence showing a positive downward trend during the reporting period. This provided assurance that absence management arrangements are effective within the division.

- **Long-Term Sickness Absence** Identified as low in volume, reflecting the relatively small size of the Clinical Research Division workforce. Long-term cases were described as being actively and appropriately managed.
- **Return-to-Work Compliance** Reported at 67% to date, representing a decline and identified as the primary area of concern for the division. This level of compliance was described as unusual for Clinical Research. It was noted that return-to-work conversations were often taking place but were not consistently recorded, due to technical or system input issues. Assurance was provided that case-by-case investigation was underway with individual managers to address this.

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

Community & Mental Health

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

- **Overall sickness absence rate** Reported as improving, with reductions noted during the reporting period. This provided assurance that absence management interventions are having a positive impact within community and mental health services.
- **Long-term sickness absence** Identified as reducing, contributing to improved overall absence performance and increased workforce stability.
- **Return-to-Work Compliance** Reported as 83% for February, representing a positive improvement and demonstrating strengthened management oversight and engagement with return-to-work processes.
- **PDR completion – Band 7 and above** Reported as having exceeded 90%, providing strong assurance on senior staff engagement with appraisal processes.
- **PDR completion – Overall workforce** Reported at approximately 76%, indicating progress but with further improvement required to achieve expected Trust-wide standards.
- **Bank staffing usage** Reported as having increased during January and February, linked to specific service pressures and delivery requirements, including additional activity and operational demand.

Resolved: The Committee noted the contents of the Community and Mental Health report

Medicine

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

- **Sickness Absence** Reported at 6%, showing an improvement compared to earlier periods but remaining a significant workforce pressure. Senior Leaders

acknowledged that, while progress has been made, sickness absence continues to impact capacity and service delivery.

- **Long-Term Sickness Absence** Reported as reducing, with assurance that focused management of long-term cases is contributing positively to overall absence trends.
- **Short-Term Sickness Absence** Identified as a persistent challenge, particularly difficult to manage due to last-minute absences, including pre-shift notifications, which affect rota planning and operational resilience.
- **Return-to-Work Compliance** Reported as having improved to 77%, the highest level achieved since September. This improvement was attributed to strengthened divisional oversight, weekly monitoring meetings, and improved understanding of ESR recording requirements. It was noted that RTW conversations were often taking place previously but were not consistently recorded. Focused action to address technical and recording issues has resulted in improved compliance figures.
- **Agency Staffing Usage** showing a reduction with tighter controls in place and improved management oversight contributing to decreased reliance on agency staff.
- **Overtime Expenditure** displaying a decrease, providing assurance on workforce cost control despite operational pressures.
- **Temporary Staffing Spend** Although a slight increase in overall spend was noted due to the need to open additional beds, assurance was provided that this remained within budget and was directly linked to vacancy cover rather than uncontrolled usage.
- **MARS** Reported that 11 individuals had exited the division through MARS, contributing to a reduction in overall WTE and changes in workforce configuration.
- **PDR Completion – overall** Identified as an ongoing challenge, particularly among Bands 5 and 6, with capacity and operational pressures cited as key barriers to completion.

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

25/26/193 **Staff Survey 2026**

The committee received the Staff Survey 2026 update and noted the contents. The committee's attention was drawn to the following:

The Committee received a comprehensive update on the NHS Staff Survey, including the publication of national results and the Trust's comparative position.

The overall staff survey results remain strong when benchmarked against comparator organisations, with the Trust continuing to perform particularly well on measures of pride and advocacy, including staff recommending the Trust as a place to receive care. However, the Committee acknowledged a downward trend in staff experience scores compared to previous years, reflecting increasing operational pressure and

organisational strain. Persistent low performance in the “We are always learning” area was highlighted as an ongoing issue, closely related to workforce capacity, access to development opportunities, and completion of appraisals.

The Committee received an update on staff survey response rates and welcomed the increased proportion of staff providing free-text comments, noting that these comments offered valuable insight into staff sentiment. Thematic analysis of the free-text feedback highlighted a workforce experiencing significant workload pressure and concern about staffing and financial constraints, alongside strong loyalty to colleagues, commitment to patients and pride in the care delivered by the Trust. DS noted that this feedback reflects a challenging baseline for staff as the organisation enters a period of significant change. Assurance was provided on the next steps, including strengthened communications, refreshed team-level conversation packs, enhanced action planning arrangements, and the establishment of a Staff Survey Action Planning Group to oversee delivery and monitoring of actions.

The Committee also supported proposals to introduce team-level “temperature checks” for teams not captured through the national survey, to strengthen real-time cultural intelligence and ensure that staff voice continues to inform leadership decision-making.

Resolved: The Committee noted the contents of the Staff Survey report.

25/26/194 **Raising Concerns FTSU Update**

Deferred to the next meeting

Resolved: The FTSU report deferred to May 2026.

25/26/195 **How We Work in the Future**

The Committee received an update on the *How We Work in the Future* programme, noting the scale, pace and complexity of delivery during the current phase of organisational change.

It was assured that the programme is underpinned by a clear financial and workforce rationale, with a defined savings target and a phased implementation approach structured around sequential “waves” of change, including senior leadership, professional services and wider system working.

The Committee noted that significant progress has been made during the reporting period, including the completion of formal consultation processes for senior leadership and senior nursing cohorts, the launch of organisational change activity within digital, people and finance services, and the commencement of consultation on system placement of services. Assurance was provided that staff engagement and communication have been prioritised, with extensive briefings, drop-in sessions and

opportunities for feedback, and that learning from early engagement has informed refinements to approach and messaging.

The Committee acknowledged the importance of robust transition planning and received assurance that detailed work is underway to ensure continuity of governance, finance, workforce systems, risk management and operational oversight as services move from divisional to system structures.

Members discussed programme risks, including financial delivery, staff capacity, staff-side engagement and the impact of change on morale and culture, and were assured that these risks are being actively managed through a dedicated programme governance structure, strengthened OD and leadership support, and close partnership working.

The Committee noted the alignment of the programme with the Trust's strategic priorities and People Plan and agreed that, while the programme remains challenging, appropriate controls and oversight are in place to support safe delivery and ongoing assurance to the Board.

Resolved: The Committee noted the contents of the report.

25/26/196 **Voluntary Redundancy Update**

The Committee received an update on the Voluntary Redundancy (VR) scheme, noting that the scheme formally opened at the end of March and will remain open until the end of April.

The Committee was informed that, at the time of reporting, a significant number of applications had been received across the Trust, with a subset assessed as meeting the agreed eligibility criteria.

The Committee noted that early approvals had been progressed for colleagues seeking to leave by the end of March, delivering a modest reduction in whole time equivalent and contributing to workforce and financial plans. Assurance was provided that external funding had been secured to support early exits, with further funding opportunities being explored to maximise benefit where departures occur in April. Members acknowledged that a number of applications, particularly from corporate services, were being considered in the context of wider organisational change activity, and that decisions in these areas would be aligned to future service models to avoid destabilising functions ahead of planned redesign.

SO discussed the importance of managing staff expectations sensitively, recognising the potential impact on morale where applications do not meet criteria or cannot be approved at the current stage, and noted the actions in place to strengthen clarity through communications, FAQs and well-attended drop-in sessions. Assurance was

provided that robust governance arrangements are in place, including scheduled decision-making panels and consistency checks, and that settlement processes are being progressed at pace to enable timely exits where approved.

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

25/26/197 **Strategic Workforce Planning Update**

The Committee received an update on Strategic Workforce Planning, which focused on the alignment of workforce capacity, capability and structure with the Trust's future operating model and financial requirements.

The Committee noted that a comprehensive bottom-up workforce planning process has been undertaken, with divisions and services completing detailed workforce plans to inform medium-term and longer-term planning. Assurance was provided that this work has strengthened the Trust's understanding of current and future workforce requirements, including skill mix, leadership capacity and professional services support, and has informed both the People risks within the Board Assurance Framework and the *How We Work in the Future* programme.

The Committee recognised that workforce planning is taking place within a highly challenging external context, including national workforce shortages, financial constraints and sustained service demand, and welcomed the move away from aspirational assumptions towards a more realistic and evidence-based approach.

MS discussed the importance of ensuring alignment between workforce planning, organisational redesign, learning and development, and recruitment and retention activity, and noted that this work is being used to inform decisions on organisational change, voluntary redundancy and future investment priorities. MS provide assurance that workforce plans will remain live documents, subject to regular review and refinement as organisational structures, service models and external conditions evolve.

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

25/26/198 **Equality, Diversity & Inclusion Update**

The Committee received an update on Equality, Diversity and Inclusion activity across the Trust and noted continued progress against key priorities, alongside areas requiring further development to strengthen assurance.

AD updated on a range of initiatives aimed at improving inclusion, belonging and equity, including the launch of targeted development programmes for internationally educated colleagues, progress with active bystander training, and continued engagement with staff networks.

The Committee noted that the active bystander programme has been positively received, with plans in place to expand delivery and establish a central hub to provide ongoing resources, guidance and visibility, supporting staff confidence to challenge inappropriate behaviour and promote psychological safety. Assurance was also provided on progress against external frameworks, including preparation for submission to the Northwest Black, Asian and Minority Ethnic Assembly framework, recognising this as an important milestone in the Trust's EDI journey. Members discussed the strengthening of links between EDI activity and wider workforce and patient equity, noting the recent reframing of the EDI risk to include patients, families and volunteers, and the importance of improving data quality and consistency, particularly in relation to ethnicity data capture.

The Committee acknowledged the ongoing challenges staff face in recording sensitive information and noted actions underway, including training and support, to build confidence and improve completeness.

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

25/26/199

Gender Pay Gap

The Committee received the annual Gender Pay Gap report and noted that the Trust's mean and median gender pay gap figures remain broadly stable compared to previous years.

The Committee acknowledged that the trust continues to have a predominantly female workforce and that the gender pay gap is largely influenced by structural factors within the medical and dental workforce, particularly the historical impact of Clinical Excellence Awards. AD noted these awards ceased in 2024 and have been replaced by the National Clinical Impact Awards, which are intended to introduce greater transparency and equity however, it was recognised that the impact of the new scheme will not be visible in pay gap reporting until future reporting cycles. The Committee was assured that changes in the medical workforce profile, including a growing proportion of female consultants over time, are expected to contribute positively to reducing the gap.

AD also noted the wider actions underway to support gender equity and progression, including the establishment of staff support groups such as the carers' network and endometriosis support group, alongside work on inclusive recruitment, sexual safety and broader equality initiatives. It was agreed that while progress is incremental, the report provides appropriate assurance, and that continued monitoring of gender, ethnicity and disability pay gaps together will support a more holistic approach to pay equity and workforce fairness.

