

BOARD OF DIRECTORS EXTRAORDINARY PUBLIC MEETING

Tuesday 23rd June 2026, commencing at 15:00

via Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	26/27/103	15:00 (2 min)	Apologies.	Chair	To note apologies.	N	For noting
2.	26/27/104	15:02 (3 min)	Declarations of Interest.	All	Board members to declare an interest in particular agenda items, if appropriate.	R	For noting
Year End Closure for 2024/25							
3.	26/27/105	15:05 (20 mins)	Draft Annual Report and Accounts for 2025/26; including: - External Audit Year-end Report, 2025/26 – 'ISA260'. - Letter of Representations.	E. Saunders/ R. Lea/ K Byrne E&Y E&Y	To approve the Trust's draft Annual Report and Accounts for 2025/6. To receive the External Audit year-end report for 2025/26 and the letter of representations.	R/D	Read report (<i>Publication date: September 2026</i>) Read report/ Appendix (<i>Publication date: September 2026</i>)
4.	26/27/106	15:25 (25 mins)	Committee Annual Reports 2025/26: - Audit and Risk Committee. - Finance, Transformation and Performance Committee. - Safety and Quality Assurance Committee.	K. Byrne J. Kelly F. Beveridge	To receive the 2025/26 annual reports of the Assurance Committees that report into the Trust Board.	A	Read reports

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- People Committee. - Growth and Opportunities Committee.	J. Revill M. Jennings			
5.	26/27/107	15:50 (5 mins)	Board Self-Certification of Compliance with the Provider Licence.	E. Saunders	To approve the proposed confirmation of compliance with condition CoS7: Availability of Resources in the Provider Licence.	R/D	Read report
Items for information							
6.	26/27/108	15:55 (4 mins)	Any Other Business.	All	To discuss any further business before the close of the meeting.	N	Verbal
7.	26/27/109	15:59 (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
Date and Time of Next Meeting: Thursday, 2 nd July 2025, Lecture Theatre 1, Institute in the Park.							

BOARD OF DIRECTORS
Tuesday, 23rd June 2026

Paper Title:	2025/26 Committee Annual Reports
Report of:	Committee Chairs
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☐ Regulation ☒
Action/Decision Required:	To note ☐ To approve ☒
Summary/ supporting information:	The Board is asked to approve the Committee Annual Reports detailing assurances in respect of compliance against individual Terms of Reference for 2025/26.
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 Impact:	None identified

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
---	---	--	--



Audit & Risk Committee Annual Report 2025/26

The Audit and Risk Committee

The Audit & Risk Committee ("ARC" or "Committee") has primary responsibility for reviewing the effectiveness of the framework for the identification and management of risks and associated controls, corporate governance and assurance frameworks. The Committee also provides a form of independent check upon the executive arm of the Board.

In addition, the Committee provides the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Statement of Internal Control.

The conduct of this remit is achieved firstly through the Committee being appropriately constituted, and secondly by being effective in ensuring internal accountability and the delivery of audit, risk, anti-fraud measures, management, governance and assurance services.

This report outlines how the Committee has complied with the duties delegated by the Board through its Terms of Reference, developments it has undertaken throughout the year, key assurances that it can provide to the Board and proposed developments for 2026/27.

Constitution

The Committee comprises three Non-Executive Directors, including a Chair with recent and relevant financial experience. Regular attendees include the Chief Financial Officer, Chief Corporate Affairs Officer, Deputy Director of Finance, Associate Director of Nursing & Governance, and Chief Operating Officer. Internal Audit and External Audit attend all meetings whilst the Anti-Fraud Service attends three meetings a year.

The Committee met six times during the year, in line with its annual Work Plan. A dedicated meeting was held to review the External Auditor's report and statutory accounts.

The Committee continues to operate effectively, demonstrating robust attendance, appropriate quoracy and constructive challenge. Private meetings were held with Internal Audit, External Audit, the Anti-Fraud Service and the Associate Director of Nursing & Governance.

The Committee has an annual Work Plan with meetings timed to consider and act on specific issues within its Terms of Reference. Six meetings were held during the year. One, in June was devoted to consideration of the External Auditors report on the Annual Accounts and ISA 260.

The Committee Chair presents a Chairs Highlight Report to the Board following each ARC meeting highlighting the documents received at the meeting, key risks and positive areas discussed and any matters to escalate to the Board or other Committee. Final minutes are also submitted to Board once approved.

In discharging its duties, the Committee meets its responsibilities through requesting assurances from internal and external sources and from Trust Officers and by directing and receiving reports in that regard. The Committee also undertakes a self-assessment of its own performance annually and identifies any actions required.

The Committee has discharged its responsibilities through structured oversight of five areas:

1. Risk Management and Assurance Framework

The Committee receives the following reports to each of its meetings¹ (all of which have previously been to the Risk Management Forum (RMF) (the executive risk meeting which undertakes the detailed review of risk across the Trust, reporting into ARC):

- Board Assurance Framework (BAF). The BAF is reviewed with updates provided on all risks provided by the Executive and overarching commentary from each Executive Risk Owner. ARC reviews the BAF to assess compliance with the Trust's Risk Management Framework. Responsibility for oversight of individual risks remains with the Board or the relevant Assurance Committee. Throughout the year a deep dive review of each risk is performed looking at adherence to Risk Appetite, appropriateness and consistency of score, whether controls and assurances are demonstrable, whether there are sufficient and time-realistic actions and if the information appears generally up to date. Where ARC identifies any concerns these are referred to the appropriate Executive Risk Owner or Assurance Committee for further investigation.
- A report from the RMF which provides:
 - a report on the Corporate Risk Register (CRR) outlining the current risk themes, actions taken and any barriers to their mitigation. The report also includes an analysis of the CRR, highlighting new risks, those with changed risk scores or that are longstanding, and actions taken. This year ARC requested that the risks are analysed between those within the Trusts control (enabling a review of the adequacy and timeliness of proposed actions) and those not wholly within the Trusts control due to, for example, reliance on third parties, national skills shortages or funding restrictions (enabling a review of longer-term actions to address the risks).
 - a summary of the "deep dives" that the RMF has undertaken in key risk areas. In 2025/26 these have covered insufficient capital funding, missing case notes incident, cyber security, high risks within the Divisions of Community & Mental Health and Medicine, digital infrastructure and servers, management of adoption records and a meeting dedicated to take stock of the impact of financial decisions made during the year through the Trusts Financial Improvement Programme.
 - the minutes from prior RMF meetings.
- Analysis of the Trust Risk Register providing a high-level overview and trends of all Trust risks covering the number and proportion of risks by score, those with static scores and longstanding risks, those overdue review and risks without action plans or with overdue actions. The risks are also analysed by severity and by Division or Corporate Service, enabling the Committee to assess the overall effectiveness of risk management across the Trust.

Other key oversight provided:

- Across the year, each of the Divisions and the Corporate Services Collaborative (on behalf of Corporate Services) presented to the Committee on their risk management processes. This enhances the Committee's understanding of operational risk management practices.

¹ Except June meeting which focuses on the Trusts Annual Report & Accounts

- ARC maintained oversight of implementation of the Trusts Risk Appetite. A pilot in the Community and Mental Health Division tested its practical application by aligning Divisional risks with agreed Risk Tolerances to support more consistent risk assessment, decision-making and escalation. Learning from the pilot will inform the wider organisational roll-out. The Board completed its annual review of Risk Appetite in May 2026, and implementation will continue in 2026/27.
- Reviewed the Fraud Risk Assessment Matrix, confirming that risks are appropriately identified, scored and mitigated.
- Maintained oversight of InPhase system development, noting strong progress in core functionality but continued work to achieve full data triangulation. Ongoing implementation of InPhase modules has now transferred into business as usual (BAU).
- Risk horizon scanning is undertaken by Committee to think about emerging and evolving risks and how they may impact the Trust. The outcomes of this discussion are provided to the Executive.
- Following identification of the removal of risk management e-learning from mandatory training requirements, the Committee considered a Risk Management Training Options paper which proposed a proportionate, Trust-wide approach to strengthening risk management capability. A blended model, combining e-learning with facilitated sessions, was supported to enhance staff awareness and understanding of risk processes, with training targeted according to role ensuring a consistent and practical framework for embedding risk management across the organisation.

The RMF presented its Annual Report on Risk Management for 2025/26 to the April 2026 ARC meeting. Chaired by the Chief Corporate Affairs Officer, RMF brings together Divisional Directors and senior clinical and operational managers plus corporate colleagues. The Report provided assurance that there are robust and embedded risk management systems, supported by effective oversight through the RMF and regular review of the BAF and risk registers. Strong progress has been made in improving the management of long-standing risks and strengthening risk culture through training and enhanced scrutiny.

In presenting its Annual Report, the following assurance statements were provided by the RMF:

The Risk Management Forum Annual Report 2025/26 confirms that risk management remains a key organisational priority, with robust, systematic processes in place to identify, monitor and escalate risk, and provides assurance that the RMF is operating effectively and is fit for purpose in supporting Board oversight.

Each year Internal Audit undertake an audit of the Assurance Framework. This year this provided Substantial Assurance, demonstrating that core risk management controls are well designed and operating effectively, with ongoing work to further develop system capability, embed risk appetite and align operational risks with strategic priorities. As a result of the audit the following statements were provided by Internal Audit in their Head of Internal Audit Opinion and Annual Report:

Structure	The Trust's Assurance Framework is structured to meet the NHS requirements of assurance best practice model.
Risk Appetite	The Trust considers Risk Appetite regularly and the Risk Appetite is used to inform management of the Assurance Framework.
Engagement	The Assurance Framework is visibly used by the Trust.
Quality & Alignment	The Assurance Framework clearly reflects the risks discussed by Board.

Oversight of each of the BAF risks is performed by Board or one of its Assurance Committees. They review their risks at each meeting and undertake deep dives on individual risks throughout the year. Assurance Committee Annual Reports are presented to ARC before onward presentation to Board. Each Annual Report included a section on the oversight of the BAF risks within their remit describing

the deep dives they have undertaken and the reports they have received that support oversight of the risks. All the Assurance Committees provided the following assurance within their report:

"Based on the processes for overseeing <the BAF risks for which it provides oversight> <Assurance Committee name> can confirm that management are effectively managing these risks and are taking timely steps to reduce their risk score."

2. Internal Audit

The internal audit service is provided by Mersey Internal Audit Agency (MIAA) in line with Global Internal Audit Standards (UK Public Sector).

Internal Audit provides an independent and objective opinion to the Accountable Officer, the Board and ARC on the overall adequacy and effectiveness of risk management, internal control and governance. From time to time, and as directed by the Committee, they also provide an independent and objective advisory service to help management improve a particular operational area.

ARC approved and monitored delivery of the Internal Audit Plan for 2025/26. The Plan is structured to enable the Head of Internal Audit to provide an Annual Opinion which includes an assessment of the:

- Design and operation of the underpinning Assurance Framework, risk management systems and supporting processes.
- Range of individual assurances from risk-based internal audits taking account of the relative materiality of the systems reviewed and management's progress in addressing weaknesses identified.
- Trust's response to internal audit recommendations, and the extent to which they have been implemented.

Throughout the year, Internal Audit provide a summary of the internal audit reports issued and management's response to address findings. For any reports that are assessed as "Limited" or "No" Assurance a senior representative from the audit area is invited to the Committee meeting to present their detailed action plan to address the findings. This year, the audit of Theatres Management Systems received Limited Assurance. The Division of Surgery will be invited to present to the June 2026 meeting to provide assurance as to the delivery of the agreed actions. Audits undertaken in 2025/26 are shown in Appendix A.

The Internal Auditors also undertake a quarterly exercise to assess the implementation of agreed actions from internal audit reports that have passed their implementation deadline. During the year ARC remained focussed on progress against overdue actions to encourage the timely closure of any gaps in the control environment. The implementation status of 40 agreed actions were assessed and the status confirmed to be:

	Number	%
Implemented	23	58
Partly Implemented	17	42
Total	40	100

Committee approval is required to extend the implementation deadline of actions if the original agreed deadline has not been met.

Within the Head of Internal Audit Opinion and Annual Report, Internal Audit reported that:

During the course of the year...we can conclude that the Trust has made **reasonable progress** with the implementation of recommendations.

The following reports were received from Internal Audit during 2025/26:

- Internal Audit Plan for 2025/26 (Approved).
- Progress on Delivery of the Internal Audit Plan 2025/26.
- Results of Internal Audit Client Satisfaction Questionnaires.
- Follow Up of Previously Agreed Recommendations.
- Head of Internal Audit Opinion and Annual Report for 2025/26.
- Internal Audit Charter (Approved).
- Draft Internal Audit Plan for 2026/27.

The key conclusion of Internal Audit's work for 2025/26 as provided in the Head of Internal Audit Opinion and Annual Report was that:

"Substantial Assurance" was given that there is a good system of internal control designed to meet the Trust's objectives, and that controls are generally being applied consistently.

For a fuller description of the Opinion, including its context, refer to the Head of Internal Audit Opinion and Annual Report

3. External Audit and Financial Governance

External audit services are provided by Ernst & Young (EY). The following reports were received from External Audit relating to 2025/26:

- External Audit Planning Report.
- External Audit Project Plan.
- Auditors Annual Report.
- ISA260 "Audit Results Report".