Resolved: The committee received and noted the contents of the Gender Pay Gap.

25/26/200 **Policies for ratification:**

- **Apprenticeship Policy**

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

Resolved: The Committee APPROVED the Apprenticeship Policy.

- **Study Leave Policy**

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

Resolved: The Committee APPROVED the Study Leave Policy

- **Disciplinary Policy**

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

Resolved: The Committee APPROVED the Disciplinary Policy

- **Resolution Policy**

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

Resolved: The Committee APPROVED the Resolution Policy

25/26/201 **Equality, Diversity & Inclusion (EDI) Minutes**

The Committee received the approved minutes of the SPF meeting held on (January 2026)

25/26/202 **Staff Partnership Forum Committee (SPF) Minutes**

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

25/26/203 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the EGC meeting held on (January 2026)

24/26/204 **Any Other Business**

There were no items of AOB

25/26/205

Review of Meeting – Chair's Report to Board

- **Board Assurance Framework – People Risks:**
Approval of the reframing of all three People strategic risks covering:
 - Workforce sustainability
 - Organisational culture and wellbeing during change
 - Equity, Diversity and Inclusion (expanded to include patients and families)
- **Strategic People Update:**
Workforce performance, including sickness absence, PDR compliance, industrial action preparedness and people risks.
- **Workforce Metrics:**
Divisional updates on sickness, vacancies, agency/bank usage and PDR compliance, with actions in place for hotspot areas.
- **NHS Staff Survey 2025:**
National benchmarking, headline themes, free-text analysis and planned Trust-wide and team-level actions.
- **How We Work in the Future Programme:**
Progress update on organisational design, workforce change waves, transition planning and programme risks.
- **Voluntary Redundancy (VR) Scheme:**
Uptake, approvals to date, funding position and staff experience considerations.
- **Belonging, EDI and Inclusion:**
Active bystander training rollout, North West BAME Framework submission and inclusion initiatives.
- **Policy Approvals:**
Ratification of updated Apprenticeship, Study Leave, Disciplinary and Resolution policies.
- **Sickness Absence:**
Although performance is improving in February, Q2 data positions the Trust as a national outlier within the NHS Oversight Framework. Sickness remains a significant strategic workforce risk.
- **Reframed People Risks:**
Revised risk definitions and target scores better reflect current risk appetite, including expansion of EDI risk beyond the workforce.
- **Organisational Change Impact:**
Risk of cultural and wellbeing pressures during workforce and system redesign remains under close oversight.
- **Voluntary Redundancy Scheme:**
Risk to morale if eligibility decisions are not consistently understood or communicated.

Date and Time of Next meeting.

Wednesday 13th May 2pm – 4:30pm – Teams

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	FTSU Guardian
Report of:	FTSU Guardian
Paper Prepared by:	Freedom to Speak Up – Progress Update Report

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:	Delivery of outstanding care ☐ The best people doing their best work ☐ Sustainability through external partnerships ☐ Game-changing research and innovation ☐ Strong Foundations ☒
Resource Implications:	None identified at present

Does this relate to a risk? Yes ☒ No ☐			
If "No", is a new risk required? Yes ☐ No ☐			
Risk Number	Risk Description		Score
BAF 2.2	Organisational culture		9
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

FREEDOM TO SPEAK UP ANNUAL PROGRESS REPORT

1. Purpose

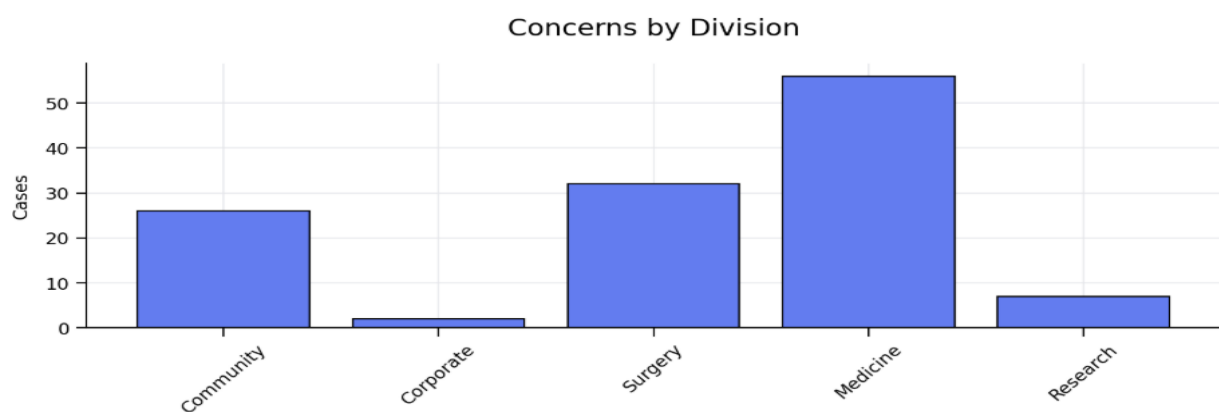
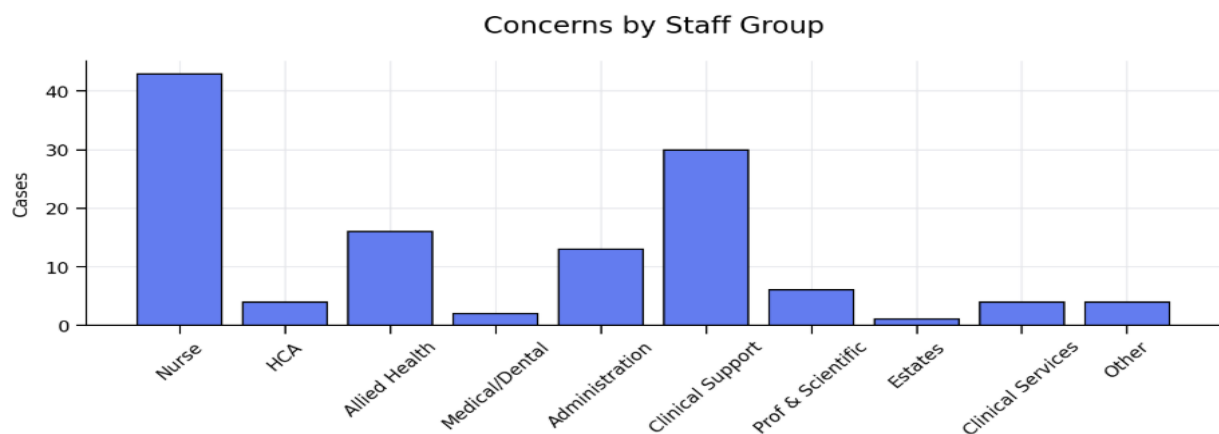
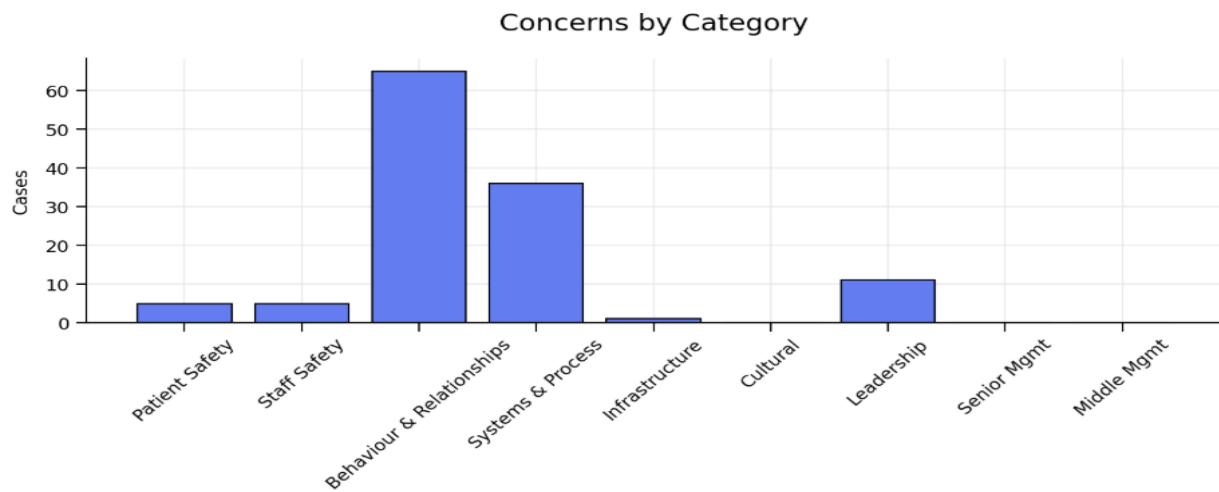
The purpose of this paper is to provide the Board with a summary of the activities of the FTSU team for 2025/2026 including the Q4 data and to outline the actions planned for the coming period.

2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

3. FTSU annual Activity

The total number of cases reported through 25/26 was 122, these are captured as single contacts on the FTSU database, as indicated by the National Guardians Office, however, each contact will, on average, have approximately 4-5 additional interactions associated with the case, therefore approximately 488-610 contacts are made between the individual, manager and lead and the FTSUG and Deputy.



Overview

This dataset provides a **three-dimensional view** of Freedom to Speak Up activity:

- **What concerns are raised (themes)**
- **Who is raising them (staff groups)**
- **Where they originate (divisions)**

Together, these offer a strong insight into organisational culture, pressure points, and engagement.

Key Themes of Concern

- **Behaviour and Relationships (65 cases)** continue to dominate, highlighting that interpersonal dynamics, communication, and workplace behaviours are the primary drivers of concern.

- **Systems and Process (36 cases)** is the second largest category, indicating that operational inefficiencies, unclear processes and misinterpretation/adoption of policies, are a major issue impacting staff experience.
- **Leadership (11 cases)** reflects some concerns around leadership practice, though at a lower level compared to behaviour and systems.
- **Patient Safety (5)** and **Staff Safety (5)** remain relatively low but may be embedded within wider system or behavioural concerns.
- Minimal or no reporting in **culture and management-specific categories** suggests either confidence in leadership or potential underreporting.

Staff Groups Raising Concerns

- **Nursing staff (43 cases)** are the most active group, reflecting both workforce size and strong engagement with speaking-up channels.
- **Additional Clinical Support (30 cases)** also shows high engagement, indicating accessibility of the Freedom to Speak Up process across non-registered roles.
- **Allied Health Professionals (16)** and **Administration (13)** demonstrate consistent contributions across wider staff groups.
- **Lower reporting groups** include:
 - Medical/Dental (2)
 - Estates & Ancillary (1)

This suggests potential variation in confidence, awareness, or use of alternative reporting mechanisms.

Divisional Insight (New Addition)

- **Medicine (56 cases)** shows the highest number of concerns, indicating that this division is the most active in raising issues. This may reflect both size and operational complexity.
- **Surgery (32 cases)** is the second highest, suggesting similar pressures in acute and procedural environments.
- **Community (26 cases)** shows strong engagement, highlighting that concerns are also being raised consistently outside acute settings.
- **Research (7 cases)** and **Corporate (2 cases)** show significantly lower activity, which may reflect smaller workforce size or different working environments.

Cross-Cutting Insights

When combining all three views:

- The **highest concern area (behaviour and relationships)** is primarily raised by **frontline staff (nursing and clinical support)** within **high-pressure divisions (medicine and surgery)**.
- This suggests that **day-to-day working relationships in operational environments** are a key driver of speaking up.
- **Systems and process issues** are also prominent and likely underpin many concerns across all staff groups and divisions.
- **Lower engagement from some staff groups (e.g., medical staff)** combined with **low reporting in certain divisions (e.g., corporate)** may indicate:
 - Cultural differences in speaking up
 - Alternative escalation routes
 - Opportunities to strengthen psychological safety

Overall Interpretation

The data demonstrates that:

- There is a **strong speaking-up culture among frontline clinical staff**
- **Workplace behaviour and operational systems** are the key organisational challenges
- **Engagement is uneven**, varying across staff groups and divisions
- Higher activity in Medicine and Surgery reflects **complex, high-demand environments**

Suggested Focus Areas

- Target interventions to improve **team culture, civility, and communication**
- Review and streamline **systems and processes and policy understanding**.
- Increase outreach to **underrepresented staff groups**

- Strengthen visibility of Freedom to Speak Up in **lower-reporting divisions**
- Continue building **psychological safety across all levels and settings**

Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a range of worker/professional groups and levels of seniority.

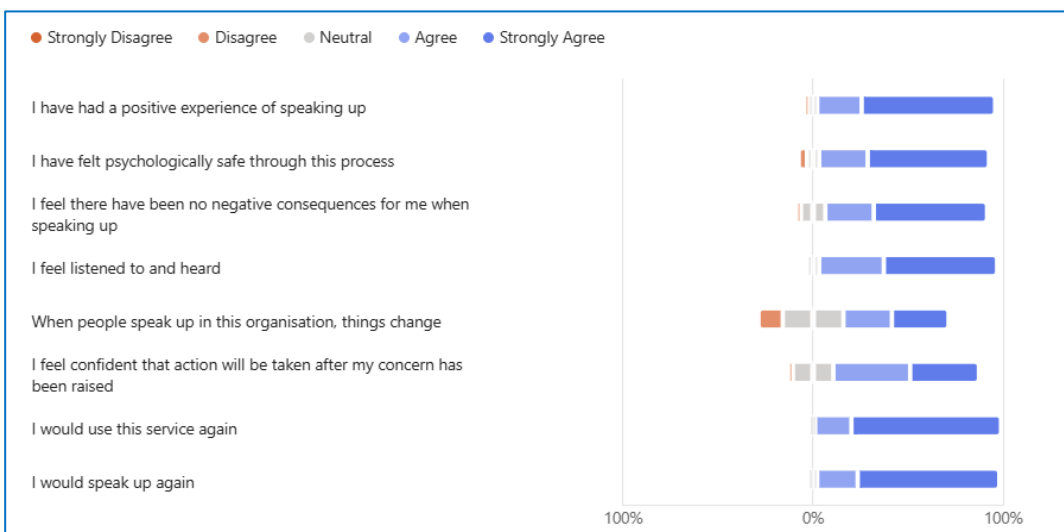
A comprehensive definition for professional groups forms part of the updated guidance.

[Recording Cases and Reporting Data \(nationalguardian.org.uk\)](https://nationalguardian.org.uk)

4. Feedback

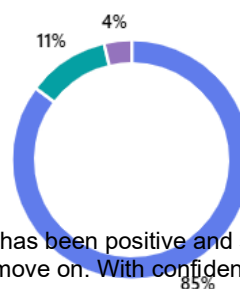
Every FTSU contact is invited to provide feedback via anonymous online form at the close of their case. An overview of feedback is provided below, along with a number of quotes from colleagues about their FTSU experiences.

Consider the statements below and say how much you agree or disagree with each by circling the appropriate response.



6. Do you feel confident, if you need to, to speak up in the future?

- Yes 23
- No 0
- Maybe 3
- Not Sure 1



"Thank you to Kerry for her time and understanding. The experience has been positive and supportive. It has been nice to have an outcome to the FTSU, which now allows us to move on. With confidence to access FTSU should there be any future need."

"This is the first time I had to approach FTSU. I felt heard and I am glad this was all dealt very professionally and the outcome feedback was provided."

“Kerry really listened and unpicked what the issues were we faced in the service. This information was taken to the relevant people who could make changes.”

“I found this service a great help in helping guide me in my situation and in helping me understanding processes and choice.”

5. Detriment

Many people who speak up fear nothing will be done or that they will suffer retaliation for having spoken up.

Individual barriers to speaking up may vary from person to person, depending on factors including their status in their organisation, their background, and personal characteristics.

It is not always easy to speak up in the health or care sectors, workers speaking up can find themselves bullied or threatened – there is a worrying trend of being reported for misconduct to their professional body.

Freedom to Speak Up guardians are required to report anonymised speaking up data on a quarterly basis to the National Guardian's Office.

During 25/25 there has been 1 report of an individual believing that they have suffered detriment by speaking up, the impact of this for this individual is that they have expressed that they may not speak up again in the future, clearly this requires addressing.

As a result of this concern, a case review is to be undertaken to understand what lessons can be learnt from this experience and how these can then be embedded within the organisation.

The individual raising the issue will be involved in this case review to provide, their lived experience.

6. Lessons Learnt

The most important aspect of anyone speaking up is the information they can provide, not their identity. Staff have the option to report concerns openly, confidentially or anonymously. When an individual chooses the confidential route the FTSUG will not share the person(s) identity without their consent, the exception to this would be if there was immediate risk of serious harm to another person.

A recent case was raised, regarding allegations of a breakdown in behaviours and relationships, these were reported confidentially and independently by several individuals, they chose this route as they believed that they would suffer a detriment should their identity be revealed. When a concern is raised confidentially, it becomes harder for investigators to ask follow-up questions, secure specific evidence, or verify claims, and this became very apparent during the case in question, causing significant stress to the alleged perpetrator, who believed their right to respond was removed, as they did not know the identity of the alleged victims.

As a result of this situation a case review was undertaken, where it was determined that the Speaking Up Policy required evaluation to determine its suitability in guiding all staff in raising concerns via the routes described previously, the challenges faced by choosing the confidential and anonymous route, the process for any concern raised via the FTSU platform and the route to involving Human Resources and when that could potentially occur. The policy has now been completed, with involvement from those staff who have had lived experience in using or being part of the FTSU process, providing invaluable feedback on the policy which has been incorporated. The policy incorporates the new trust values and is due to go for ratification at the next Peoples Committee.

7. Staff Survey results 2025

Question	Response 2024	Response 2025	National Best	Average results	Worst results
Q20a I would feel secure raising concerns about unsafe clinical practice.	79.72%	77.35%	79.16%	69.82%	57.41%
Q20b I am confident that my organisation would address my concern.	68.85%	63.50%	68.23%	53.94%	37.97%
Q25e I feel safe to speak up about anything that concerns me in this organisation	70.04%	67.24%	71.81%	58.85%	42.11%

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	61.53%	56.62%	63.99%	46.18%	29.15%
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In the 'We have a Voice' section we have seen a drop in all 4 questions relating to raising concerns, this picture can be seen nationally with a 5 year low for these questions, clearly indicating a decline in confidence by staff to raise concerns. This requires a shift in our approach to how FTSU is 'felt' across the organisation, with a focus on visibility, a programme to roll out the new Speak Up Policy to provide clarity on the process and a revision of our FTSU champion network, plus a focused approach at understanding the challenges staff face in raising concerns.

8. Freedom to Speak Up Visibility Programme

The visibility programme continues to thrive across the organisation, with regular sessions throughout the month. These visits are supported by our executive colleagues and our CEO, John Grinnell, has attended monthly with regular slots planned.

Moving forward we will be utilizing the staff survey results as a framework for these visits, this allows for prioritization of areas/departments to be attended and a focus on lines of questioning. Actions from these walkabouts are shared with ward/department leads and themes are shared at the Thriving Teams meeting, along with other gathered intelligence via FTSU.

This programme has promoted the visibility of the FTSU service across the organisation and an enhanced understanding of what speaking up is, as part of the FTSU vision, it will be used to promote the new policy and the new values.

9. Networks/EDI

Freedom to Speak Up and Equality, Diversity, and Inclusion (EDI) complement each other by ensuring that all employees, particularly those from underrepresented backgrounds, feel psychologically safe to voice concerns or suggest improvements without fear of retaliation. The relationship between FTSU, EDI and our established networks will help eradicate discriminatory cultures and will drive continuous organisational learning. Throughout 25/26 these relationships have strengthened with a clear requirement for this to continue, given the staff survey results and the challenges staff with protective characteristics, in raising concerns.

Advancing into 26/27 there will be an increased initiative to further strengthen relationships as the core benefits could potentially be:

- **Reduction in Discrimination and Harassment:** FTSU provides an active reporting channel for issues like bullying or bias. When tied to EDI targets, organizations can pinpoint exact demographics facing discrimination and take targeted action.
- **Building Psychological Safety:** Employees from diverse backgrounds require absolute confidence that speaking up will be met with supportive, action-oriented responses rather than punishment.
- **Improving Retention and Culture:** Staff are more likely to stay in environments where they feel heard and respected. Celebrating diverse voices helps create a culture of belonging.

How we will achieve this :

- **Diverse Champions:** Appointing Freedom to Speak Up Guardians and Champions from diverse backgrounds to ensure all staff have relatable advocates to approach.
- **Data-Driven Accountability:** Reviewing speaking-up data by protected characteristics to ensure marginalized groups do not face disproportionate retaliation or inequitable outcomes.