The Committee reviewed key documents from the Finance Team in support of the production of the Annual Report and Accounts:

- Annual Report and Accounts 2025/26.
- Going Concern Statement laying out why it is appropriate to prepare the Trust's Accounts on a going concern basis.
- Accounting Issues Update (proactive flagging of areas that might require Committee attention due to e.g. change of accounting standards or Trust accounting approach or unusual, complex or one-off transactions).

As part of the external audit process EY requires the Trust to provide a number of representations relating to the accounting and reporting processes ("Letter of Representation") and provision of specific information in relation to oversight and management of risk relating to the financial statements (Letter "Understanding how the Audit Committee gains assurance from management"). The ARC Chair and/or Chief Financial Officer sign these documents on behalf of the Trust before the accounts are finalised.

An unqualified opinion on the Accounts for 2025/26 was provided to the Board in June 2026.

Financial Governance

The following reports were presented by the Finance Team to provide assurance on financial control matters:

- Waiver (of quotation and tender requirements as laid down in Standing Financial Instructions) Activity.

- Key findings from External Audit data analysis.

Following identification of an issue in relation to the Trusts Lease Car Control Account, whereby a balance had built up over multiple years due to a weakness in controls resulting in Receivables being overstated by £1.5m, a paper was presented to provide assurance that procedures relating to control accounts had been reviewed, and mitigations identified to prevent further issues including additional training and review. The Committee then commissioned an internal audit to look at the Balance Sheet Control Accounts processes which resulted in a number of further actions and Moderate Assurance.

4. Counter Fraud

The Counter Fraud Service (CFS) is provided by MIAA. The aim of counter fraud work is to support improved NHS services and to ensure through awareness raising and local proactive work that fraud within the NHS is clearly seen as being unacceptable. Work undertaken is a mixture of proactive (such as fraud awareness communications, provision of fraud alerts and bulletins) and reactive (such as reviews of potential frauds, focussed fraud exercises such as National Fraud Initiative data matching and procurement fraud prevention). During the year the Failure to Prevent Fraud Offence (FTPFO) was implemented. The CFS undertook a number of awareness raising sessions in this regard and updated fraud related policies to reflect the new requirements.

A risk-based Counter Fraud Annual Plan was delivered throughout the year, supported by regular reporting to the Committee and close oversight by the Chief Financial Officer. Fraud referrals and investigations were managed appropriately, with all referrals reviewed and progressed to investigations where required. A proven fraud related to a manager signing off NHSP shifts for staff who had not completed a full shift resulting in termination of the manager's employment. Governance arrangements for fraud reporting, investigation and recording were robust, supported by use of the national CLUE system and regular monitoring of outcomes. The Committee was therefore assured of a strong and proactive counter-fraud framework, with continued focus on risk assessment, prevention and organisational awareness.

The Counter Fraud Annual Report provided assurance that there are effective counter fraud, bribery and corruption arrangements that are operating in line with national standards.

The Trust achieved an overall 'Green' rating against the Government Functional Standard 013 for Counter Fraud, reflecting a strong and embedded control environment. One element (relating to Fraud Risk Assessment) was assessed as Amber, reflecting the need to update the assessment in response to the FTPFO and methodology changes; actions are in place to strengthen this area during 2026/27.

5. Clinical Audit

ARC is responsible for the oversight of Clinical Audit but detailed oversight is undertaken by the Safety & Quality Assurance Committee (SQAC) on its behalf via the SQAC Terms of Reference. Clinical Audit plays a vital role in helping improve the quality of clinical pathways and patient outcomes. The Clinical Audit Plan includes Nationally Mandated Audits, Confidential Enquiries, Service Improvement Programmes, Surveillance Programmes and Trust Priority Audits which are aligned to strategic objectives, quality priorities and areas of concern. Delivery of Divisional Clinical Audits is overseen by the Clinical Outcomes & Effectiveness Board (CEOB) with high-level delivery statistics reported to SQAC and ARC.

Overall, the Committee was partially assured of the effectiveness of Clinical Audit processes, recognising an effective and active CEOB providing operational oversight of delivery of the audits, effective reporting to SQAC but with further work required to assure implementation of agreed actions.

The Trust Clinical Audit Activity (for Nationally Mandated and Trust Priority Audits) has been delivered in line with accepted practice.

An Internal Audit of Clinical Audit Processes provided Moderate Assurance with improvements recommended for monitoring and scrutiny of the implementation of agreed actions, ensuring final reports and action plans are captured on the Clinical Audit Database and regarding a cancellation process for registered audits.

6. Receipt of management assurance on Data Quality, Programme Management and Legislative / Regulatory Compliance

Data Quality

The Committee received the Data Quality Annual Assurance Report, which provided management assurance that there are robust data quality governance arrangements which are operating effectively across the Trust.

Key data quality metrics reported in the Annual Report include:

- Data Quality Maturity Index (DQMI) – this offers a rounded assessment of data quality through several data sets. In December 2025 the Trust received a score of 90.3, exceeding the national average of 70.3, and maintained high quality and validity across Admitted Patient Care and Outpatient datasets. The Trusts DQMI score is in line with peers.
- Mental Health Services Data Set (MHSDS) – this is a patient level, output-based data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with mental health services. The Trust received a score of 86.7% compared to the 64.8% national score for NHS Trusts.
- Clinical Coding – Meeting the target of 90% for clinical coding in Secondary Diagnosis and Primary and Secondary Procedure, but recognising that a 5-percentage point improvement is needed for Primary Diagnosis to achieve target.

Effective governance is supported through the Data Quality Steering Group (reporting into the Digital Centre of Excellence and onto Finance, Transformation and Performance Committee (FTPC)) alongside the development of internal dashboards to proactively identify and address data quality issues. A risk (scored 15) relating to inappropriate sharing of demographics is being actively managed and targeted improvement work is underway in key areas including clinical coding accuracy and the reduction of “not stated” ethnicity data (currently around 20% of patient records) to support health inequalities analysis. Progress has been made in developing infrastructure and processes, including a new data platform for MHSDS and improved reporting tools, with a comprehensive forward plan to further enhance data quality, system integration and performance reporting. The Committee was therefore reassured of a strong and continually improving data quality framework supporting reliable decision-making and regulatory compliance.

Programme Management

The Committee received the Project Management Assurance Annual Report from the Delivery Management Office (DMO), which provided partial management assurance that programme and project governance arrangements are established and continuing to mature in support of delivery of the Trust’s Vision 2030 Strategy.

During 2025/26, the DMO further strengthened its approach to assurance of programme governance, including the introduction of:

- Assurance Ratings based on defined standards covering scope, benefits, planning, risk management and stakeholder engagement.
- Confidence Ratings relating to key elements of the programmes covering maturity level, and confidence in delivery of finances, business case readiness, benefit plan, resource plan and delivery plan, with an overall % Confidence provided for each programme.

Assurance and Confidence Ratings are applied using documented evidence and reported regularly through transformation governance structures, enabling effective escalation of risks and issues.

While progress in programme delivery is evident, the partial assurance reflects ongoing development of control maturity, with further focus required on strengthening governance consistency, financial planning, benefits realisation and programme documentation. A framework and forward plan are in place for 2026/27 to embed these improvements and enhance assurance across the transformation portfolio.

Freedom of Information Act (FoIA) Compliance

The Committee received the FoIA Assurance Report, which provided management assurance that there are appropriate systems to support compliance with FoIA legislation and promote openness and transparency. During 2025/26, the Trust received 646 requests (to end February 2026) and achieved 84.53% compliance with statutory response times, below the internal 95% target, with delays primarily attributable to management response times, executive approval of responses and increasing complexity of requests. There were no reported FOIA-related risks, incidents or regulatory actions, and compliance continues to be supported through routine governance oversight and policy updates. Improvement actions have been progressed, including enhanced reporting, awareness activity and process review, with a forward plan to strengthen organisational engagement, improve response timeliness and increase efficiency through automation and better request management. The Committee was therefore reassured of a stable and controlled framework, with targeted actions to improve performance against statutory timescales.

Data Protection Act Compliance

The Committee received the Data Protection Annual Assurance Report which provided a summary of activities to support compliance with the General Data Protection Regulation (GDPR), Data Protection Act 2018 and NHS Data Security Protection Toolkit (DSPT). The report provided management assurance that there are robust data protection and information governance (IG) arrangements which are operating effectively across the Trust.

Compliance with statutory requirements has been demonstrated through:

- Achievement of a “Standards Met” position for the DSPT following delivery of an Improvement Plan.
- “Reasonable” assurance (the second highest rating) from an independent Information Commissioner’s Office voluntary audit of Cyber and Children’s Data Governance.
- 80.08% compliance against statutory disclosure timeframes for Data Subject Access Requests (DSARs).
- Use of Data Protection Impact Assessments for new systems and processes that involve processing of personal data.

There was an 8.5% reduction in the year in IG and cyber security incidents reported on InPhase, with one reportable incident managed appropriately with no adverse impact. While performance in DSARs compliance reduced in the year, mitigating actions have been identified to improve delivery. The Committee was therefore reassured of a strong and improving control environment, with a forward plan to sustain compliance and respond to emerging data security risks.

Clinical and Non-Clinical Claims

To be updated following June meeting

7. Governance and Effectiveness of the Committee and its Independent Assurance Providers

During the year a number of documents were reviewed by ARC in relation to its own governance and governance processes within the Trust:

Committee Governance:

- ARC Terms of Reference and Work Plan.
- ARC Annual Report 2025/26.

Trust Governance

- Draft Annual Governance Statement.
- Annual Reports of the Trust's Assurance Committees.
- Gifts & Hospitality Register.
- Policies and Strategies Approved or Ratified:
 - Board Assurance Framework.
 - Risk Management Strategy.
 - Corporate Governance Manual (six-month review).
 - Standing Financial Instructions and Scheme of Reservation and Delegation.
 - External Communications Policy.

Committee Effectiveness and that of Independent Assurance Providers

Each year the Committee undertakes a self-assessment of its own effectiveness and a review of the effectiveness of its assurance providers and maintains an Action Log to monitor implementation of any agreed actions. This year a self-assessment of compliance with the Committee's Terms of Reference was performed, a detailed questionnaire was completed to assess the effectiveness of Internal Audit whilst a light touch (single question) review was undertaken for External Audit and the Counter Fraud Service.

There were no significant weaknesses identified in any of the reviews, with agreed actions relating to:

- Repeating the benchmarking of internal audit resources with peers in the region to ensure that the Trust remains in line (particularly in the light of the current external and financial challenges).
- Working with SQAC and CEOB to introduce an effectiveness review process for Clinical Audit.
- Considering the Committee's ongoing approach to assurance on data quality.

The agreed actions were added to the Action Log, delivery of which is monitored regularly throughout the year.

Developments in 2025/26

The priorities highlighted for 2025/26 highlighted in the prior Committee Annual Report were:

Priority	Position
Further roll-out of the Risk Tolerances.	Following a pause due to significant changes in the external environment this is being restarted and will be monitored by ARC as part of its normal Committee operations.

Priority	Position
Oversight of InPhase Phase 2 project implementation.	Phase 2 has now progressed to BAU. A new priority for 26/7 has been developed relating to the next phase of developing InPhase.
Introduction of a “Risk Horizon Scanning” agenda item to anticipate upcoming risks, particularly those arising from the external environment.	In place.
Agree (with SQAC) the information and assurances provided to both Committees from Clinical Audit.	Carried forward to 26/27 and to be agreed with the Governance Team following completion of its organisational development.
Agreement of a schedule of deep dive reviews of the BAF risks such that each risk is reviewed by ARC throughout the year.	In place.

The following further activities are highlighted for Board’s attention:

- The Committee wishes to recognise the positive outcomes from the Community & Mental Health Divisions pilot of implementing Risk Appetite. This was undertaken thoughtfully and with diligence and care and the learnings from this experience will significantly assist in the effective rollout across the rest of the Trust.
- Following discussions with MIAA and internally (with the FTPC Chair, Chief Digital & Transformation Officer and Mark Jennings – Non-Executive Director) a Cyber Reporting Group has been established, chaired by Mark Jennings, to ensure cyber activity is aligned to strategic objectives, monitor delivery of actions arising from Digital internal audits and the DSPT and remains responsive to operational and clinical priorities. The Group will report regularly into FTPC with an annual assurance report to ARC. This represents a significant improvement in the Board oversight of cyber processes and risk.

Assurance Statement

Based on the Committee’s processes for gaining assurance as summarised above, the Committee members can confirm that:

- They agree to the declaration reported to the Board of Directors in respect of the Annual Governance Statement.
- The Assurance Framework is fit for purpose.
- Systems for risk management identify and allow for the management of risk.
- There are robust governance arrangements.
- There are sound systems of financial control.
- The Trust operates a robust internal control environment.

Whilst providing these assurances ARC has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments and Priorities for 2026/27

Whilst the Committee has performed its duties as delegated by the Board and mandated through its Terms of Reference, in the forthcoming year focus will be given to the following matters to further improve its effectiveness:

- Further embedding of the Risk Appetite Framework, building on the Community & Mental Health Division pilot to support more consistent risk assessment, clearer escalation routes and stronger alignment between operational decision-making and the Board's agreed Risk Tolerances.
- Considering the ongoing effectiveness of the Trusts risk management systems and changes that might be required following award of Advance Foundation Trust status, potential "chain" working, and demand for greater collaboration with regional partners.
- Working with SQAC, CEOB and the Governance Team to:
 - Understand and support the next phase of development of InPhase with a view to achieving increased and automated data triangulation to enable more effective and real time oversight of risk, performance and control effectiveness.
 - Introduce an effectiveness review process for Clinical Audit.
 - Agree the Clinical Audit reporting needs of SQAC and ARC to minimise duplication.
 - Oversee the introduction of formal processes to provide assurance as to the implementation of learning and agreed actions from Clinical Audits.

Kerry Byrne, Audit and Risk Committee Chair
June 2026

AUDIT AND RISK COMMITTEE – RECORD OF ATTENDANCE 2025/26

The quorum necessary for the transaction of business: two members

* Risk agenda items only

Member/Date of Meeting	2025					2026	TOTAL	
	Apr	June	July	Sept	Dec	Feb		
MEMBERS								
Kerry Byrne (Chair) Non-Executive Director	✓	✓	✓	✓	✓	✓	6 / 6	100%
Gerald Meehan Non-Executive Director	✓	✓	✓	✓	✓	✓	6 / 6	100%
Jo Revill Non-Executive Director	✓	✓	✓	✓	✓	x	5 / 6	83%
Quoracy achieved	YES	YES	YES	YES	YES	YES	6 / 6	100%
ATTENDEES								
* Adam Bateman Chief Operating Officer	✓	N/a	x	✓	✓	x	3 / 5	60%
Emily Kirkpatrick Deputy Director of Finance	✓	✓	x	✓	✓	✓	5 / 6	83%
Rachel Lea Chief Financial Officer	x	x	✓	✓	✓	✓	4 / 6	67%
Jackie Rooney Assistant Director of Nursing & Governance	✓	✓	✓	x	✓	✓	5 / 6	83%
Erica Saunders Chief Corporate Affairs Officer	✓	✓	✓	✓	✓	✓	6 / 6	100%
External Audit (EY)	HR	HR / DS	N/a	DS	HR	HR	6 / 6	100%
Internal Audit (MIAA)	GB / KS	GB / KS	KS	GB	KS	GB /KS	6 / 6	100%
Counter Fraud Service (MIAA)	PB	N/a	N/a	VM	N/a	KM	3 / 3	100%

External Audit Representatives:

Mr D Spiller (DS)
Mr H Rohimun (HR)

Internal Audit Representatives:

Mr G Baines (GB)
Mrs K Stott (KS)

Counter Fraud Service Representative:

Ms V Martin (VM)
Mr P Bell (PB)
Ms K McArdle (KM)

Appendix 1 – Assurance Levels of the audits within the 25/26 Internal Audit Plan:

Audit Title	Assurance Level
Assurance Framework	Met Requirements
Key Financial Controls:	
• General Ledger	Substantial
• Accounts Payable	Moderate
• Accounts Receivable	High
• Treasury Management	High
• Budgetary Control	Substantial
Governance of the NHS Children & Young People's Gender Service (North West)	Substantial
Remote Access	Moderate
Financial Measures (Grip and Control)	Substantial
Balance Sheet Control Accounts	Moderate
Theatre Management System	Limited
Clinical Audit	Moderate
Divisional Clinical Governance	Substantial
Asset Management Processes	Substantial
Data Security & Protection Toolkit:	
• Overall Assessment	High Risk
• Veracity of Trust's Self-Assessment	High Confidence
Conflicts of Interest	Substantial
Governance of the Financial Improvement Programme	Audit Ongoing
Governance of the Workforce Efficiencies Programme	Audit Ongoing



Finance, Transformation and Performance Committee Annual Report 2025/26

Introduction

The Finance, Transformation and Performance Committee (FTPC) presents its Annual Report for the period **1 April 2025 to 31 March 2026**. The report provides assurance to the Trust Board that effective governance, oversight and control arrangements are in place in relation to financial sustainability, operational performance, transformation delivery and efficiency, digital enablement, and strategic investment.

As a core assurance committee of the Board, FTPC has provided robust scrutiny of financial performance, cost improvement delivery, capital and digital investment, demand and capacity management, and system productivity. The Committee has played a pivotal role in supporting the Trust's ambition to deliver safe, high-quality services within a challenging financial and operational environment, whilst maintaining alignment with **Vision 2030**, system priorities and national NHS planning requirements.

The Finance, Transformation and Performance Committee

FTPC's purpose is to provide assurance to the Board of Directors that the Trust has effective arrangements in place to:

- maintain financial sustainability and value for money;
- deliver agreed transformation and efficiency programmes;
- oversee operational performance and productivity;
- ensure robust governance of capital, digital and major investment decisions; and
- support delivery of the Trust's strategic objectives.

The Committee operates under delegated authority from the Trust Board and discharges its responsibilities through review of:

- the annual workplan;
- in-year financial and performance reports;
- Cost Improvement Programme (CIP) delivery;
- transformation and productivity programmes;
- capital and digital investment;
- system and partnership performance; and
- exception and deep-dive reports on areas of risk.

Constitution

Throughout 2025/26, FTPC maintained a balanced and experienced membership combining Non-Executive challenge, Executive leadership and senior operational insight. Membership remained aligned with the Committee Terms of Reference, ensuring appropriate expertise across finance, operations, transformation and digital.

The Membership comprises:

Non-Executive Director x 2 one of whom shall be the Chair
Chief Executive

Chief Finance Officer
Chief Operating Officer / Deputy Chief Executive
Chief People Officer
Chief Transformation and Digital Officer
Chief Corporate Affairs Officer
Chief Strategy and Partnerships Officer
Chief Nursing, AHP and Experience Officer

Expected to attend each meeting are the Associate Director of Finance, Deputy Director of Finance and Director of Transformation. This breadth of membership ensured the Committee maintained a strong multi-disciplinary perspective at all meetings. FTPC remained consistently quorate throughout 2025/26, with attendance demonstrating high levels of engagement from both Executive and Non-Executive members. A schedule of attendance at the meetings is provided in Appendix A.

The Committee's work plan supports delivery of the Trust's strategic priorities, with a focus on CIP delivery, capital governance, productivity and system performance.

Principal Review Areas / Achievements in 2025/26

Top 5 Risks

Trust Financial Performance (delivery of the Financial Plan) and System Position

Against a backdrop of system-wide financial constraint, heightened cost pressures and in-year volatility in national funding and assumptions, FTPC maintained close oversight through monthly finance reports, year-end forecast scenarios and run-rate analysis, with a particular focus on recurrent versus non-recurrent savings and the impact of system pressures across Cheshire and Merseyside. The Committee scrutinised divisional performance, income assumptions, pay and non-pay trends, and cash flow position, alongside regular engagement with ICB and NHS England colleagues. External scrutiny (PwC, NHSE and system reviews) was explicitly considered by FTPC and used to strengthen internal grip and governance.

Mitigations and controls:

- Executive-led Financial Improvement Programme (FIP) with strengthened governance, SRO ownership and confidence ratings.
- Tightened workforce controls, including vacancy management, bank and agency restrictions, review of fixed-term contracts and MARS schemes.
- Improved financial grip through enhanced reporting, coding recovery actions and non-pay controls.
- Ongoing engagement with the ICB and NHSE to manage plan assumptions, industrial action funding and system risks.

In a challenging system financial context, FTPC received assurance that robust controls were in place, financial risks were clearly articulated, and mitigations were actively managed, with appropriate escalation through Trust and system governance routes. While delivery remained challenging, the Committee was assured that risks were proactively mitigated and escalated appropriately.

Capital Programme

During 2025/26 the Trust operated within an increasingly restrictive national capital regime, with limited and uncertain CDEL availability, heightened scrutiny from NHSE, and minimal flexibility to move funding between years.

FTPC exercised sustained scrutiny of the capital programme, including in-year CDEL position, prioritisation decisions, business case approvals and phasing assumptions. The Committee explicitly recognised that this risk was largely externally driven by national capital controls rather than internal governance issues.

Mitigations focused on robust capital prioritisation, phased delivery, strengthened Capital Management Group oversight, proactive engagement with NHSE and ICB partners, and limited use of charity funding to provide flexibility where appropriate. Capital risks were regularly reviewed and reflected in the Board Assurance Framework.

FTPC was assured that, despite ongoing national constraints, capital risks were being responsibly and transparently managed, with safety-led prioritisation and strengthened governance arrangements in place.

Efficiency Programme

The Committee received regular updates on CIP delivery, scheme quality, confidence ratings and quality impact assessments. Particular scrutiny was applied to pay, non-pay and productivity-based schemes, alongside divisional ownership and delivery assurance.

Mitigations included tighter scheme governance, clearer accountability through SROs, strengthened workforce controls, and increased focus on recurrent savings. FTPC also tested alignment between efficiency delivery and operational performance throughout the year. The in-year CIP delivery was largely achieved, however the Committee noted that recurrency remained a key strategic risk, with only around half of savings assessed as recurrent by year-end. This risk has been explicitly carried forward into 2026/27 and is being addressed through the Target Operating Model, transformation programme reset, and strengthened benefits realisation arrangements.

FTPC was assured that, although delivery remained challenging, governance of the efficiency programme strengthened over the year and risks were being actively managed and escalated.

Benefits Realisation, Governance and Prioritisation of Change Programme to 2030

The Committee received regular updates on the transformation portfolio, Target Operating Model (TOM) development, collaboratives and benefits realisation tracking. FTPC scrutinised programme scope, delivery confidence, phasing and alignment with Vision 2030 and the Medium-Term Plan.

The following mitigations and controls were positively received: the reset and consolidation of transformation governance into a single, clearly prioritised portfolio; the introduction of benefits tracking directly linked to financial outcomes and workforce plans; strengthened clinical and executive leadership through enhanced oversight via the Clinical Cabinet and Transformation Board; and improved alignment of transformation delivery with workforce, productivity, and digital programmes.

FTPC was assured that transformation maturity improved during the year, governance was clearer, and benefits realisation was increasingly realistic and aligned to delivery capacity, though continued focus is required.

Campus and Park Developments

FTPC monitored delays, costs, and delivery risks for major campus and park projects throughout the year, including NICU/SDEC, Elective Hub, and Springfield Park. Risks increased due to PFI constraints, contractor reliance, and national funding limits. Regular assessments kept track of dependencies, mitigation plans, and escalation routes, with executive oversight on high-risk projects. Mitigation measures included improved governance, phased deliveries, proactive partner engagement, and close monitoring of operational and safety impacts. Despite some ongoing external and infrastructure-related

risks, FTPC confirmed campus risks were managed transparently and under robust governance.

Financial Updates

Monthly Financial Position Reports

FTPC received monthly financial position reports throughout 2025/26, providing assurance on in-year financial control, emerging risks and mitigating actions. While the Trust operated in a highly constrained and volatile environment, with reliance on non-recurrent measures at points during the year, the Committee was assured that financial performance was actively managed, risks were clearly articulated, and appropriate actions were taken to maintain control and escalate residual risks.

Cost Improvement Programme

Throughout 2025/26, the Committee received regular and detailed reports on delivery of the Trust's Cost Improvement Programme (CIP), which represented a critical component of the Trust's financial sustainability and system credibility. The in-year CIP requirement was significant (circa £22–23m) and was set against a backdrop of:

- sustained operational pressures;
- workforce constraints and sickness absence;
- pay and non-pay inflation;
- industrial action; and
- a limited ability to rely on commissioner growth or activity-based income.

While the majority of the in-year CIP requirement was achieved, enabling the Trust to maintain financial control, the Committee consistently recognised that recurrent savings remained below target, representing a key residual risk to be addressed through the Trust's transformation programme in 2026/27.

Workforce Establishment and Pay Control

Workforce metrics were consistently considered alongside financial performance and CIP delivery, recognising workforce as both a critical cost driver and a key enabler of safe and effective care.

Monthly reporting demonstrated that pay expenditure and workforce establishment remained under significant pressure, driven by vacancies in key clinical roles, medical locum dependency, sickness absence and the legacy impact of industrial action. FTPC routinely scrutinised:

- whole-time equivalent (WTE) trends;
- vacancy levels and recruitment controls;
- bank, agency and premium staffing usage; and
- divisional workforce forecasts.

As the year progressed, reports showed a reduction in overall WTE, supported by tighter vacancy management and workforce controls, particularly in non-patient-facing and corporate roles. The Committee recognised these actions as necessary to support financial recovery, while remaining alert to the potential impact on operational resilience and staff wellbeing.

Recognising the inter-dependency between workforce availability, productivity delivery and access performance, workforce sustainability remains a material strategic risk, particularly in specialist clinical areas, and will continue to require close oversight through 2026/27 as part of the Trust's financial and transformation agenda.

Integrated Performance Report

Throughout 2025/26, the Committee received monthly Integrated Performance Reports (IPRs), providing oversight of operational performance, access, productivity and delivery of

national standards, alongside their financial implications. The IPRs formed a key component of FTPC's assurance framework, supporting triangulation between performance, workforce and financial sustainability. The reports covered a consistent and comprehensive range of performance metrics, including:

- elective activity, RTT and long-wait positions;
- urgent and emergency care performance;
- diagnostics and outpatient access;
- productivity indicators (including theatre utilisation and clinic efficiency);
- delivery against national and regional standards; and
- key operational risks and trajectories.

Issues identified through IPRs were escalated as appropriate through:

- targeted deep dives at FTPC;
- cross-committee escalation (particularly to SQAC and People Committee where safety or workforce risks intersected); and
- inclusion within the Board Assurance Framework where performance risk remained persistent or material.