10. Deputy Freedom to Speak Guardian

After taking into consideration workload, service resilience and visibility it was decided in 2025 to open recruitment for a Deputy FTSUG role. This decision was not without complexity, due to the FTSU National Guardians Office (NGO) guidance on the role of FTSU champions (strictly not able to hold cases) while insisting each NHS organization has only one designed FTSUG that can receive NGO training and register on the NGO public directory. The proactive decision to move beyond this model was given approval, and ultimately we were able to appoint Joe Fitzpatrick, Internal Communications Manager, into the part time, unpaid role from 1 January 2026. Joe has long been a FTSU champion, and worked closely with Kerry and Erica on several adjacent and/or similar programmes in the past (such as Listening Into Action), and has been able to take on this extra role in addition to his Communication Team responsibilities. His particular focus has been, as well as taking on his own caseload, exploring further technical opportunities to improve reporting (see InPhase section below) as well as leading on a newly refreshed FTSU Champions Network programme.

11. InPhase

NGO guidance requires organisations to provide a robust anonymous reporting system for colleagues. We have used a number of different options in the past, including a bespoke Alder Hey Innovation provided application, as well as Microsoft Forms links. Over the course of this past year we have explored different options that would provide more benefits than the existing routes, and have since worked closely with the Risk and Governance Team to develop a bespoke InPhase FTSU reporting module.

InPhase provides a number of benefits; it is an already familiar and well used platform for a large proportion of staff who use it to report under different circumstances, it can be modified to provide much more detailed and robust data collection and reporting capabilities (which we will use to illustrate FTSU performance and impact in future reports), and has functionality to completely lockdown the system access to only the FTSUG and Deputy FTSUG.

The new module was soft launched w/c 27 April 2026, and will be the focus of a rolling awareness campaign over the summer months 2026.

We are grateful to Katherine Martin, Risk Systems Development Lead, for her help in scoping, developing and delivering this new advance which will make it easier and safer for colleagues to report issues through to FTSU.



12. Freedom to Speak Up Champions

The FTSU Champions Network is a longstanding group of volunteer colleagues who act as local advocates for the FTSU programme. Their role is to sign post to either the FTSU contact points and/or further information and support as required. The Deputy FTSUG has been tasked to take a new look at this group, to provide more consistent visible leadership as well as rigour to the champion role itself.

We have taken inspiration and advice from colleagues in the NW FTSUG Network, including Guardians from LUFT and LHCH who were generous with their time and insight when we met earlier in April 2026.

Based on those conversations, as well as with other FTSUGs from across our region, we have developed a new Champion programme which will launch out for applications from June 2026. The programme includes new and robust champion application processes (with a new requirement to seek line manager approval), champion training packages, and information and support to line managers of champions.

13. Training

The **Speak Up, Listen Up, and Follow Up** modules are a suite of e-learning training resources developed by the [National Guardian's Office](#) (NGO) and are designed to foster a safe, inclusive, and communicative workplace culture.

The training is split into three specific phases to cover all levels of an organisation:

1. Speak Up (Core Training for All Staff)

- **Target Audience:** All workers, regardless of their role or contract terms.
- **Focus:** Covers what speaking up is, why it matters, how workers can raise concerns, and what they can expect to happen when they do.

2. Listen Up (Training for Managers)

- **Target Audience:** Managers and supervisors at all levels.
- **Focus:** Equips managers with the skills to listen to concerns, understand the personal and structural barriers staff face when speaking up, and respond to issues with empathy and professionalism. [[1](#), [2](#)]

3. Follow Up (Training for Senior Leaders)

- **Target Audience:** Executive and non-executive directors, senior leaders, and board members.
- **Focus:** Promotes a consistent, effective "Freedom to Speak Up" culture across the system. It provides a space for leaders to reflect on how their organization measures effectiveness, handles feedback, and ensures that raised concerns result in action and learning

All three modules were mandated via the Education Governance Committee in August 2023, the Speak Up training is mandated for all staff and was easily implemented, however the two remaining modules have faced a challenge as the target audience has been difficult to isolate via ESR, moving through 2026 our Learning and Development team are looking at how these two modules can be implemented, updates will be provided.

Module 1 uptake had decreased slightly during Q3 and Q4, this has now seen a slight increase to 91.19 %, moving forward focus will be given to those areas not achieving the required compliance.

BOARD OF DIRECTORS

Thursday, 4th June 2026

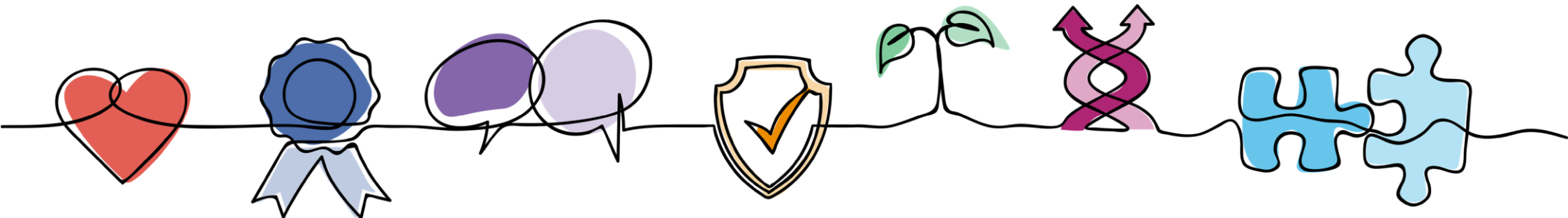
Paper Title:	Freedom To Speak Up Review Tool for Boards
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Chief Corporate Affairs Officer

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Action/Decision Required:	To note ☒ To approve ☐
Summary / supporting information	The report provides 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.
Strategic Context This paper links to the following:	Delivery of outstanding care ☐ The best people doing their best work ☐ Sustainability through external partnerships ☐ Game-changing research and innovation ☐ Strong Foundations ☒
Resource Implications:	None identified at present

Does this relate to a risk? Yes ☒ No ☐ If "No", is a new risk required? Yes ☐ No ☐			
Risk Number	Risk Description		Score
BAF 2.2	Organisational culture		9
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

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: [A guide for leaders in the NHS and organisations delivering NHS services](#), which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.fts-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