Annual Plan updates

FTPC concluded that Annual Plan updates throughout 2025/26 demonstrated:

- a robust and realistic planning approach in a highly constrained environment;
- appropriate recognition of risk, particularly in relation to CIP recurrency, workforce and system dependency; and
- strengthened alignment between financial planning, transformation priorities and operational delivery.

While acknowledging that the Plan remained finely balanced and subject to external risk, FTPC was assured that assumptions were well-understood, delivery risks were clearly articulated, and appropriate mitigations and escalation arrangements were in place.

Financial Improvement Programme

During the year, the Trust established a Financial Improvement Programme (FIP) in response to the considerable financial challenge confronting the NHS. This initiative was designed to tackle several key issues, including the need to deliver a substantial Cost Improvement Programme (CIP), manage cost pressures arising from workforce factors and inflation, and address underlying structural problems impacting the organisation's financial position.

Throughout the 2025/26 period regular updates regarding the progress of the Financial Improvement Programme were received. The Programme served as the Trust's principal mechanism for achieving financial recovery, increasing grip and control over financial processes, and supporting the long-term sustainability of the organisation.

FTPC concluded that FIP updates throughout 2025/26 demonstrated:

- strengthened grip, control and executive oversight over the course of the year;
- tangible contribution to maintaining in-year financial control in a highly constrained environment; and
- improved clarity on the limits of non-recurrent savings.

Financial Improvement Checklists

During 2025/26, the Committee received updates on the Financial Improvement Checklist, which was used as a mechanism to track progress against a range of actions arising from internal audits, external reviews and financial improvement workstreams.

The Checklist provided assurance on the completion status of key financial control and improvement actions identified over the previous two years, supporting the Trust's wider

Financial Improvement Programme and strengthening overall financial governance. FTPC was assured that actions arising from audits and financial improvement work were largely completed or appropriately in progress, with remaining items embedded within longer-term improvement programme.

2025/26 Financial Plan Update

Regular updates on the Trust's Financial Plan were received during 2025/26, providing oversight of its development, refinement and delivery within a highly constrained national and system context. FTPC tested alignment between financial assumptions, operational deliverability and workforce capacity, challenging optimism bias where identified.

A consistent theme in Financial Plan updates was the risk associated with CIP recurrency. FTPC noted that while in-year delivery was achievable through mitigations, a material proportion of savings were non-recurrent, creating an underlying risk to sustainability. This informed the Committee's support for strengthened transformation, Target Operating Model development and longer-term workforce redesign. While recognising that the Plan remained high-risk and subject to external factors beyond the Trust's control, FTPC was assured that assumptions were well-understood, delivery risks were explicitly identified and appropriate escalation and mitigation arrangements were in place.

Debt Write-Off Reports

During 2025/26, the Committee received periodic Debt Write-Off reports as part of its routine financial governance and control oversight. FTPC concluded that the Debt Write-Off reports received during 2025/26 demonstrated appropriate financial control, transparency and governance, with write-offs limited in scale, fully provided for, and subject to proper recovery and approval processes. The Committee was assured that debt write-off activity did not represent a material financial risk and was managed in line with Trust policy.

Closing the Financial Gap

Throughout 2025/26, FTPC received regular "Closing the Financial Gap" updates, providing focused assurance on actions being taken to address the remaining gap between the Trust's forecast financial position and the approved plan.

The Committee recognised that the gap was dynamic and multi-factorial, requiring both short-term mitigation and longer-term structural solutions and consistently challenged the realism of proposed mitigations and sought assurance on deliverability rather than headline position alone.

While recognising that a residual gap and recurrency risk remained at points during the year, the Committee was assured that actions were actively managed, appropriately escalated and increasingly aligned with longer-term transformation and sustainability plans.

Medium Term Plan

FTPC received multiple updates concerning the progress of the Medium-Term Plan. The committee provided thorough scrutiny on:

- the practicality of projected workforce reductions alongside anticipated performance recovery and access improvements;
- the sustainability of forecasted productivity gains in forthcoming years;
- reliance on commissioner proposals and system-level initiatives that remain unconfirmed; and
- the distinction between in-year mitigations and enduring structural solutions.

The Committee determined that the 2025/26 Medium-Term Plan updates have:

- strengthened transparency regarding the Trust's financial challenges over the medium term;

- demonstrated enhanced cohesion among financial recovery efforts, workforce planning, and strategic transformation; and
- effectively reflected delivery risks and external dependencies.

While recognising that the MTP continues to present substantial risk and depends on consistent delivery, FTPC is confident that the foundational assumptions are transparent, risks are clearly articulated, and robust governance structures are in place to support ongoing refinement and execution.

National Cost Collection Index Review

The Committee received and considered the National Cost Collection (NCC) Index Review for 2024/25, providing assurance on the Trust's relative cost position and the quality of submitted costing data.

FTPC was advised that Alder Hey's National Cost Collection Index score for 2024/25 was 100, placing the Trust in line with the national average and below the average of peer organisations. This represented an improvement compared to previous years and provided reassurance that the Trust's reported costs were appropriately aligned with national benchmarks.

The improvement in the Index position was attributed primarily to data quality corrections and improvements, rather than structural changes in service delivery costs. FTPC noted the importance of this distinction, recognising that enhanced data accuracy provides a more reliable baseline for future financial and productivity analysis.

Divisional Updates

Quarterly updates from each of the clinical divisions and corporate services were received, summarised as follows:

Surgery Division

Surgery Division updates highlighted a combination of income shortfall and cost pressures, including the impact of changes to weekend working arrangements, tariff adjustments (notably in spinal surgery), and inflationary pressures in drugs, devices and clinical supplies. The recovery plan emphasised tactical CIP delivery, productivity improvement in theatres, strengthened control of discretionary spend, and longer-term transformation of elective pathways and workforce models. FTPC received assurance that recovery actions were clinically led and aligned with Trust-wide financial improvement priorities

Medicine Division

The Medicine Division provided regular updates to FTPC in response to a material forecast overspend, driven primarily by non-pay pressures (including blood products, drugs and clinical supplies) and unavoidable pay pressures associated with hard-to-recruit roles, maternity leave and sickness absence. Recovery actions focused on strengthened workforce controls, targeted non-pay cost mitigation and improved coding and income capture. FTPC noted that while grip and oversight had strengthened, delivery remained challenging due to service sustainability requirements and external pressures.

Community Division

The Community Division reported relative financial stability compared with acute divisions, with positive variance in some areas driven by workforce vacancies, particularly within mental health services. Updates highlighted continued focus on productivity, waiting time management and safe workforce models. FTPC noted ongoing risks associated with recruitment, commissioning uncertainty (including non-recurrent funding for some services) and the need to sustain performance improvements.

Corporate Services

Corporate updates highlighted a forecast overspend, driven primarily by non-pay pressures including energy, estates costs, utilities, legal fees and PFI-related expenditure. FTPC noted that Corporate CIP delivery was over-achieved on a non-recurrent basis, and requested additional scrutiny of corporate non-pay budgets to better understand structural cost drivers and opportunities for longer-term mitigation.

Across all divisions, FTPC used the updates to:

- scrutinise delivery confidence and recovery actions;
- test alignment with CIP, FIP and “closing the financial gap” activity; and
- ensure that recovery plans did not compromise quality, safety or operational resilience.

Operational Updates

Campus and Park Development

Throughout 2025/26, FTPC received regular Campus and Park Development updates from the Development Directorate, providing assurance on progress, risks and governance of the Trust’s major capital and infrastructure programmes.

FTPC concluded that Campus updates during 2025/26 provided appropriate visibility and assurance over a complex and high-risk delivery environment. While recognising that external capital constraints, PFI dependencies and technical issues continued to limit pace and flexibility, the Committee was assured that:

- progress was being made where possible;
- governance and oversight were robust; and
- risks were clearly understood, transparently reported and appropriately escalated.

Private Finance Initiative Performance

During 2025/26, FTPC received regular PFI performance reports, providing oversight of the operational, contractual and financial performance of the Private Finance Initiative (PFI) estate and its impact on service delivery, safety and financial sustainability. These reports aligned primarily to strategic infrastructure risks and were closely linked to campus and estates assurance and provided direct assurance against BAF Risk 1.3.

PFI reports highlighted ongoing infrastructure and building defect issues, including matters affecting water systems, energy usage and wider estate reliability. FTPC was advised that unresolved defects had the potential to impact service delivery, operational resilience and costs if not actively managed. The Committee received assurance that:

- a detailed remedial action plan was in place and jointly agreed with the Special Purpose Vehicle (SPV);
- performance against the plan was reviewed monthly and escalated where required; and
- additional mitigations were implemented to reduce operational risk while longer-term solutions progressed

Digital and Data Collaborative

During 2025/26, the Committee received updates on the Digital and Data Collaborative, focusing especially on the deployment of Lyrebird ambient voice technology and progress in tackling coding and transcription backlogs.

Lyrebird Ambient Voice Technology

The Committee noted Lyrebird’s large-scale implementation, which assisted clinicians by automating letter generation, reducing transcription backlogs, and improving clinical

documentation. FTPC observed significant benefits, including greater productivity, less administrative work, faster communication with patients and families, and progress toward digital maturity and operational recovery.

Coding Performance and Data Quality

FTPC updates noted that coding backlogs had caused operational, financial, and audit risks related to income recognition and data completeness. Mitigating actions included increasing coding capacity, redesigning workflow, using AI clinical summaries, and enhancing digital processes. These measures have significantly reduced backlogs and improved coding reliability, with ongoing efforts to maintain sustainable improvements.

FTPC welcomed the clearer articulation of benefits realisation and the integration of digital initiatives into wider performance and financial recovery arrangements.

Organisational Development Collaborative

In 2025/26, the Finance, Transformation and Performance Committee reviewed updates on the Organisational Development (OD) Collaborative and its “10% plans”, which are part of the Trust’s transformation and financial recovery efforts. The OD Collaborative aims to help divisions and corporate functions make up to 10% productivity, efficiency, or capacity gains through changes to work methods, not short-term cuts. Progress during the year was variable but increasingly aligned with the Target Operating Model; delivery continues to rely on digital, workforce, and service redesigns. The Committee requested clearer milestones, benefits, dependencies, and resource needs. Key risks include workforce limitations, competing priorities, inconsistent readiness, and over-ambitious goals without sufficient infrastructure. Nonetheless, the Committee affirmed the importance of the OD Collaborative and 10% plans, noting sound governance, phased delivery, and focus on sustainable change.

Improving access to care in the current financial environment

FTPC received assurance on the Trust’s approach to improving access to elective, urgent, diagnostic and follow-up care within a highly constrained financial environment recognising that productivity improvements alone were not sufficient to fully offset growth in demand.

The report set out a multi-faceted approach to managing access pressure with significant emphasis on improving follow-up access through strengthened controls.

FTPC concluded that the report demonstrated a pragmatic and risk-aware approach to improving access within financial constraints. While acknowledging that demand and funding pressures remained significant, the Committee was assured that:

- access risks were well understood and transparently reported;
- controls for safe waiting list management and follow-up care were in place and operating; and
- improvement actions were aligned with affordability, workforce capacity and quality considerations.

Re-imagining Appointment Scheduling Services & Reducing Rates of WNB

FTPC received a report which set out a clear vision to modernise outpatient booking and scheduling in order to improve access, experience and productivity while reducing Was Not Brought (WNB) rates. Targeted actions to reduce the Trust-wide WNB rate from 10.7% to 8% include:

- improved demographic and contact data verification;
- consistent application of the Trust’s access and WNB policy;
- a Trust-wide WNB communications campaign to improve understanding and engagement; and

- specialty-specific initiatives, including delivery of ADHD appointments in schools to reduce barriers to attendance.

Progress during 2026/27 will be monitored through Integrated Performance Reporting and access recovery oversight.

Creating Future Shape of Alder Hey

The Committee received the report *Creating the Future Shape of Alder Hey – Outline Plan (Aug–Dec 2025)*, which set out a coherent, integrated approach to reshaping the organisation in response to sustained financial pressure, workforce constraints and increasing system expectations. The Plan was positioned as a bridge between in-year recovery actions and a multi-year transformation trajectory. The report described a joined-up approach to shaping Alder Hey's future intended to underpin both financial recovery and service transformation.

The Committee was assured that the work was aligned to financial recovery, workforce planning and Vision 2030, while recognising that successful delivery would require sustained focus and strong governance over subsequent years

Neonatal Partnership

Throughout 2025/26, FTPC received regular updates on the Liverpool Neonatal Partnership (LNP), providing assurance on progress, performance, governance and risks associated with the delivery of neonatal services across partner organisations. FTPC noted good progress across the Liverpool Neonatal Partnership, with evidence of strengthened collaborative working between Alder Hey and Liverpool Women's Hospital.

While acknowledging ongoing dependencies relating to equipment availability and campus development, the Committee was assured that the Neonatal Partnership remained well-governed and focused on delivering safe, high-quality neonatal care through collaborative working.

NHS Oversight Framework

During 2025/26, the Committee received regular updates on the Trust's position under NHS England's NHS Oversight Framework (NOF) 2025/26, providing assurance on organisational performance, leadership capability and regulatory position. As at Q3, Alder Hey was assessed as Segment 1, indicating consistently high performance across five domains (access, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity) and delivery against plans.

Transformation Strategy

FTPC received regular updates on the Trust's Transformation Strategy, providing assurance on the progress, focus and governance of transformation activity aligned to Vision 2030, financial sustainability and future ways of working. During the year, the programme had been re-focused and prioritised to reflect capacity, delivery risk and the financial context. In addition, a Transformation Board was formally established to oversee a single, unified transformation programme, bringing together digital, service and workforce transformation under one governance structure and align to the FIP.

Digital Futures Strategy

Regular updates on the Digital Futures Strategy were provided throughout the year, providing assurance on progress against the Trust's digital, data and AI ambitions and their contribution to productivity, quality and staff experience. Updates were positioned as a core component of the Trust's wider transformation programme.

FTPC was updated on a range of digital initiatives closely aligned with operational improvement priorities

FTPC concluded that Digital Futures Strategy updates during 2025/26 demonstrated good progress across multiple high-impact digital priorities and noted positive external recognition, with the Trust being shortlisted for national awards for both Lyrebird implementation and community digital solutions.

Procurement Monitoring

During the year the Committee received regular Procurement Monitoring updates from Health Procurement Liverpool (HPL), providing assurance on procurement performance, cost improvement delivery and strategic development across the Trust. FTPC noted that procurement Cost Improvement Programme (CIP) delivery was above plan at multiple points during the year, including October 2025 and February 2026. Procurement continued to make a positive and recurrent contribution to the Trust's overall Financial Improvement Programme.

Operational Delivery Networks

An update on Operational Delivery Networks (ODN) was presented to FTPC, providing assurance on the Trust's role in hosting and overseeing specialist mandated networks on behalf of the wider North West system. Alder Hey hosts two mandated North West Specialist Services Operational Delivery Networks, operating on behalf of providers across the wider regional footprint. The report provided assurance that the Trust continued to meet its obligations as host of the mandated ODNs and arrangements remained appropriate to support safe and effective system-wide delivery of specialist services.

Green Plan 2025-2028

In March 2026, the Committee received a formal presentation of the Alder Hey Green Plan 2025–2028 developed in line with NHS England's updated Green Plan guidance (2025) and national Net Zero commitments. FTPC noted that delivery would be supported through defined governance structures and operational delivery groups with no additional resource implications and was content to approve the Plan ahead of Trust Board approval and onward submission to NHS England.

Clinical Coding

FTPC received assurance on the Trust's clinical coding position, noting sustained operational pressures since August 2025 (including workforce capacity gaps and periods of sickness) and the associated risk to timely income capture (Risk 238, score 16). The Committee was assured that a recovery plan is in place and being actively monitored, with targeted prioritisation to reduce backlogs, short-term capacity support, improved oversight through validation tools and dashboards, and alignment with wider digital solutions to strengthen resilience. Further updates will be provided as actions embed and progress continues toward a sustainable operating model, including recruitment and retention and longer-term workforce development.

Business Cases

The following business cases were approved by FTPC:

- AlderCare 2.2 (Expanse)
- Pharmacy cabinet (to replace end-of-life electronic drug storage cabinets, with costs to be included in the 26/27 financial plan).

External Scrutiny

During 2025/26, FTPC received and considered the outputs from a number of external financial and system reviews. These reviews provided independent assessment of the Trust and system's financial management, governance and delivery capability, and informed the Trust's response to heightened national and system scrutiny.

FTPC received assurance that the Trust had responded constructively to the findings of the external reviews. The outputs of the external reviews were used to inform subsequent Annual Plan, Financial Plan and transformation discussions within FTPC, ensuring that external challenge was embedded into internal decision-making and assurance processes.

Policies approved

Treasury Management (Cash) Policy

BAF Oversight & cross-Cutting Themes

During 2025/26, the Finance, Transformation and Performance Committee provided focused and consistent oversight of the six principal Board Assurance Framework (BAF) risks delegated to it:

Ref	Risk	Score	Target
		IxL	
1.2*	Children and young people waiting beyond the national standard to access planned care and urgent care	4x5	3x3
1.3	Building and infrastructure defects that could affect quality and provision of services	4x4	2x2
1.4*	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	3x5	3x3
3.1	Failure to fully realise the Trust's Vision for the Alder Hey Campus	3x2	2x2
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	4x4	4x2
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	4x5	4x3

* Joint responsibility with SQAC

The Committee reviewed these risks at every meeting, supported by monthly Executive updates, improved triangulation with divisional performance data, and strengthened links between financial, operational, digital and transformation intelligence.

BAF Risk 1.2 — Children and young people waiting beyond the national standard to access planned care and urgent care

FTPC considered this risk primarily through its impact on capacity, productivity, financial sustainability and enabling infrastructure. Assurance focused on:

- the financial and operational consequences of sustained access pressures;
- the effectiveness of recovery and productivity initiatives;
- the role of digital systems and data quality in supporting accurate performance reporting; and

- capital and estate constraints affecting flow, diagnostics and elective activity.

The Committee was assured that recovery activity was underpinned by clear financial grip, supported by transformation programmes and capital prioritisation, while recognising the continued fragility caused by demand growth and system pressures.

BAF Risk 1.3 — Building and infrastructure defects affecting service provision

FTPC maintained close oversight of this risk through:

- regular Campus and Capital Programme updates;
- scrutiny of infrastructure-related cost pressures and delivery risks;
- oversight of PFI-related risks, mitigations and escalation arrangements; and
- consideration of the financial consequences of infrastructure defects.

The Committee recognised the progress made in mitigating immediate risks but noted that legacy infrastructure issues, capital constraints and dependency on external funding continued to create delivery risk, warranting ongoing focus into 2026/27.

BAF Risk 1.4 - Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies. FTPC monitored this risk through:

- Monitoring of mental health access, RTT, demand and recovery actions through the IPR.
- Scrutiny of Community Division workforce capacity, vacancies and recruitment risks.
- Review of demand pressures and reduced partner agency support impacting timely access.
- Oversight of productivity, pathway redesign and improvement actions to reduce waits.

BAF Risk 3.1 — Failure to fully realise the Trust's Vision for the Alder Hey Campus

FTPC monitored this risk through:

- oversight of the Campus development programme and associated business cases;
- scrutiny of capital affordability, phasing and prioritisation decisions; and
- alignment between campus developments, clinical strategy and financial planning.

The Committee recognised the Campus as a critical enabler of Vision 2030 and acknowledged that delivery required sustained coordination across estates, capital, finance and clinical services. While mitigation was judged to be proportionate, the Committee noted that external dependencies and capital availability remained key constraints.

BAF Risk 3.2 — Failure to execute Vision 2030 transformation in the current operating environment

Transformation delivery was a standing focus throughout the year. FTPC provided assurance through:

- scrutiny of the Transformation Strategy and prioritisation of programmes;
- oversight of governance arrangements, including establishment of a unified Transformation Board;
- monitoring alignment between transformation activity and financial benefits realisation; and
- assessment of workforce capacity and leadership capability to deliver change at pace.

The Committee welcomed clearer prioritisation, stronger governance and improved linkage between transformation and financial recovery, while recognising that delivery risk remained due to scale, pace and competing operational pressures.

BAF Risk 3.4 - Failure to meet financial targets and capital commitments

This risk remained a central focus for FTPC throughout the year. Assurance activity included:

- monthly scrutiny of Trust and system financial performance;
- oversight of the Financial Improvement Programme (FIP) and cost improvement delivery;
- review of capital affordability, prioritisation and exposure to national funding constraints;
- approval of key financial governance arrangements; and
- close monitoring of income risks linked to operational performance, coding, and productivity.

The Committee noted improved financial grip and transparency but concluded that the risk remained appropriate given the changing NHS financial regime, scale of recurrent savings required and ongoing capital pressures.

Cross-Cutting Assurance Themes Identified by FTPC in 2025/26

Across its oversight of BAF risks, the Committee identified several recurring themes:

- Financial and Capital Interdependency

Delivery of strategic ambitions was increasingly constrained by the interaction between revenue recovery, capital availability and external funding decisions. FTPC emphasised the importance of disciplined prioritisation and realistic phasing.

- Transformation Capacity and Delivery Risk

The scale of change required heightened the importance of leadership capacity, sequencing and benefits realisation. The Committee welcomed clearer governance but highlighted delivery confidence as a continuing area of focus.

- Digital and Data Enablement

Operational performance, productivity and financial assurance were increasingly dependent on digital systems, data quality and resilience. FTPC noted improvements but reinforced the need for sustained investment and integration with transformation planning.

- Infrastructure as a Strategic Enabler

Estate condition, campus development and PFI constraints were recognised as critical enablers and risk factors across multiple BAF risks, requiring continued coordinated oversight.

- System-Wide Pressures

Many risks were driven by external system factors, including demand growth, workforce availability and funding regimes. FTPC emphasised partnership working while ensuring organisational sustainability was not compromised.

Overall, the Finance, Transformation and Performance Committee is assured that the Trust has robust and increasingly mature arrangements in place to manage the Board Assurance Framework risks within its remit. While significant challenges remain, particularly in relation to financial sustainability, transformation delivery and capital constraints, the Committee is assured that mitigations are appropriate, governance has strengthened, and clear improvement trajectories are in place entering 2026/27.

Two extra ordinary meetings were held during the year, both to review and decide actions relating to a pipework issue.

Items to bring to the Board's attention

There are no matters to highlight.

Assurance Statements

Through the various mechanisms set out above, the Committee has gained assurance that the Trust's financial, operational and contractual systems and processes were operating at a satisfactory level.

Based on the information provided, the Committee members can confirm that the assurance framework is fit for purpose and that the control environment is operating at a satisfactory level with areas to improve on highlighted below. FTPC also agrees to the declaration reported to the Board in respect of the Annual Governance Statement.

The Committee holds key relationships with Growth and Opportunities Committee enabling:

- Links to specific issues in a multi-factorial way; specifically in relation to financial considerations and quality improvements;
- Risks to service quality are addressed;
- A cohesive approach to innovation.

A Summary Report is presented to the Board following each FTP Committee meeting highlighting the documents received at the meeting, key risks and positive areas discussed and any matters to escalate to the Board or other Committee. Final minutes are also submitted to Board once approved.

Committee Priorities for 2026/27

Building on the assurance activity and system-wide themes identified throughout 2025/26, the Finance, Transformation and Performance Committee has identified the following priorities to guide its work in 2026/27. These priorities reflect the scale of recurrent financial challenge, continued access and productivity pressures, constrained capital, and the need to convert transformation and digital investment into measurable benefits.

- **Financial Performance** – deliver the financial plan, strengthen grip and control, and improve forecasting and recovery.
- **Operational Performance Oversight Framework** provide oversight of access, productivity and delivery of standards, aligned to the NHS Oversight Framework.
- **CIP and Transformation** – deliver recurrent CIP and a prioritised transformation portfolio with clear benefits realisation.
- **Capital and Campus** – maintain robust capital governance, safety-led prioritisation and delivery oversight across campus programmes.
- **Growth and Investment** – Paediatric Chain.

John Kelly
Committee Chair
April 2026

APPENDIX A

FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE - RECORD OF ATTENDANCE 2025/26

Quorum: A quorum shall consist of the Chair or nominated deputy, one other NED, two Executive Directors

MEMBERS

Member / Date of Meeting	2025									2026			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
John Kelly (Chair) (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	12/12	100%
Shalni Arora (Non-Executive Director)	x	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2/3	67%
Jo Williams (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12	100%
Mark Jennings (Non-Executive Director)	n/a	✓	x	✓	✓	✓	✓	x	x	✓	✓	x	7/11	64%
John Grinnell (Chief Executive)	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	✓	10/12	83%
Melissa Swindell (Chief People Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12	100%
Nathan Askew (Chief Nursing AHP & Experience Officer)	✓	✓	✓	x	✓	x	✓	x	x	✓	✓	x	7/12	58%
Adam Bateman (Chief Operating Officer)	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Erica Saunders (Chief Corporate Affairs Officer)	✓	✓	x	x	x	x	x	✓	✓	✓	✓	x	6/12	50%

Member / Date of Meeting	2025									2026			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Kate Warriner (Chief Transformation and Digital Officer)	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	Deputy	Deputy	11/12	92%
Rachel Lea (Chief Finance Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	11/12	92%
Dani Jones (Chief Strategy and Partnerships Officer)	✓	x	✓	x	✓	✓	x	x	✓	✓	x	x	6/12	50%
QUORUM ACHIEVED	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	12/12	100%

ATTENDEES

Member / Date of Meeting	2025									2026			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Emily Kirkpatrick (Associate Director of Finance)	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Andy McColl (Deputy Director of Finance)	✓	x	✓	x	✓	x	x	x	✓	x	x	x	4/12	33%
Natalie Palin (Director of Transformation)	✓	✓	✓	x	✓	✓	✓	x	x	✓	✓	✓	9/12	75%



Safety & Quality Assurance Committee Annual Report 2025/26

Introduction

The Safety & Quality Assurance Committee (SQAC) presents its Annual Report for the period **1st April 2025 to 31st March 2026**. The report provides assurance to the Trust Board that the organisation has effective systems, processes, behaviours, and cultures in place to ensure the delivery of safe, high-quality, clinically effective and patient-centred care.

As a core assurance committee of the Board, SQAC plays a critical role in triangulating “ward-to-board” evidence and ensuring that the Trust remains sighted on emerging risks, thematic trends, regulatory requirements, and quality improvement opportunities. During 2025/26, the Committee provided strengthened oversight across all CQC domains, with enhanced linkage to the Vision 2030 strategic framework, the Trust’s Patient Safety Strategy, and the evolving national landscape including the PSIRF implementation, new CQC Single Assessment Framework, and wider health inequalities priorities.