1 = significant concern or risk which requires addressing within weeks

2 = concern or risk which warrants discussion to evaluate and consider options

3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes
Enter summarised commentary to support your score. The FTSU Guardian is a full time post directly line managed by the Executive lead. The NED lead meets with the FTSUG and Exec lead as a triumvirate on a monthly basis to ensure line of sight of all key issues of concern. In addition, the FTSUG also has monthly one to one meetings with the Chief Nurse and Chief Executive. Quarterly formal reports to the Board have been in place for a number of years and have continued to develop to reflect themes and lessons learned. In addition, quarterly reports are submitted to the People Committee. The FTSUG also produces an annual report on the activities of the service – this will be the second year for this. Speaking up arrangements are kept under review to continue to ensure they reflect best practice and guidance from the NGO.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
None currently – arrangements fit for purpose	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
I challenge the board to develop and improve its speaking-up arrangements	Yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am involved in overseeing investigations that relate to the board	N/A to date
I provide effective support to our guardian(s)	Yes
Enter summarised evidence to support your score. The NED lead meets on a monthly basis with the FTSUG and Executive lead in order to receive updates on concerns raised, any trends, national or local developments and future plans. The NED lead has continued to focus on information provided to the board on a quarterly basis to improve transparency in terms of process whilst maintaining confidentiality. The NED lead is proactive in raising the profile of her role which has resulted in members of staff seeking direct access to her as the NED lead from time to time. The NED lead is committed to championing speaking up at Board level and to demonstrate this externally through attendance at relevant national or system events.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
NED lead to continue to support improvements in reporting content and format – this has proved extremely useful feedback	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes
We regularly and clearly articulate our vision for speaking up	Yes
We can evidence how we demonstrate that we welcome speaking up	Yes
We can evidence how we have communicated that we will not accept detriment	Yes
We are confident that we have clear processes for identifying and addressing detriment	Yes
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	Yes
We regularly discuss speaking-up matters in detail	Yes
Enter summarised evidence to support your score. In 2023/24 the Board approved an FTSU strategy position statement in support of the Trust's Vision 2030 and underpinning People Strategy. This continues to direct our focus. The Board also approved the FTSUG's proposal to include the national Speaking Up training module as mandatory training for all staff. Compliance rates with this training are consistently above 90% across the organisation. The Trust has had in place an annual Speaking Up week for a number of years and the Guardian has a well-publicised programme of visibility visits to all areas of the organisation including community locations. During the last 12 months members of the Board have continued to accompany the Guardian on these visits in order to reinforce key messages with regard to speaking up principles at Alder Hey including unacceptable behaviours that should not be tolerated by staff. The visibility programme cycle will continue in the current year to ensure organisation wide coverage; include board member attendance across the year. Our most recent staff survey results demonstrate the Trust's continued progress in this area.	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes
Enter summarised evidence to support your score. A central pillar of the Trust's People Strategy is to ensure we foster a culture and environment in which all of our staff can thrive and develop. The adoption of a Just and Restorative culture is part of that development and is woven through key aspects of our work including the Patient Safety strategy, delivered via the Patient Safety board. FTSU is a recognised tool in the patient safety strategy and the Guardian regularly spends time with teams in order to support individuals who have experienced safety incidents and need support through the learning process. The Guardian has developed strong relationships with the chairs of the staff networks and has worked in partnership with them on specific cases. In the last year a Thriving Teams MDT approach has been established by the Trust's Director of Culture and Organisational Development which includes the FTSUG alongside colleagues from the SALS team and HR colleagues. This has proved an effective means of triangulating information with regard to teams who need extra support; the Director of Culture is keen to develop an approach to analysing the rich data that is now available to the organisation as a means of developing a cultural dashboard and enhancing ways in which we currently understand how staff are feeling.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to develop the FTSU data set and triangulation with other information sources such as SALS, incidents and concerns raised through other routes.	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	No
Enter summarised evidence to support your score. The Board took the decision to create a full time Guardian role in 2023. A formal part time Deputy was appointed in December 2025 from among the existing FTSU Champions. This role will enable a refocus on the recruitment and retention of Champions as a cohesive team representing all areas of the Trust, as well as a review of the Speaking Up policy and arrangements for electronic recording of concerns on the Trust's InPhase system.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Formalise updated workplan for 2026/27 to reflect Deputy appointment	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes
Enter summarised evidence to support your score. The national Speaking Up policy was adopted by Alder Hey in September 2022 which was in advance of the mandated deadline. The policy has recently been updated to reflect learning from a formal case review undertaken at the end of 2025. One of the issues arising in the case related to anonymity and the impact on the outcome of the process if the member of staff raises concerns elects to retain anonymity throughout. This has now been given prominence and clarity in the policy to enable staff to consider this with all of the correct information available. The policy is due to be ratified by the People Committee in June 2026. Alder Hey has a centralised Document Management System which contains all policies, accessible on the Trust intranet.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Ensure the policy is referenced routinely in FTSU communications plans.	
2 FTSUGs to signpost to policy at induction sessions.	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	Yes
We measure the effectiveness of our communications strategy for Freedom to Speak Up	No
Enter summarised evidence to support your score. The Trust's internal communications manager has worked closely with the Guardian from the beginning of her tenure and they have developed a rolling comms plan that has included the development of visual collateral such as banners and lanyards, through to the annual Speaking Up Week in October which over time has used mechanisms such as pledges by senior leaders in relation to speaking up. The Guardian has also supported colleagues to bring their experiences to board meetings through the 'Staff Story' slot. Whilst we have not to date developed any effectiveness metrics per se, the year on year improvement in staff survey results relating to the raising concerns questions demonstrate steady improvement and places us as a high scoring organisation in this regard.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider a methodology for measuring the impact of FTSU comms other than the annual staff survey metrics.	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	No
Enter summarised evidence to support your score. The organisational compliance rate with the NGO speaking up training module currently stands at 98%. The Guardian has a specific session with new starters at each corporate induction.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 The Guardian to engage with the Head of Learning and Development to consider how the Speaking Up training module can be evaluated.	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	Yes
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes
Enter summarised evidence to support your score. The Guardian works with managers as required when issues are raised in their area. There have been notable examples of positive and productive joint working in the last 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Guardians to consider specific learning sessions for managers following visibility activities.	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes
Enter summarised evidence to support your score. The Guardian is a key member of all organisational forums that focus on staff wellbeing, enabling her to undertake horizon scanning for potential hotspots as issues arise in particular services for example. This now includes the Thriving Teams MDT meeting. One key source of data (anonymised) is the SALS service. The Guardian has developed a close working relationship with the SALS team since it was put in place in 2020; the Director of Culture and OD is also leading the the Trust's cultural development programme.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to refine data sources, analysis and triangulation as part of board assurance and learning.	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	Yes
Enter summarised evidence to support your score. The FTSUG analyses the case studies published by the NGO to ensure that any learning that can be derived for Alder Hey is assimilated. The Guardian also draws learning from network events that can be adopted by the Trust and similarly has regularly offered her time to guardians in other organisations who have expressed an interest in the Alder Hey approach. Following the publication of this year's staff survey results other organisations are reaching out to the FTSUG to seek advice.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider formalising the dissemination of learning from elsewhere through an annual report eg to the People Committee.	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Enter summarised evidence to support your score. The Guardian has been in post since 2018 having been recruited through an open internal process. She subsequently undertook NGO training and remains registered as Alder Hey's Guardian. The Deputy Guardian has also completed the formal training and has been entered on the national register.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 N/A	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes
Enter summarised evidence to support your score. There is a long-standing robust management support structure in place for the FTSUG. She reports to the Executive lead, including monthly one to one meetings, as well as a monthly meeting with both the Executive and NED lead jointly and has open access to the Executive lead at other times to discuss specific cases. She also meets on a monthly basis with the Chief Nurse, who is her professional lead as well as with the Chief Executive. She has standing open access to meet with the Trust Chair on request. The Guardian has an annual PDR with the Executive lead with agreed performance objectives and development opportunities identified. She is able to access emotional support/clinical supervision from the Director of Culture and Organisational Development. The FTSUG routinely reports the Trust's data to the NGO in accordance with stipulated requirements.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes
Enter summarised evidence to support your score. The FTSUG keeps a detailed confidential database on which she documents each case. As part of the closure process of each case, individuals are asked about their experience and whether they would use the service again. This information is summarised for the quarterly board assurance report in addition to the number of open cases and the length of time they have been open; any delays in closing cases are documented with the reason for the delay. The Trust has invested in the FTSU module on the InPhase system and following testing in relation to confidentiality measures, has gone live; its use by staff as against other reporting mechanisms will be evaluated during the course of the next 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider more proactive board endorsement of FTSU activities through Speaking Up week.	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes
We know who isn't speaking up and why	No
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	No
Enter summarised evidence to support your score. Whilst the Trust scores well on staff survey metrics relating to raising concerns, it is understood that there is scope for improvement and a better insight into the factors that enable and disable staff from speaking up. Work has been done to identify barriers such as professional boundaries, geographical location, confidentiality etc. and the development of the team of Champions has aimed to address these by actively recruiting Champions from all parts of the organisation both in terms of service and structure but also in terms of characteristics and background. The Deputy Guardian's review of the Champion role will incorporate this aspect in the coming year. The FTSUG has been working closely with the staff networks to gain a better understanding of any barriers for particular groups and take steps to address them. This work will develop further in the coming year and form part of the quarterly board report.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider targeted work to identify groups or individuals who may be reluctant to use speaking up mechanisms.	

2 Develop a methodology to assess changes in appetite to raise concerns among staff groups identified and contributing factors.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	Yes
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes
Enter summarised evidence to support your score. The FTSUG considers the issue of detriment specifically with each member of staff who raises a concern. She follows up with individuals after the concern has been closed to ensure that no detriment has arisen. This is reflected in the board report which is overseen by the Executive and NED leads.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Review the questions in relation to detriment and consider supplementary information as appropriate.	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	No
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	No
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	No
Our improvement plan is up to date and on track	No
Enter summarised evidence to support your score. We do not currently have a standalone FTSU strategy, having taken the view that speaking up must rather be an integral part of our overarching People Strategy. We developed a position statement in support of the People Strategy which can be developed into an improvement plan but again this must align to the work that is currently underway in relation to the Trust's cultural evolution and revised values. The short survey that was undertaken during 2024 to seek the views of staff with regard to the accessibility and effectiveness of FTSU is a good platform on which to build; it is intended to run the survey again this year to track progress.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider the development of an FTSU improvement plan	
2 Consider appropriate metrics to evaluate improvement	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	No
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	No
Our speaking-up arrangements have been evaluated within the last two years	Yes
Enter summarised evidence to support your score. Our speaking up arrangements were formally audited during 2023/24 by MIAA and substantial assurance obtained with regard to the process. The scope of the review included policies and procedures, staff and training, actions taken as a result of concerns and lesson learning. All recommended actions from the audit have been fully implemented.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider structured evaluation of staff attitudes to speaking up out with of the annual staff survey.	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes
Enter summarised evidence to support your score. The quarterly board assurance report has developed significantly over time and last year underwent some structural changes suggested by the NED lead. Periodically the standard report has been supplemented by case studies and self-assessments which can be built into the workplan at intervals during the year. The annual report to the board reflects the totality of FTSU activity over the previous 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to refine the quarterly report to include the areas identified in this assessment with oversight from the NED lead.	
2 Continue to develop the formal annual report on FTSU activity as referenced above.	

Erica Saunders
Chief Corporate Affairs Officer/Executive lead for FTSU
May 2026

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Monday 27th April 2026 at 1pm**
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)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
In Attendance:			
	Ms K Byrne	Non-Executive Director	(KB)
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mr. G. Wadeson	Associate Director of Finance	(GW)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Mr A McColl	Deputy Director of Finance	(AMc)
	Mrs J Holloran	Deputy Development & Estates Director	(JH)
	Ms. N. Palin	Director of Transformation	(NP)
	Mrs. J Tsao	Executive Assistant (Minutes)	(JT)
Agenda item:			
26/27/03	Paul Sanderson	Chief Pharmacist	(PS)
26/27/06	Wendy Jolley	Category Manager	(WJ)
26/27/06	Alex Watkinson	Senior Category Lead	(AW)
26/27/12	Chloe Lee	Deputy Chief Operating Officer	(CL)
26/27/12	Graeme Montgomery	Business Accountant Surgery	(GM)
26/27/12	Nickita Pickard	COO, Medicine Division	(NP)
26/27/12	Laura Simon	Business Accountant Medicine	(LS)
26/27/13	Kate Walker	Manager, Community and Mental Health Division	(KWal)
26/27/13	Esme Evans	Business Accountant. CMHD	(EE)
Apologies:			
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)

26/27/01	Welcome and Apologies The Chair welcomed everyone to the meeting and noted the apologies received.
26/27/02	Minutes of the Last Meeting The minutes of the last meeting held on 25 th March 2026 were approved subject to a review by Erica Saunders on the commercial sensitivities in the Campus section. Action: ES
26/27/03	Matter Arising and Action Log FTPC went through and discussed outstanding actions: FTPC Priority Areas

	RL introduced the above previously named 5 Top Risks. JK agreed priority areas for 26/27 1. Financial Performance 2. Operational Performance – Oversight Framework 3. CIP and Transformation 4. Capital and Campus 5. CYP Pead Chain Development DJW queried where funding would be monitored. RL advised that as item 5 would not be presented every month another priority could be added to monitor funding. The chair noted CIP and Transformation is internal, item 5 including funding would be the external outlook. FTPC agreed to amend item 5 to: 5. Paediatric Chain FTPC discussed clarity between FTPC oversight and Growth and Opportunities Committee. JG noted a review of the committee workplan showing areas being covered by each committee would support this. Pharmacy Outsourcing PS provided background noting the tender process started in October 2026 and updated the committee on the latest position in relation to the tenders received. A discussion took place on the areas that are being worked through including building changes and recruitment of staff. It was agreed a meeting would take place with Executive Team on outcome of tender and feedback to committee. Action: Execs/PS
26/27/04	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.
26/27/05	Top 5 Risks 1. System Financial Performance 2. Trust Financial Performance The 2 items above were received under Financial Plan 206/27. 3. Campus & Capital Programme JH provided highlights of the campus programme and in particular noted the progress made on the PFI contractual discussions. 4. Transforming Alder Hey (ways of working, futures, AI & Digital) An update was received under Financial Plan 26/27. 5. Operational performance (productivity, access, targets, benchmarking) FTPC received the IPR report for M12. Resolved: FTPC noted the current position in relation to the Top 5 Risks.
26/27/06	Procurement for the Collaborative Contract of Decontamination Services WJ provided background noting the tender was out to service with a three year contract. The current contract at Alder Hey has expired and is currently