This annual report reflects not only the breadth of business discussed but the maturity of assurance processes, the deepening triangulation across divisions, and the increasing emphasis on culture, learning, and system partnership working.

The Safety & Quality Assurance Committee

The Safety & Quality Assurance Committee’s purpose is to provide assurance to the Board of Directors that the Trust’s systems, processes and culture ensure the highest standards of clinical quality in terms of patient safety, clinical effectiveness and patient/carer experience to our children and young people and their families.

The Committee has delegated authority from the Trust Board to oversee the effectiveness of clinical quality, clinical practice and clinical governance within the Trust, ensuring that all supporting systems and processes enable staff to adhere to their duty of candour. It does this principally via the Divisional Directors and Divisional Directors of Nursing who have the authority to implement the Trust’s Quality Strategy and supporting Quality Aims within and across Divisions, supported by the central functions.

The Committee discharges its responsibilities through review of a comprehensive annual workplan, scheduled deep dives, divisional quality assurance reports, corporate updates, regulatory submissions, and highlight reports from oversight groups such as:

- Patient Safety Programme Board
- Clinical Effectiveness & Outcomes Group (CEOG)
- Patient Experience & Engagement Group
- Liverpool Neonatal Partnership Governance Group

Constitution

Throughout 2025/26, the Safety & Quality Assurance Committee (SQAC) maintained a strong and experienced membership, combining Non-Executive challenge, Executive leadership, and senior clinical insight. Membership aligned with the Committee's Terms of Reference and ensured appropriate representation across all functions contributing to clinical quality, safety, patient experience, and regulatory compliance.

The Membership comprises:

- Non-Executive Director x 3 one of whom shall be the Chair
- Chief Medical Officer
- Chief Nursing Officer, AHP and Experience Officer
- Chief Operating Officer / Deputy Chief Executive
- Chief Corporate Affairs Officer
- Chief Transformation and Digital Officer
- Associate Chief Nurses x3
- Head of Nursing for Research
- Lead for each sub-committee x3

This breadth of membership ensured the Committee maintained a strong multi-disciplinary perspective at all meetings. SQAC remained consistently quorate throughout 2025/26, with attendance demonstrating high levels of engagement from both Executive and Non-Executive members. A schedule of attendance at the meetings is provided in Appendix A.

The Committee has an approved work plan incorporating all statutory and regulatory requirements which is used to review the establishment and maintenance of an effective system of quality governance, patient safety and risk management across organisations activities and aligned to the Trust's strategic priorities.

Principal Review Areas / Achievements in 2025/26

Safe

The Safe domain remained a central focus of the Committee's work. Several cross-cutting workstreams, incident reviews, and improvement programmes provided strong, maturing assurance that systems and processes were in place to protect children and young people from avoidable harm.

Patient Safety and Incident Response

The Trust has continued to implement the Patient Safety Incident Response Framework (PSIRF). The Committee noted advances in:

- The quality and thoroughness of incident investigations
- Thematic insights gained from retained items, medication errors, and documentation concerns
- Greater involvement from staff, parents, and carers in the learning process
- Linking incident themes with complaints, claims, and clinical audits

Two high-profile investigations involving retained items were managed transparently, resulting in clear system-level lessons and enhanced controls within theatres and peri-operative pathways. External reviews were commissioned for these never events, and lessons learned have been applied Trust-wide. The PSIRF annual self-assessment achieved 91%, improving by 8% compared to the previous year.

Sepsis and Deteriorating Patient

The Committee maintained close and ongoing oversight of sepsis performance throughout the year. In particular, inpatient compliance with the timely administration of antibiotics remained robust and consistent. However, the Safety and Quality Assurance Committee (SQAC) identified some variation in achieving the 60-minute target for antibiotic delivery in certain clinical settings. In response, the Committee welcomed and supported focused improvement initiatives, the revision of clinical pathways, and the introduction of refreshed training to address these areas of variation and promote even more reliable practice for patients showing signs of sepsis or clinical deterioration.

Infection Prevention and Control (IPC)

Quarterly IPC reports continue to provide strong assurance of a well-governed system, with proactive management of seasonal pressures, strengthened environmental hygiene practices, and enhanced surveillance. IPC compliance remains high, with ongoing adherence to the Health and Social Care Act Code of Practice. External audit and peer review outcomes were positive, and all recommended improvements have been progressed, including:

- Expansion of IPC Champion roles
- Additional environmental audits
- Increased cleaning capacity and deployment of new technologies in high-risk areas (ICNet)

Challenges noted within the service include:

- Antimicrobial Resistance work remains constrained to weekdays due to capacity limitations; oversight is provided through the Patient Safety Programme Board (Workstream 17).
- Measles incidents were effectively managed, with rapid responses commended by local health protection teams.
- An increase in *C. difficile* incidents, particularly in high-risk groups (Oncology/Haematology), consistent with wider North West regional trends. *C. difficile* deep-dive reviews identified no lapses in care across several cases

Transition

During the year, SQAC received and noted regular updates on transition arrangements for children and young people moving to adult services, maintaining visibility of transition as a Trust-wide quality and safety priority. Updates highlighted ongoing work to reduce unwarranted variation, improve communication and handovers, and strengthen consistency across services. Key risks identified include variability in transition pathways between specialties, capacity pressures within adult services leading to delays, and the potential for gaps in care during handover. Mitigations in place include clear ownership through divisional reporting, continued SQAC oversight, and Trust-wide engagement activity aimed at embedding shared learning into practice, including structured workforce development focused on improving transition capability and confidence.

Safeguarding

The Trust's safeguarding arrangements continued to strengthen, with:

- Enhanced supervision processes
- Improved digital systems for documentation and triage, now fully integrated with Meditech
- Learning from audits and external reviews embedded into practice

The Committee noted ongoing workforce pressures linked to increasing multi-agency requirements and emphasised the need to maintain compliance and training uptake, particularly for Level 3. A training needs analysis was undertaken during the year which is aligned to the Intercollegiate Guidance and underpins delivery and monitoring. Compliance at year end was: Safeguarding Adults L1 96%, L2 92%, Safeguarding Children L1 95%, L2 89% and L3 84%.

Safe Waiting List Management

The Committee received assurance that waiting list safety continues to be closely monitored, with a particular focus on follow-up accuracy, high-risk patient cohorts and specialty-specific backlogs. A strengthened review and validation process has been implemented, supported by enhanced division-led oversight. As a result, the volume of overdue follow-ups has reduced by 50%. Introduction of a new outcome-capture form has improved data accuracy to 90%, thereby reducing the risk of harm arising from administrative error.

Patient Safety Board (PSB) (Improvement Workstreams)

The Patient Safety Board has delivered notable improvements across harm reduction, escalation processes, investigation quality, patient involvement, and governance maturity. Key advancements include strengthened PSIRF delivery, enhanced resuscitation and deterioration systems, expanded Patient Safety Partner integration, improved medication safety, and upgraded safety metrics reporting. PSB's sustained focus on restrictive practices, antimicrobial resistance, consent processes, and cultural development has significantly increased organisational safety oversight and assurance.

Drugs & Therapeutics Committee (DTC)

The Drugs & Therapeutics Committee continues to strengthen the Trust's medicines governance framework, delivering notable achievements across medicines safety, optimisation, and assurance. Recent progress includes robust evaluation of new medicines and clinical technologies, improved horizon-scanning and financial planning through development of a dedicated drug budget report, enhanced learning from medication incidents via the Medication Safety Committee, the appointment of a Controlled Drugs Accountable Officer and ongoing standardisation of policies and therapeutic guidelines across DTC sub-groups. Despite these gains, several risks remain: medicines governance processes are still maturing in some areas, medication error rates continue to require focused mitigation, and rising costs associated with high-cost therapies present ongoing financial pressure. The need to ensure full and timely compliance with national guidance, combined with variability in non-medical prescribing oversight, also represents areas where continued strengthening is required.

Quality Assurance Rounds

Quality Assurance Rounds (QARs) continued to offer effective ward-to-board assurance, allowing the Trust to evaluate safety, quality, experience, and leadership at the service level. QARs help teams share achievements and challenges, seek support, and provide qualitative and quantitative insights aligned with the CQC's five domains. In 2025/26, 14 QARs covered diverse specialties, highlighting collaboration, staff resilience, national standards, and innovation like the ISLA digital platform. Main concerns included recruitment, service delivery, technology, medication shortages, and transition risks; these are promptly addressed and escalated as needed. QARs continue to be an important assurance tool and will continue to be regularly monitored by SQAC.

Caring

The Committee observed a sustained organisational commitment to improving the experiences of children, young people and families.

Patient and Family Experience

Recent patient experience reports highlight a strong organisational commitment to listening to and acting on the views of children, young people and families, aligned to the Trust's Vision 2030 ambitions. Feedback systems remain robust, with triangulation of complaints, compliments, FFT and satisfaction data routinely informing improvement activity, supported by the Patient Experience subgroup and Trust-wide governance structures

Quarterly reports highlighted:

- High satisfaction in most inpatient and outpatient settings
- Positive feedback on compassion, communication and staff attitude
- The growing impact of the Family Wellbeing Hub
- Strong engagement with families from areas of higher deprivation

The Committee welcomed increased use of digital surveys, real-time insights and case studies within reports. In addition, PLACE assessments provide further assurance of environmental quality, privacy, dignity and accessibility, ensuring patient experience is embedded across both clinical and non-clinical domain.

Children & Young People's Voice

Youth engagement programmes continued to strengthen. Young people contributed to service redesign, research projects, co-production activities and patient safety initiatives. The Youth Forum is recognised as a key stakeholder in shaping the Experience of Care Self-Assessment Framework; the Committee acknowledged this as a significant cultural asset for the Trust.

Engagement with children and young people continues to strengthen, including innovative approaches such as the development of a child-friendly Patient Experience Booth and active Youth Forum involvement in shaping the Patient Experience Strategy.

Liverpool Neonatal Partnership

Throughout the year, SQAC received regular assurance on the Liverpool Neonatal Partnership, noting sustained improvements in quality, safety and governance alongside ongoing system pressures. Key achievements included strengthened partnership governance and parent engagement, improved staff qualification compliance, progress against national neonatal quality metrics, and achievement of UNICEF Baby Friendly Initiative Level 2 accreditation. However, SQAC continued to monitor significant risks relating to workforce pressures—particularly high sickness absence at Liverpool Women's—operational challenges arising from non-co-location, unresolved digital integration issues affecting infusion pump data, and delays to the new neonatal build with potential impacts on staffing, training and patient experience. These risks are subject to active mitigation through collaborative improvement plans, enhanced governance oversight and continued reporting to SQAC.

The Cheshire & Merseyside Best Practice Model for Children and Young People's Community Eating Disorder Services

SQAC received and noted the Cheshire & Merseyside Best Practice Model for Children and Young People's Community Eating Disorder Services, which has been developed by Alder Hey to provide a consistent, evidence-based approach to community eating disorder care across the ICB footprint. The model introduces standardised pathways, including a dedicated ARFID pathway for children and young people with neurodiversity, improves access to specialist expertise, integrates physical health monitoring with mental health care,

and reduces unwarranted variation between providers. SQAC noted the anticipated benefits of improved equity, consistency and alignment with national guidance, while requesting ongoing assurance regarding implementation challenges, workforce and resource implications, and how benefits for children and young people will be measured as the model is embedded across the system.

Neurodevelopmental Pathways

SQAC received assurance from the Neurodevelopmental Pathways Report, noting significant progress following a formal transformation programme that introduced a single diagnostic and assessment pathway alongside a treatment pathway, making Alder Hey the only provider in Cheshire and Merseyside operating this model. The Committee noted improvements in efficiency, patient experience and risk management through redesigned clinical models, digital enablement, and strengthened safety escalation processes. However, SQAC continued to monitor key risks relating to sustained growth in referrals, extensive waiting lists with the 52-week target not yet achieved, ADHD medication supply constraints, and delays in transition to adult services. These risks are subject to ongoing mitigation through enhanced triage, risk stratification, workforce and capacity initiatives, and continued oversight through divisional governance and SQAC reporting.

Effective

SQAC received extensive assurance that clinical care was evidence-based and outcomes focused, with a clear emphasis on improving consistency and embedding learning across Divisions.

Ward Accreditation

During the year, SQAC received assurance on the Trust's Ward Accreditation programme, which was strengthened to provide consistent, ward-level assurance against key quality and safety standards. An annual accreditation plan was approved, with all wards scheduled to hold a current accreditation, supported by clear action planning where mandatory standards were not initially met. Early outcomes demonstrated strong performance across caring and safety domains, alongside constructive identification of improvement themes, particularly within the 'Safe' domain, to support continuous improvement. SQAC continued to emphasise the importance of maintaining up-to-date accreditations and ensuring that learning and action plans are embedded through divisional governance arrangements.

Addressing Health Inequalities – Improve My Life Chances

SQAC is assured that reducing health inequalities is embedded within the Trust's Vision 2030 supported by clear leadership, system partnerships and formal governance routes. The Trust has moved beyond strategy into delivery, with targeted action on access, prevention, community-based care, data insight and equity-focused service design. While challenges remain in fully quantifying impact and addressing the wider determinants of health, robust plans and system collaborations are in place to support sustained improvement.