	continuing a rolling basis with Synergy Health (UK) Ltd t/a Steris Instrument Processing. DJW asked if a longer term contract could be provided to look at future options. WJ advised this had been agreed to be completed within the first 12 months of the contract. As this is a short term contract the equipment will not be replaced, however it will be maintained. Resolved: FTPC APPROVED Procurement for the Collaborative Contract of Decontamination Services.
26/27/07	Travel and Expenses Policy EK presented the updated policy for approval. It was noted that feedback on the current policy had been that the rates were low, however on review EK updated that the rates met with national guidance and any exceptions would be approved on singular basis. FTPC noted this however raised concern on some of the low rates and wanted to ensure staff safety was met when looking at hotels. Expenses would be recommunicated that they would need submitting within 3 months. MS noted ongoing discussion regarding increase in fuel prices and national guidance. MJ asked if communications could include staff would now be taxed as a liter is over 45p. Resolved: FTPC APPROVED Travel and Expenses Policy.
26/27/08	FTPC Annual Report The annual report was presented to the committee. FTPC agreed that the overall content of the Annual Report was appropriate. A specific request was made to update the concluding section to ensure it accurately captured the current top risk themes discussed at the meeting, including those relating to financial sustainability and delivery priorities, before submission to the Board. Action: Jill Preece Resolved: FTPC Approved the Annual Report to be presented to Trust Board.
26/27/09	NHSE Checklist An update was presented on the latest position for the various checklists. AC noted out of 36 actions 4 are outstanding. Of the actions outstanding: • Review of additional PAs started last year and is being worked through. • Medium Term Plan has been processed as a 3 year model. PWC recommendation is for the NHSE Checklist to be presented at FTPC quarterly. FTPC noted this would be added to FTPC workplan. Action: AC The Chair asked how Alder Hey compared to other Trusts. It was noted that reports from external Trusts are not shared. Resolved:

	FTPC provided assurance on the NHSE Checklist.
26/27/10	2026/27 Financial Plan The Chair congratulated Divisions on meeting the recovery targets for 25/26 and it was agreed the focus of this session would be to look ahead in to 26/26. RL noted the current challenging position in relation to CIP, however update the committee on the comparison of this years position to last years where £5.8m of green schemes have been completed compared to £3.1m last year. The Voluntary Redundancy scheme remains open and panels are taking place to review applications. RL went through details from the recent CIP Insight Workshop highlighting financial opportunity areas and how this would be aligned against the transformation programme. The Chair asked the surgery division if there was anything new within the findings. NP said it provided clarity on leads. AB said the workshop was to provide services with support for where areas can be reduced. Supporting services to work differently going forward and review if vacancies need recruiting before processing. RL went through other mitigations that are being pursued with a target of £5m benefit in year. JG discussed the complex situation with the Vacancy Redundancies and where services can run safely with reduced staffing. JG asked leads to make decisions on VR as soon as possible. NP added as leadership roles have now been recruited to they will be able move forward with VR applications. DJW noted the Board of Directors support. DJW asked MS why some areas are struggling with approval of VRs. MS noted a number of challenges including a significant applications form within the same staff groups. Transformation Benefits The Chair asked for an update in relation to Urgent Care programme. RL said it would be helpful to review the scope of this programme. Action: NP to provide update on UEC programme. Workforce MS presented the latest position in relation to workforce and the progress towards the reduction in the annual plan. It was noted the reduction in temporary staffing spend for M1. A discussion was held on a possible phase 2 of vacancy redundancies to offer to clinical teams once these services have been reviewed. Going forward further VR panels are planned to review and conclude all existing applications Resolved:

	FTPC noted the current position against 2026/27 Financial Plan.
26/27/11	Professional Services CP provided an update on Professional Services performance. FTPC noted that Professional services as whole had identified and largely developed their CIP targets. It was acknowledged that earlier establishment of leadership arrangements and clearer operating models had supported delivery and control within Professional Services. Resolved: FTPC received the quarterly update for Professional Services previously named Corporate Division.
26/27/12	Surgery Division CL presented Surgery Division performance update. It was noted that the Division ended 2025/26 with a £3.2m deficit, representing an improvement against forecast and a material improvement compared with the mid-year position. Looking forward, CL went through 2026/27 position, noting a material adverse variance driven largely by the increased CIP requirement. It was recognised that delivery of the Surgery Division CIP remained high risk, with a need for continued focus on workforce controls, productivity and service redesign. FTPC emphasised the importance of strong clinical engagement to support delivery of sustainable change. Resolved: FTPC received the quarterly update for the Surgery Division.
26/27/13	Medicine Division NP presented the Medicine Division update highlighting the end of year position with a £3.2m deficit, which represented an improvement against forecast and a significant improvement compared with the mid-year position. FTPC acknowledged that this improvement had been driven by actions taken in the latter part of the year, including income recovery, improved financial grip and mitigating actions agreed through executive scrutiny. From an income and activity perspective, there was an under-performance against ERF during the year, driven by industrial action, equipment failures and case-mix changes. FTPC were advised that mitigating actions had been reflected in the 2026/27 plan, including increased capacity, productivity improvements and coding initiatives, with particular focus on targeted specialties. Resolved: FTPC received the quarterly update for the Medicine Division.
26/27/14	Community Division ES presented the Community Division update highlighting adverse variance for 2026/27. The increase is mainly driven by increased CIP requirement and the assumption that only a proportion of vacancy benefit achieved in 2025/26 would be recurrently deliverable going forward. FTPC acknowledged that the Division had benefited from significant vacancy savings in the prior year. An update was received on community pathways and demand management, including neurodevelopmental and community mental health services. Digital

	tools and pathway redesign were expected to support improved productivity within community services, including opportunities to increase throughput without proportionate increases in staffing. Resolved: FTPC received the quarterly update for the Community Division.
26/27/15	Digital Futures KW reported Alder Connect went live last week and feedback has been positively received. Resolved: Due to timescales it was agreed an update would be provided at the next meeting with a strategic forward look for the year highlighting priorities.
26/27/16	Board Assurance Framework Resolved: FTPC received and noted risks within the BAF.
26/27/17	Any Other Business No further business was discussed.
26/27/18	Review of the Meeting The Chair congratulated teams on reaching £7.2m Year End target.
	Date and Time of Next Meeting: Wednesday 3rd June at 3pm via Teams

BOARD OF DIRECTORS

Thursday, 4th June 2026

Paper Title:	Board Assurance Framework Report (April 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 April 2026	As detailed in the report

Level of assurance (as defined against the risk in InPhase)	☐ Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ Not Assured Evidence indicates poor effectiveness of controls
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Board Assurance Framework 2026/27

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives and delivery of Vision 2030.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

BAF Risk		Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people not having timely and safe access to elective, urgent and follow up care.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Increased waiting times for Specialist Mental Health community services.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust	People Committee
3.1	Failure to fully realise the Trust's Vision for the Alder Hey Campus	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	Finance, Transformation and Performance Committee
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	Finance, Transformation and Performance Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Growth and Opportunities Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 10th March 2026

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x1
1.2 AB	Children and young people not having have timely and safe access to elective, urgent and follow up care	FTPC / SQAC	5x3	3x3
1.3 RL	Building and infrastructure defects that could affect quality and provision of services	FTPC	4x4	2x3
1.4 LC	Increased waiting times for Specialist Mental Health community services.	FTPC / SQAC	3x5	3x3
STRATEGIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	4x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x4	2x3
2.3 MS	Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Alder Hey Campus	FTPC	3x2	2x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	FTPC	4x4	4x2
3.4 RL	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	FTPC	4x5	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	4x4	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Growth and Opportunities	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	FTPC	4x4	2x4

4. Summary of updates to end of April 2026:

- ***Inability to deliver safe and high-quality services (NA).***

BAF risk 1.1 has been reviewed and update in line with the changing external context. SQAC have reviewed the work plan for the year at the April meeting and will monitor progress against it.

- ***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.

April performance against 2026/27 targets:

- Acute (95% by September'26) - ED performance achieved 87.1%, against the new national paediatric target of 95%
- RTT (70.1% by March 2027) - 69.1% in month
- Pts >52 weeks (0 by March 2026) - Currently 201 with the majority under dentistry. This is a proposed metric by C&M Provider Collaborative.
- DM01 (97%) - Performance slightly reduced in April to 92.5%

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***

Risk remains elevated due to multiple unresolved asset and compliance issues impacting clinical resilience, statutory compliance and service continuity. Responses from Project Co remain outstanding despite formal notification.

- ***Increased waiting times for Specialist Mental Health community services. (LC).***

BAF risk reviewed. Risks remain the same and controls in place.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***

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 updated. Updates to actions relating to How We Work in the Future OD plan and Safety Culture development programme. No change to risk rating.

- ***Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust (MS).***

All actions and risks reviewed and on track.

- ***Failure to fully realise the Trust's Vision for the Alder Hey Campus (RL).***

Risk reviewed. no change to score. external works to NICU (blue light route) due to be handed over to Trust as a partial completion 15th May 2026 (TBC). This will enable final demolition of substation 1 construction of the ED car park and completion of the Park end of Summer 2026.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).***

The Transformation Programme, including HWWWITF, is moving from mobilisation into delivery as a core enabler of Vision 2030 and the Trust's Medium-Term Plan. The programme is expected to deliver significant workforce, productivity and financial benefits aligned to the Financial Improvement Programme (FIP).

There is a risk that the programme does not deliver the required benefits at the pace needed to support the Trust's financial and strategic objectives. This risk is heightened by the scale and complexity of the change, dependency on successful delivery of HWWWITF Phase 1 as the primary enabler for wider transformation, and the need to deliver transformation alongside ongoing operational pressures.

While early benefits are beginning to be realised in some areas, delivery maturity remains uneven across the portfolio, with several high-value programmes still in scoping or early delivery phases.

Mitigation

Mitigations are focused on strengthening delivery discipline, prioritisation and programme grip across the portfolio, including:

- Strengthened governance through the CEO-chaired Transformation Board, with increased focus on delivery, benefits, resources and timelines
- Narrowing focus to a smaller number of high-impact programmes and critical priorities
- Development of a clearer roadmap, milestone plan and gateway approach to improve sequencing and management of dependencies
- Use of a single integrated benefits framework through FIP to align activity, workforce and financial benefits and avoid duplication
- Regular delivery reviews and short-term planning cycles to strengthen oversight, accountability and escalation of risks
- Ongoing alignment of transformation resources and capacity to priority areas, with active reprioritisation where required

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***

No change to risk score of 20.

2026/27 plan agreed and plans in place to deliver but with significant emphasis on recurrent CIP delivery and whilst development of CIP plans is progressing the risk adjusted forecast remains below expected target. Weekly submission on CIP remain in place. Workshops have been held with senior leads and priority areas agreed to take forward along with executive sessions with each area.

Financial Governance manual reviewed and updated for new financial year with clear oversight and escalation framework.

- ***System working to deliver 2030 Strategy (DJ).***

Risk, control and actions reviewed and updated. No change to risk rating in month.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***

Risk score remains 9. Risk will need to be re-articulated in line with new Bring me the Future systems plans including approach to financial sustainability, comms and education/culture. Finance action now complete with balanced year end position across Futures.

- **Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).**

Risk reviewed remains at 16. EPR data centre work now complete with remaining data centre work scheduled now for June. Key items supported at Capital Prioritisation Group supporting the refresh of aging infrastructure (network and telephony).

Good progress being made via Digital, Data and AI Collab with Patient Portal now live with 40,000 families registered. AVT Roll out close to completion and data platform on track to complete in August. Realised benefits for 25/26 currently being collated.

Staff consultation now in progress and expected to complete in May. CIP target almost 100% complete and aiming for overachievement.

5. Corporate risks (15+) linked to BAF Risks (as at 6th May 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
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

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
522	Gi Physiology Service Unavailability and Fragility	3x5	Medicine	2.1	Jan 2026	Feb 2026
287	Radiology consultant on-call is at risk of failure	4x4	Medicine	2.1	May 2025	Sept 2025
534	Risk of transmission of waterborne pathogens in the healthcare environment	4x4	Corporate Services		Feb 2026	Feb 2026
293	Staffing in Biochemistry	4x4	Medicine	2.1	Dec 2024	May 2025
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
444	Then there is a risk the organisation will be unable to provide an effective and timely service for tertiary Neurology patients	4x4	Medicine	2.1	Apr 2023	June 2024
458	Disruption in patient's supply of medication and / or treatment	4x4	Community	2.1	Oct 2025	Oct 2025
464	Reduced Haematology consultant workforce	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
492	NICU go live delay	4x4	Corporate Services	3.1	Nov 2025	Nov 2025
288	CAMHS Planned Safeguarding Supervision	3x5	Community	2.1	Nov 2024	Nov 2024
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 (NEW)	4x4	Other – NW Neonatal ODN	3.4	Apr 2026	Apr 2026
543	Delays in timely recruitment (NEW)	4x4	Community	2.1	Mar 2026	Apr 2026
461	Breaching urgent or routine treatment targets in Sefton CAMHS (NEW)	3x5	Community	1.4	Oct 2025	Apr 2026
557	Contrast shortage - Radiology & Cath Lab (NEW)	5x3	Medicine		Apr 2026	Apr 2026
1.2 Children and young people not having timely and safe access to elective, urgent and follow up care (5x3=15)						
462	Children and young people will not receive their ASD assessment within the agreed timescale	4x4	Community	1.4	Jul 2021	*Apr 2023

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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 (NEW)	4x4	Community	2.1	Oct 2025	Apr 2026
461	Breaching urgent or routine treatment targets in Sefton CAMHS (NEW)	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
522	Gi Physiology Service Unavailability and Fragility	3x5	Medicine	1.1	Jan 2026	Feb 2026
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
444	Then there is a risk the organisation will be unable to provide an effective and timely service for tertiary Neurology patients	4x5	Medicine	1.1	Apr 2023	June 2024
287	Radiology consultant on-call is at risk of failure	4x4	Medicine	1.2	May 2025	Sept 2025
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
293	Staffing in Biochemistry	4x4	Medicine	1.2	Dec 2024	May 2025

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
520	Pharmacy Capacity	4x4	Medicine	1.2	Dec 2025	Dec 2025
480	Delayed initiation and review of ADHD medication (NEW)	4x4	Community	1.4	Oct 2025	Apr 2026
543	Delays in timely recruitment (NEW)	4x4	Community	1.1	Mar 2026	Apr 2026
545	Booking and Scheduling (Care Co-ordination Team) Staff Shortage (NEW)	4x4	Community		Apr 2026	Apr 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 (NEW)	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					

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
368	Digital infrastructure capacity and age	4x4	Corporate Services		May 2025	May 2025
556	Single point of failure on remote access solution (NEW)	5x3	Corporate Services		Apr 2026	Apr 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	Risk Rating		
Safe		Nathan Askew	Actual	Target	Assurance Committee
			9	4	Safety and Quality Assurance Committee

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards in the current challenging financial environment.

Control description	Control assurance (How is this control monitored?)
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
Administration of IV antibiotics within 1hr for CYP with suspected sepsis	Monitored monthly through SQAC
Brilliant Basics	Formal and informal training and coaching available to support departments to make positive changes. Reported to board bi-annually including update against NHS Impact Self-Assessment.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Internal: Patient safety meeting actions monitored through SQAC External: Care Quality Commission (CQC), MIAA
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board
Programme of quality assurance rounds, ward and departmental accreditation is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC. Triangulation of data through Aggregated Analysis Reports to SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I)	Annual QIA assurance report and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAs
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. External: Care Quality Commission, MIAA, NHS Improvement
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
The Trust has a Patient Experience Group that reports against the workplan derived from the Patient Experience Strategy based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. Chairs report to SQAC.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.

Gaps in Controls / Assurance
1. Robust reduction programme in the number of medication incidents and near misses 2. The 2030 vision sees a shift towards an experience led organisation without additional resources for delivery of the plan 3. Increased oversight relating to financial pressures is resulting in inability to deliver 2030 Strategy, with the high level of CIP potentially impacting the ability to keep services safe 4. Triangulation of data in relation to inequalities 5. Lack of systematic collection of outcomes data 6. Safeguarding supervision

Action	Description	May 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
☒ 1. Medication Errors and Near Misses	1. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2027	Dashboard in place with insight into the causes of medication errors and a proactive reduction plan monitored through Patient Safety board.
☒ 2. Patient Experience	2. Experience Strategy Group established to evaluate resource required. SQAC will have oversight of ambition and achievements of the Group	31/03/2027	PEG continues to report into SQAC
☒ 3. Financial pressures – potential impact	3. Monitoring via FIP decision docs and EQIAs.	31/03/2027	no further controls required, monitoring controls are in place. RMF taken on responsibility for review of FIP decisions

Children and young people not having timely and safe access to elective, urgent and follow up care.				
Risk Number			Strategic Objectives	
1.2			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
Effective		Adam Bateman	Actual	Target
			15	4
Assurance Committee				
- 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	May 2026	
		Due Date	Action Update
☒ Recruit a Locum Consultant in ENT	The executive board have approved a paper which allows the department to recruit a Locum Consultant	31/10/2025	The department have a locum consultant post advertised and at least one interested candidate. However one of the locum consultants who is currently working for the department has resigned therefore the department may recruit however it may not lead to an increase in capacity
☒ 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		
Safe		Rachel Lea	Actual	Target	Assurance Committee
			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	May 2026	
		Due Date	Action Update
☒ Appropriate Legal Advice	Continue to seek appropriate legal, commercial and technical advice	31/05/2026	Immediate requirement for formal responses and time-bound plans from Project Co. - formal notification issued to Project Co covering all matters. Maintain enhanced monitoring and interim mitigations. Progress legal position on defects.
☒ 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	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.
☒ Chillers	Persistent performance issues with no confirmed delivery programme for full reinstatement.	31/03/2027	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	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. 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	Risk Rating		
- Caring - Effective - Responsive - Safe - Well-Led		Lisa Cooper	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	May 2026	
		Due Date	Action Update
☒ Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	30/05/2026	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
☒ 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	30/05/2026	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	30/05/2026	work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025
☒ 78+ week waits	To review CYP reported as 78+ weeks without a ROM - to ensure all CYP have ROM attached	31/05/2026	
☒ MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	30/06/2026	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

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.					
Risk Number			Strategic Objectives		
2.1			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Safe - Well-Led		Melissa Swindell	Actual	Target	Assurance Committee
			16	4	People 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 portal enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
Monthly monitoring through Ops Board, Board, Execs and People Committee	Regular reporting of delivery against compliance targets via divisional reports
Nurse Retention Lead	Bi-monthly reports to PC
Nursing Workforce Report	Reports to People Committee, SQAC and Board
PDR and appraisal process in place	Monthly reporting to Board and PC
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
People Policies	All Trust Policies available for staff to access on intranet
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Workforce Efficiencies Programme	Monitored at 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	May 2026	
		Due Date	Action Update
☐ 2. Sickness absence levels higher than Trust Target	A detailed review of sickness absence has been undertaken and presented to people committee and Executives, and the next action is to implement a 90-day attendance Improvement Programme, based on the principles of the improvement project undertaken at East Cheshire NHS Trust, through appreciative inquiry. In addition 2 members of the HR team have been repurposed solely to support the management of sickness absence.	31/03/2026	The 90-day improvement programme has concluded. The outputs of appreciative inquiry through the programme have provided the sickness team with enhanced feedback, thus ensuring that the targeted interventions remain appropriate.
☒ 1. Training and Development	1. The development hub is reaching the final stages of development and will be launched April / May 2026. TNA's continue to be undertaken and reviewed as BAU.	31/05/2026	Professional hub is ready to launch pending reporting to people committee prior to launch taking place.
☒ 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	
☒ 4. Consistency of inclusive practices.	4. A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2027	EDI Plan is monitored at both People Committee and EDI Steering group and is progressing against plan.
☒ 5. The national and regional requirements to reduce NHS financial deficit, which is directly impact	5. Monitored through Financial Improvement Programme	31/03/2027	The WTE continues to be closely monitored and reported to both FTP Committee and People Committee. Target Operating Model, will also address the Trust workforce plan and consultation on wave one is close to completion. Trust Voluntary Redundancy Scheme has just been launched and will close April 2026.

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families					
Risk Number			Strategic Objectives		
2.2			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Caring - Safe - Well-Led		Melissa Swindell	Actual	Target	Assurance Committee
			12	4	People 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	May 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. 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.	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
☒ Culture data insights and intelligence		30/06/2026	Staff survey team level data analysed according to Thriving categories and shared with execs and divisional leads. Data being used to scope interventions in challenges areas in discussion with wider Thriving Teams MDT. Data will also be used to inform targeted support plan for teams and leaders during the organisational restructure.
☒ 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.
☒ 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.	30/07/2026	SALS data and themes and data from OD coaching contacts being shared via HWWWIF programme to support effective communications and targeted support during organisational restructure.
☒ Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	31/07/2026	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 identified 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 and enable effective merging of services and teams and support transition to new empowered clinical leadership model for the organisation.	30/09/2026	Provisional dates set for Induction sessions for new system leaders to help to orient themselves to the new structures and systems, enable them to reflect on the impact on them of the changes, and support them and build capability in leading others through change and developing high performing teams. Plan is for 3 half day workshops followed by a year long programme for them (and other leaders in each system) to become Thriving Leaders. First induction session planned for 9th June 2026
☒ 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.