North West Gender Service

Since its launch on 1 April 2024, the regional Children & Young People's Gender Service—jointly delivered by Alder Hey and Royal Manchester Children's Hospital—has established a fully compliant service model aligned to the NHS England interim service specification. The service is now operating as a regional centre with standardised clinical pathways, defined SOPs across assessment, care planning and transfers of care, and strengthened multi-agency governance through the National Provider Network and Clinical Reference Group.

The development of *Willow Mere* has been completed, providing a dedicated facility that enhances clinical, therapeutic and staff environments. This supports the delivery of safe, high-quality care for children, young people and their families.

Risk relating to Pathways Trial of puberty-suppressing hormones for gender incongruence

SQAC received and considered assurance on the risks associated with the Pathways Trial of puberty-suppressing hormones for children and young people with gender incongruence. The Committee noted two principal risks: the complexity and ongoing legal scrutiny surrounding safeguarding and consent, particularly the assessment of Gillick competence, and the absence of a fully established endocrinology pathway to support trial participants. Legal advice has been sought, guidance is in development, and the risks are actively managed through the divisional risk register with continued oversight and reporting to SQAC, reflecting the high-profile and evolving national context of this work.

Mortality

Mortality at Alder Hey remains stable with no long-term upward trend, and the overall number of deaths has decreased from a peak of 82 in 2024 to 68 in 2025, the lowest in the period, reflecting sustained improvement and effective review processes. The Child Death Review (CDR) process continues to strengthen in response to learning from HMRG and bereaved families, and thematic analysis has improved organisational insight into contributory factors such as communication, documentation and recognition of severity. Key risks requiring continued SQAC oversight include recurring seasonal peaks in mortality, ongoing vulnerabilities in documentation and communication, and the complexity of neonatal and PICU mortality patterns, alongside operational pressures that may impact timely CDR completion.

Organ Donation

During the year, SQAC received assurance on the Trust's organ donation activity, noting the significant national gap between demand and supply for paediatric organ donation and the importance of maintaining organ donation as a routine end-of-life care option. The Trust referred 24 children and young people for potential organ donation, resulting in one successful donation following consent, with the donated heart utilising new technology under MHRA compassionate authorisation—the first such use in the UK for a young person. SQAC noted continued improvements in governance, policy, staff education and organisational culture to support donor identification and family approach, recognising that even a single donation represents a significant and life-changing outcome.

Equality Delivery System 2022

SQAC received assurance on the Trust's Equality Delivery System 2022 (EDS22) assessment, noting that Alder Hey achieved an overall score of 26 across the three EDS domains, placing the Trust in the "Achieving" category and representing an improvement on the previous year's score. The Committee noted strong evidence of inclusive service delivery, workforce health and wellbeing, and inclusive leadership, alongside improved alignment of EDS work with health inequalities priorities. SQAC welcomed the strengthened approach to stakeholder engagement, evidence validation and governance, and noted that a formal EDS action plan is being developed to address identified improvement areas and embed equality objectives into operational planning, with progress to be monitored through established governance routes.

Clinical Audit and NICE

The Committee provides comprehensive oversight of clinical audit activities through an organised work programme and well-defined escalation pathways. Regular monitoring takes place via routine reporting on the Trust's Clinical Audit Plan, covering progress against

nationally mandated and specialty-specific audits. This includes the tracking of milestones for data collection, sign-off, submission deadlines, and exception reporting to highlight areas where delivery may be at risk.

SQAC receives assurance from the Clinical Effectiveness & Outcomes Group / Board (CEOG/CEOB), which serves as a dedicated forum for the detailed scrutiny of audit quality, methodology, and governance. This structure ensures that divisional leads are fully aware of their responsibilities and have the necessary support to meet audit requirements. When national bodies collect audit returns and provide feedback, queries, or required actions, SQAC ensures that these items are logged, assigned to relevant owners, and actioned through a tracked plan. This plan includes clear timescales, evidence of completion, and re-audit where necessary.

This approach enables the Committee to offer robust assurance to the Trust Board regarding the delivery and timely submission of mandated clinical audits, the implementation and ongoing monitoring of actions notified by external agencies, and the translation of audit learning into measurable service improvements and sustained compliance.

SQAC has recognised significant advances in clinical audit capability through organisation-wide initiatives such as the Clinical Audit Masterclass. This programme is designed to deepen staff knowledge in key areas, including audit methodology, registration processes, effective data use, and the integration of audit outcomes into quality improvement efforts.

Despite these improvements, challenges remain, particularly regarding team capacity and preparedness to meet the expected audit quality standards. Staff continue to express concerns about their confidence and readiness in the lead-up to upcoming audit deadlines. The Trust remains focused on strengthening documentation practices, compliance monitoring, and the prompt submission of audit deliverables, as evidenced by frequent reminders issued to divisions regarding audit report deadlines for SQAC.

Compliance with NICE guidance across the Trust continues to be strong. Notable improvements have been seen in the identification of gaps and the establishment of clear ownership for action plans, ensuring effective and sustained implementation of NICE recommendations.

Well-Led

The Committee saw clear evidence of strong leadership behaviours, maturing governance, and an organisational commitment to openness, learning and staff wellbeing. The year saw strengthened alignment between SQAC, CEOG, the Patient Safety Programme Board and the broader integrated governance structure. Chair's highlight reports from subgroups improved clarity around risk and learning. Divisions increasingly demonstrated a balanced, reflective approach to presenting challenges.

Workforce and Culture

The Committee acknowledged continued pressures across key clinical areas, including vacancies and training compliance challenges which are being monitored through the risk register. However, across all divisions there is evidence of sustained focus on staff wellbeing, leadership development, psychological safety and learning culture. Improvements in sickness absence are evident in several clinical divisions, alongside strong engagement with appraisal and personal development processes. SQAC recognises, however, that the scale of required workforce change, ongoing sickness absence pressures in some areas, and the pace of transformation and financial improvement activity present material risks to staff morale and capacity. These risks are actively mitigated through clear leadership oversight, People Committee scrutiny, and a continued emphasis on compassionate, transparent decision-making. SQAC will maintain close oversight to ensure workforce

changes are delivered safely and sustainably, and that the Trust remains a supportive, inclusive and positive place to work.

External Scrutiny

The Committee had oversight of several external reviews, inspections and accreditations such as CQC Inspections, Fuller Public Inquiry and the Southport Public Inquiry. The Trust demonstrated transparent engagement with regulators, timely responses to improvement notices, and strengthened processes for tracking and assuring action plans.

BAF Oversight & cross-Cutting Themes

During 2025/26, the Safety & Quality Assurance Committee provided focused and consistent oversight of the three principal Board Assurance Framework (BAF) risks delegated to it:

Ref	Risk	Score	Target
		IxL	
1.1	Inability to deliver safe and high-quality services	3x3	2x2
1.2*	Children and young people waiting beyond the national standard to access planned care and urgent care	4x5	3x3
1.4*	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	3x5	3x3

* Joint responsibility with FT&P

The Committee reviewed these risks at every meeting, with monthly updates from Executive leads, improved triangulation with divisional data, and strengthened linkage to quality performance, operational metrics and incident themes.

BAF Risk 1.1 — Inability to Deliver Safe and High-Quality Services

This risk remained a central focus for SQAC due to its breadth and the impact of fluctuating operational pressures. Across the year, the Committee:

- Scrutinised divisional quality assurance reports for early indicators of system weakness
- Monitored trends in incidents, PSII findings, complaints and clinical audit
- Oversaw the implementation of multiple improvement programmes (e.g., documentation, clinical letters, sepsis training, diagnostics notifications)
- Assessed the effectiveness of safety-critical pathways, including medicines optimisation, deteriorating patient management and infection control
- Ensured learning from external reviews (including IR(ME)R) was embedded

The Committee concluded that while the Trust demonstrated sustained strengths in many aspects of safe clinical practice, the risk remained appropriate due to ongoing pressures in demand, workforce, financial pressures and digital infrastructure. Mitigations were clearly articulated, mature, and demonstrated impact over time.

BAF Risk 1.2 — Children and young people waiting beyond the national standard to access planned care and urgent care.

This risk reflects system-wide and seasonal pressures on capacity, flow and access to timely care. SQAC reviewed:

- Divisional oversight of elective and urgent pathways
- Safe management of waiting lists, including follow-up backlogs and risk categorisation
- Emergency Department pressures, especially surges in demand and complexity
- Operational mitigations linked to triage, streaming, escalation and winter planning

- Impacts of digital systems on validation accuracy and performance reporting
- The Committee recognised significant operational challenges but received assurance that:
- Safety measures for waiting lists were continually strengthened
 - Escalation plans were clear, well-used and responsive
 - Divisional teams demonstrated ownership of performance deviations
 - System partnerships were increasingly effective in managing flow and demand
- The Committee supported continued investment in pathway redesign, digital tools and targeted workforce initiatives to strengthen resilience going into 2026/27.

BAF Risk 1.4 — Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies

SQAC provided scrutiny of the Community & Mental Health Division's improvements during a year of high operational pressure and sustained demand increases. Assurance focused on:

- Waiting times for mental health assessments and ongoing therapy
- Capacity challenges arising from workforce changes and partner agency constraints
- Continuity planning following reopening of key inpatient and community services
- Quality and safety oversight of neurodevelopmental pathways
- Safeguarding interface risks, particularly for vulnerable young people waiting longer than planned
- Integration of learning from incidents relating to documentation, communication and handover
- The introduction of internal standards, targeted clinical leadership support, and new workforce models helped stabilise the risk position.
- SQAC welcomed the increased transparency and clarity of divisional reporting and supported further review of the risk articulation for 2026/27 to reflect maturing mitigations and the evolving regional context.

Cross-Cutting Assurance Themes Identified in 2025/26

Throughout the year, the Committee identified several system-wide themes that cut across all three BAF risks:

- Digital Dependencies and Infrastructure

Recurring issues with diagnostics notifications, transcription turnaround, and data quality highlighted the growing dependency on digital systems. SQAC welcomed progress on integrated observations, workflow redesign and automation opportunities, but emphasised the need for sustained investment and early engagement of clinicians in digital planning.

- Documentation, Communication and Administrative Safety

A number of incidents and complaints stemmed from timing errors, document accuracy, transcription delays and communication breakdowns. The Committee viewed this as a multi-factorial issue requiring combined action across IM&T, clinical services, training, and corporate governance. Improvements were noted, but this will remain a priority area for 2026/27.

- Workforce Pressures in Key Clinical Areas

Workforce strain continued to feature, particularly in specialised services (e.g., safeguarding, mental health, theatres, medical imaging). The Trust's ability to maintain safety and quality despite these pressures was recognised, but SQAC stressed the importance of sustained, long-term planning and clear articulation of the quality impact of vacancies and turnover.

- Growth in Demand and Complexity

Across urgent care, planned care, mental health and neurodevelopmental pathways, rising demand increased operational and quality pressures. The Committee highlighted the importance of improving pathway efficiency, strengthening partnerships and evaluating service models to manage future demand sustainably.

- **Variation in Training and Compliance**

Training compliance (sepsis, safeguarding, documentation, digital systems) required ongoing reinforcement. SQAC recognised improvements made through blended learning and clinical leadership support, particularly in sepsis training and documentation updates.

- **Learning from Incidents and External Reviews**

Themes from PSII investigations, external inspections, peer reviews and serious incidents provided powerful learning opportunities. Key improvements included enhanced checklists, strengthened governance around high-risk procedures, and clearer escalation frameworks across specialty teams.

Overall, the Committee is assured that the Trust has robust, evolving systems in place to monitor and manage these key strategic risks, with clear improvement trajectories and maturing governance capability.

Responsive

The Responsive domain remained a key assurance thread due to ongoing capacity pressures, complexity of presentations and increased demand across urgent, planned and mental health services.

Clinical Research

SQAC is assured that appropriate governance, safety and oversight arrangements are in place for clinical research activity, with effective management of serious adverse events and strong alignment to regulatory and sponsor requirements. The Board recognises, however, that workforce vacancies and infrastructure dependencies, particularly relating to MRI capacity, continue to present challenges to research delivery and income generation. These risks are actively managed through divisional leadership and targeted oversight arrangements, including dedicated steering groups.

Access and Flow

The Trust managed sustained demand through improved triage processes, enhanced pathways with community and primary care partners, and investment in digital validation tools. Despite operational pressures, the Committee received assurance that safe pathways were maintained and risks escalated appropriately.

Southport Incident

SQAC has received regular and structured updates on the Southport incident, including formal consideration of the internal learning review and associated action plan, progress reports on implementation, and oversight of safeguarding and workforce impacts. The Committee has been sighted on areas of partial assurance and has ensured appropriate escalation and continued monitoring through established governance and risk management arrangements.

Complaints & PALS

Complaints performance during the year showed clear and sustained improvement across the Trust, with consistently high response-time compliance, including 92% of formal complaints responded to within 25 working days in Q3 and PALS concerns achieving over

93% resolved within 5 days. Divisional performance has been particularly strong, with Medicine maintaining excellent timeliness and Community & Mental Health achieving their highest recorded compliance. The Trust also continues to demonstrate exemplary openness through 100% compliance with Duty of Candour requirements, alongside strengthened thematic analysis and learning processes that ensure feedback drives targeted service improvement. These successes reflect a maturing, patient-centred complaints system with improving early resolution and growing focus on equitable support for children and young people, including those with SEND.