Failure to successfully embed workforce Equity, Diversity & Inclusion practices across Alder Hey Children's NHS Foundation Trust					
Risk Number			Strategic Objectives		
2.3			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
- Effective - Well-Led		Melissa Swindell	Actual	Target	Assurance Committee
			12	4	People 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	May 2026	
		Due Date	Action Update
☒ 6. Lack of systematic reporting on demographic data for the communities we serve	6. need to agree and develop	01/04/2026	
☒ 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	06/04/2026	Mutual Mentoring Programme is progressing well. The LCR Leadership Shadowing Programme has now ended and Alder Hey will continue to work in partnership with LCR to identify any further opportunities. The 'Grow to Lead' international staff development programme is due to launch in April 2026 with expression of interest to go out to staff Feb 2026. Mutual Mentoring programme launched. Alder Hey part of the LCR Leadership Shadowing programme. Development of Grow to Lead Leadership Programme targeted at International recruited staff, including sponsors to support candidates. Closer monitoring of uptake of CPD uptake
☒ 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.
☒ 5. Sufficient EDI resources to support the EDI agenda		30/09/2026	
		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
☒ 4. Limited organisational awareness, training, and governance around legal duties	4. Launch EDI training programme. Training needs to be assessed to identify learning needs. Inclusive recruitment and selection training to be developed and launched which includes EDI. Neurodiversity training to be delivered to specific clinical areas.		
☒ 1. Recruitment practices do not target diverse communities	1. Launch Recruitment and Selection training incorporating EDI throughout. Revise Recruitment and Selection Toolkit which includes support and guidance on inclusive recruitment practices. Review of recruitment materials to ensure inclusivity. Target recruitment campaigns in under represented community groups working in collaboration with Liverpool City Region Race Equality Hub	31/03/2027	Recruitment practices have been reviewed and resources developed to support candidates and also recruiting managers. Inclusive recruitment training has been launched. Accessible and Inclusive Recruitment Practices working group established. Recruitment and Selection training incorporating EDI throughout now launched.

Failure to fully realise the Trust's Vision for the Alder Hey Campus				
Risk Number			Strategic Objectives	
3.1			Collaborate for children & young people	
CQC Domains	Linked Risks	Owner	Risk Rating	
- Effective - Safe		Rachel Lea	Actual	Target
			6	4
			Assurance Committee	
			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 FTFC and reported through this mechanism with clear risk and escalation where required. - Stakeholder events / reported to Trust Board and CoG - Weekly tracking through Senior Development Team Meetings
Strategic Estates and Space Allocation Group to approve changes to the campus to ensure alignment to vision	- Monthly meetings chaired by exec lead and supported by DD

Gaps in Controls / Assurance
CAMPUS: 1. Affordability 2. Stakeholder Engagement

Action	Description	May 2026	
		Due Date	Action Update
☒ CAMPUS 1: Stakeholder Engagement	Engage with LCC, Friends of Springfield Park and community stakeholders and issue regular Comms	31/12/2026	Action 90% complete and business as usual until full handover of the Park to LCC by December 2026
☒ PARK 1: Adoption of the SWALE by United Utilities	Engage with planning consultants to assist with planning requirements.	31/07/2027	Overflow to the new drain - linked with developer site - due for completion July 2026. 12 month monitoring period then required to July 2027

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment				
Risk Number			Strategic Objectives	
3.2			Collaborate for children & young people	
CQC Domains	Linked Risks	Owner	Risk Rating	
Well-Led		Kate Warriner	Actual	Target
			16	4
Assurance Committee				
Finance Transformation & Performance Committee				

Description
Risk of failure to continue to deliver the ambitions of Vision 2030 given multiple competing demands of the system coupled with variable capacity, balancing financial savings with longer term transformation

Control description	Control assurance (How is this control monitored?)
Board Governance	Reports to Board and FTPC
Executive Portfolios all incorporate elements of Vision 2030 delivery	Reports to People Committee, SQAC and GO in accordance with programme remit
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.

Action	Description	May 2026	
		Due Date	Action Update
☒ 1. Developing skills and capacity to deliver the Strategy 2030	The approval of the People Plan by the Trust Board marks a significant milestone in ensuring we understand the skills and capabilities needed for our Future Workforce (2030). The upcoming phase in our strategic plan, Shape of Alder Hey 2030, will further allow us to assess the broader skills and capabilities our workforce will require to meet future needs.	31/03/2026	The development of the How we will work in the future - is a significant decision and will ensure that the organisations skills and structures - support the delivery of Vision 2030. Development of our Strategic Blueprints has allowed us to identify the future skills and capabilities required to support successful delivery of Vision 2030
☒ 2. Failure to deprioritise to enable requisite focus on areas of need and transformational change	Focus on transformational change	31/03/2026	Draft of new Strategic Programme 2026-2030 has been developed and is going through further iterations
☒ 3. Risk of mission creep associated to the Strategy	Sharp focus at Strategy Board on core mission	31/03/2026	Continue to manage as a responsibility of the Transformation Board. Continue to manage as a duty of the Portfolio Board

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments.				
Risk Number		Strategic Objectives		
3,4		Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating	
- Effective - Responsive - Safe - Well-Led		Rachel Lea	Actual	Target
			20	4
Assurance Committee				
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	May 2026	
		Due Date	Action Update
☒ Devolved specialist commissioning	Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk Financial analysis to be undertaken on impact of revision to allocations Regular exec to exec meetings with specialized commissioning	31/03/2026	Regular reporting to strategic execs and assurance to FTP and Trust Board Regular exec to exec meetings with specialized commissioning continues
☒ High risk recurrent Efficiency programme	Transformation programme to be established reporting into the portfolio board and weekly execs. New reporting dashboards to be put in place reporting weekly to execs and into FTPC showing the latest CIP position with focus on recurrent schemes.	31/03/2026	Transformation programme now in place with weekly check ins on collaboratives reporting into the portfolio board and weekly execs.
☒ 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.
☒ 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	Risk Rating	
Well-Led		Danielle Jones	Actual	Target
			16	4
Assurance Committee				
- 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). May 26 Update: Awaiting response from RMCH on the updated MOU. A recent MIAA audit has formally recommended a refresh of the MOU and subsequent re-meet between the organisations in order to fulfill the required governance of the gender development service. This work is being prioritised.
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. May 26 Update: Control is unchanged - remain hosts of the Beyond programme.
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy. May 26 Update: position is unchanged from April.
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 May 26 Update: A new BMTF SLT will support the development / co-design highlighting what capacity and capability will be needed.
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. May 26 Update: No further updates on the delegation agenda.
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings. May 26 Update: No significant update to report this month.
Growth and Opportunities Committee oversight of growth element of Vision 2030.	March 26 Update: The GO Committee met last week and had a positive and productive meeting focused on robotic surgery and global observerships. The committee is developing well and its role in the growth element of Vision 2030 is embedding. May 26 Update: The committee met again 30th April and the meeting brought together colleagues from across the BMTF system to progress this agenda.
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board May 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 May 26 Update: Partnership governance is still under review and will need to connect into the 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 May 26 Update: Partnership working continues, no significant updates this month.
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 May 26 Update: relationships are consistently maintained.
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	Membership of CMPC provider collaboratives. May 26 Update: Control is unchanged - membership remains in place.
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES Partnership Plans developing with CYP focus. May 26 Update: The Strategy Team are working closely with the Mental Health and Community Division on ensuring we have the right representation at Place meetings and forums, and an approach has been agreed to ensure we maintain relationships.

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	May 2026	
		Due Date	Action Update
☒ 1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2026	Still awaiting clarity from Commissioners (March 26)
☒ 3. CYP System and Partners	3. NHS England's Medium Term Planning guidance has clarified the NHS Operating Model including a re-set of the foundations in which to transform care and deliver on the 3 shifts of the 10 Year Health Plan. This will need to done in collaboration / partnership across the CYP system.	31/03/2026	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)	31/03/2026	No further update for March 26
☒ 2. Impact of delegation of Specialist Commissioned services into ICBs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2027	Awaiting further clarity on delegation in March 26

Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.				
Risk Number			Strategic Objectives	
4.1			Pioneering Breakthroughs	
CQC Domains	Linked Risks	Owner	Risk Rating	
• Caring • Effective • Safe • Well-Led		John Chester	Actual	Assurance Committee
			9	Growth and Opportunities Committee
			4	
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	May 2026	
		Due Date	Action Update
☒ 5. Comms Strategy for Futures	Development of Futures comms approach	30/09/2025	This work will be superceded by new comms planning linked to the new system structure - transfer of Futures comms resource to comms team is underway.
☒ 4. Capacity and capability	Create an R&I enabled workforce through the Futures Develop Pillar	31/03/2026	This work will need to be transferred to the new BMTF SLT and a re-articulated risk - BMTF SLT proposal currently under review.

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families

Risk Number			Strategic Objectives		
4.2			Revolutionise Care		
CQC Domains	Linked Risks	Owner	Risk Rating		
Effective Safe		Kate Warriner	Actual	Target	Assurance Committee
			16	4	Finance Transformation & Performance Committee

Description
Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Control description	Control assurance (How is this control monitored?)
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence tracking delivery
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
Digital 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	May 2026	
		Due Date	Action Update
☒ Review of Benefits from Digital, Data and AI Collab and produce report.	Produce a report on realised benefits. Links to Transformation at Pace gap in control	29/05/2026	Benefit report drafted and under review. Good progress made on Digital, Data and AI Collab.
☒ 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	First Cyber Reporting group chaired by NED took place in April and will meet quarterly. Wider improvement plan is progressing well.
☒ Experienced Resources - Complete Target Operating Model	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce. This will now be completed through the Target Operating Model workstream. Links to experience resource gap in control.	30/06/2026	Digital Organisational change is due to complete in May and deliver its anticipated savings. It is hoped that the service can then recruit into key roles where there are currently gaps.
> ☒ Digital systems review	Digital systems review	30/10/2026	EMIS Data migration is in planning. Currently aiming for end of August to transition all staff over from EMIS to Meditech.
☒ 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	EPR Data centre complete. Core data centre delayed due to supplier issues. Now aiming to complete in June and working with supplier on penalties. Network refresh tender is currently underway and telephony will commence following this but both items were supported at capital prioritisation group.