Facilities Management performance and responsiveness

SQAC has received regular updates on Mitie's facilities management performance, including delivery against an agreed improvement plan and the development of enhanced performance dashboards. While service levels were reported as high, the Committee has maintained oversight to ensure improved transparency of repair data and sustained improvement. Follow-up reporting has been scheduled and received to support ongoing assurance.

SQAC received regular updates on the longstanding building and cultural challenges within its Tier 4 inpatient mental health provision, including estate limitations that impact the therapeutic environment and sustained workforce pressures inherent in high-acuity services. These risks are actively managed through formal governance arrangements, with environmental risks recorded and monitored via the corporate risk framework and cultural challenges addressed through targeted workforce, leadership and wellbeing actions. SQAC and associated forums maintain oversight to ensure that mitigations remain proportionate, that risks are transparent, and that the safety, experience and wellbeing of patients and staff continue to be prioritised. The Trust has maintained ongoing engagement with NHS England regarding these issues which have been discussed through commissioning, capability and regulatory interfaces, with NHS England sighted on both the historical context and the Trust's improvement actions. Engagement has focused on system-level understanding of risk, service sustainability and the need for sustained cultural and leadership improvement alongside estate considerations.

Clinical Ethics Leadership

The Committee regularly received updates from the Clinical Ethics Committee confirming that:

- Ethical oversight procedures were strong
- Educational programmes covering ethics and law were growing

The Trust continues to take proactive steps to address new ethical issues, such as documentation for neurodivergent young people and complex consent processes.

Mental Health and Neurodevelopmental Services

The Trust has improved the Neurodevelopmental (ND) service through a structured transformation programme aligned with Cheshire & Merseyside ICB recovery work. Major achievements include a single joint ND pathway for combined ASD/ADHD assessment, formalised SOPs for MDT panels, adult transition, private diagnosis verification, and medication governance, all ensuring consistent, NICE-aligned decisions. Enhanced operational and clinical capacity and new roles like Peer Support Workers have boosted support for families. Ensuring consistency across ND pathways, sufficient MDT capacity, and safe prescribing remains a challenge requiring ongoing oversight via SQAC to manage risks and maintain service quality for patients and families.

Emergency Preparedness, Resilience & Response (EPRR)

The Trust continues to strengthen its Emergency Preparedness, Resilience and Response (EPRR) arrangements, with updated policies and SOPs ratified during the year and steady progress delivered through the Emergency Preparedness Group to improve Core Standards compliance. Key workstreams have focused on modernising incident coordination processes and enhancing business continuity planning, supported by strengthened governance and training requirements. Although the Trust remains non-compliant under the more rigorous national assurance regime, a robust remedial action plan is in place with ICB partners and continues to be actively monitored

External inspections, regulatory compliance & accreditation

In 2025/26, the Committee maintained strong oversight of the Trust's compliance with regulatory standards, statutory requirements, accreditation, and external reviews. The Committee systematically reviewed all relevant external reports received by the Trust and tracked the implementation of related actions, ensuring that lessons learned were effectively integrated into both operational and clinical settings.

Specialties subject to peer review or accreditation such as burns, cardiac surgery, and other high-risk areas actively collaborated with external assessors in a constructive manner. When improvements were needed, such as better documentation consistency or stronger governance, divisions developed and presented clear action plans that were subsequently monitored through SQAC. The Committee took assurance from:

- Transparent and timely reporting from divisions
- Clear articulation of controls, mitigations and improvement actions
- Evidence of shared learning across service lines

In March 2025, the CQC inspected Community and Mental Health, ASD & ADHD Services. The services were rated outstanding with no recommendations; however, an internal improvement plan was implemented, including Meditech enhancements to make risk information more visible and accessible. This included a new Risk and Care Plan function, a tool to manage externally sourced risk documents, improved use and visibility of risk flags, and a Power BI dashboard to support caseload and risk oversight.

The Committee reviewed a formal assessment of externally sourced services following concerns raised during the CQC inspection of the nuclear medicine service. The assessment identified the need for stronger oversight, standardised governance, and clearer contractual assurance mechanisms.

SQAC endorsed the introduction of:

- A standardised SLA governance framework
- A defined approval and review pathway
- Improved documentation and intelligence on external provider performance

This programme of work will continue into 2026/27, with the Committee maintaining oversight of compliance and quality outcomes.

Overall, the Committee was assured that external scrutiny is being used positively to strengthen safety, quality and governance, supported by a culture of openness and proactive improvement.

Items to bring to the Board's attention

There are no matters to highlight.

Assurance Statements

Based on the information provided, the Committee is satisfied that:

- the systems of control governing clinical quality, safety and experience are largely effective;
- risks are well-identified, proactively managed and appropriately escalated;
- the organisation is continually improving, with clear measurable progress against previous years; and
- there is strong alignment between operational practice, governance scrutiny and strategic ambition.

SQAC confirms that the Trust's assurance framework is fit for purpose and supports the declarations reported to the Board in respect of the Annual Governance Statement.

Based on the Committee's processes for gaining assurance on clinical audit work as summarised above, the Committee members can confirm that:

- The remit and resources dedicated to clinical audit activities are appropriate for the Trust to meet its obligations for the Quality Account.
- The mandated Clinical Audit Work Programme has been delivered.

The Chair of SQAC is a member of the People Committee enabling links to specific workforce issues in a multi-factorial way, specifically in relation to patient safety and quality improvements.

The Committee summarises escalations to the Board of Directors at the end of every meeting.

Committee Priorities for 2026/27

Building on the assurance activity, learning and system-wide themes identified throughout 2025/26, the Safety & Quality Assurance Committee has identified a set of strategic priorities to guide its work for the coming year. These priorities reflect both ongoing areas of focus and newly emerging risks requiring strengthened governance, enhanced visibility and sustained executive attention.

- **Strengthen digital safety, reliability and governance** – digital systems underpin an increasing proportion of clinical safety activities, administrative workflows and data reporting. Continued oversight of reduction of unacknowledged diagnostics notifications and optimised Meditech workflows will remain a priority along with oversight of Integrated Observations deployment and assurance that digital transformation initiatives incorporate safety considerations.
- **Sustain improvements in Patient Safety Culture & PSIRF Maturity** – although significant progress has been made, the transition to fill PSIRF maturity will remain a key workstream.
- **Deepen work on Health Inequalities, Experience and Co-Production** through supporting the use of segmented data to identify inequalities in complaints, incidents and experience. Strengthen oversight of Experience of Care Framework implementation.
- **Focus on workforce sustainability & the quality impact of staffing pressures.** SQAC will seek enhanced assurance on 'hard-to-fill roles', recruitment and retention strategies in 'pressure-point' specialties and the strengthening of safe staffing governance, escalation and early warning mechanisms.

- **Maintain close oversight of demand, flow and mental health system pressures** – these risk link directly to BAF 1.2 and 1.4 and will remain central to SQAC's work (waiting list management and follow-up, impact of new staffing models in mental health and neurodevelopmental services, ensuring the visibility of resilience and surge planning across Divisions).

Professor Fiona Beveridge
Committee Chair
April 2026

APPENDIX A

SAFETY & QUALITY ASSURANCE COMMITTEE - RECORD OF ATTENDANCE 2025/26

Quorum: A quorum shall consist of the Chair or nominated deputy, one other NED, two Executive Directors (one of whom must be the Chief Medical Officer or Chief Nursing Officer and AHP/HCP Lead, or their designated deputy). Meetings were held virtually via Microsoft Teams.

Member / Date of Meeting	2025									2026			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Fiona Beveridge (Chair) (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	N O M E E T I N G H E L D	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	11/11	100%
Kerry Byrne (Non-Executive Director)	x	✓	✓	✓		✓	✓	✓	✓	✓	✓	x	9/11	82%
Gerald Meehan (Non-Executive Director)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11	100%
Alfie Bass (Chief Medical Officer)	x	✓	x	x		✓	✓	x	✓	x	✓	✓	6/11	55%
Nathan Askew (Chief Nursing AHP & Experience Officer)	✓	✓	✓	✓		✓	✓	Deputy	✓	✓	✓	x	9/11	82%
Adam Bateman (Chief Operating Officer)	✓	x	x	✓		✓	✓	✓	✓	✓	✓	✓	9/11	82%
Erica Saunders (Chief Corporate Affairs Officer)	✓	✓	✓	x		✓	x	✓	x	✓	✓	✓	8/11	73%
Kate Warriner (Chief Transformation and Digital Officer)	Deputy	Deputy	Deputy	x		Deputy	Deputy	x	Deputy	x	x	Deputy	7/11	64%
Rachael Pennington (ACN - Surgery)	✓	x	x	✓		x	✓	✓	✓	✓	✓	✓	8/11	73%

Member / Date of Meeting	2025									2026			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Jacqui Pointon (ACN – Community & MH)	x	✓	✓	✓		✓	✓	✓	x	x	✓	✓	8/11	73%
Cathy Wardell (ACN - Medicine)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11	100%
Laura Rad (Head of Nursing for Research)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	x	10/11	91%
Jackie Rooney (Sub-Committee lead CEOG)	x	✓	✓	x		✓	x	✓	✓	✓	x	x	6/11	55%
Chris Talbot (Sub-Committee lead PSB)	x	x	x	x		✓	x	x	x	x	✓	x	2/11	18%
Pauline Brown (Sub-Committee lead PEEG)	x	x	x	x		x	x	x	x	x	x	x	0/11	0%
QUORUM ACHIEVED	YES	YES	YES	YES		YES	YES	YES	YES	YES	YES	YES	11/11	100%

People Committee Annual Report 2025/26

Introduction

The People Committee presents its Annual Report for the period **1st April 2025 to 31st March 2026**. The report provides assurance to the Trust Board that that governance, oversight and monitoring arrangements in relation to workforce matters are effective and that the Trust's People Plan continues to support delivery of Vision 2030.

This annual report reflects the breadth of workforce matters overseen by the People Committee along with the increasing maturity of assurance arrangements in relation to delivery of the People Plan. Over the year, the Committee has strengthened its focus on monitoring progress across the Plan's priorities, supported by deeper triangulation of workforce intelligence from Divisions and Trust-wide metrics. There has been a sustained emphasis on understanding impact, embedding learning and addressing areas of risk or slippage, ensuring that delivery of the People Plan remains aligned to Vision 2030 and supports the development of a sustainable, engaged and thriving workforce.

The People Committee

The People Committee's (PC) purpose is to provide assurance to the Board of Directors that governance and monitoring mechanisms in relation to all workforce matters are robust and that the strategic objectives relating to people as set out in the Trust's People Plan are met.

The Committee operates under delegated authority from the Trust Board and oversees workforce strategy, culture, wellbeing, equality, diversity and inclusion, leadership development and workforce sustainability, drawing assurance from Divisional reports in support of the delivery of high-quality patient and family centred care, Trust-wide metrics and supporting groups.

Constitution

Throughout 2025/26, the People Committee maintained a strong and appropriately balanced membership, bringing together Non-Executive challenge, Executive leadership and senior operational insight. Membership was aligned to the Committee's Terms of Reference and ensured appropriate representation across all functions contributing to workforce strategy, organisational culture, leadership capability, staff wellbeing and equality, diversity and inclusion.

The Membership comprises:

- 3 Non-Executive Directors one of whom shall be the Chair
- Chief People Officer
- Chief Operating Officer
- Chief Nursing, AHP and Experience Officer
- Chief Medical Officer
- Chief Corporate Affairs Officer
- 1 x Senior representative from each Division

Expected to attend each meeting: Deputy Chief People Officer, Associate Director of Organisational Development, Alder Hey Academy Director, Head of Equality, Diversity and Inclusion and the Chair of Staff Side.

This breadth of membership enabled the Committee to maintain a strong, multi-disciplinary perspective in its discussions and decision-making. The People Committee remained consistently quorate throughout the year, with attendance demonstrating high levels of engagement from both Executive and Non-Executive members. A schedule of attendance at meetings is provided in Appendix A.

The Committee operated to an approved annual work plan aligned to statutory and regulatory requirements and the Trust's strategic priorities, providing structured oversight and assurance on delivery of the People Plan and the effectiveness of workforce governance arrangements across the organisation.

To ensure that the People Committee remains strategic and assurance led, it is supported by a number of forums and working groups, including staff side structures and leadership and organisational development groups, which provide operational oversight and escalate matters of exception.

Principal Review Areas / Achievements in 2025/26

Delivery of the People Plan

Based on the reports, metrics and updates received throughout 2025/26, the People Committee is assured that delivery of the Trust's People Plan is progressing appropriately and remains aligned to Vision 2030. The Committee has maintained regular oversight of People Plan priorities, supported by routine monitoring through Trust-wide and Divisional workforce intelligence, Board Assurance Framework risk updates and targeted deep-dive discussions. This has enabled the Committee to strengthen assurance through improved triangulation of data, clearer understanding of variation and risk, and a more consistent focus on impact and outcomes.

The Committee recognises the progress made during the year in strengthening workforce governance, improving the quality and use of people data, and embedding a greater focus on organisational culture, leadership capability and staff wellbeing. At the same time, the Committee has maintained visibility of ongoing challenges, including sickness absence, workforce capacity pressures and the complexity of delivering People Plan ambitions within a constrained system context. The Committee is assured that these challenges are understood, actively managed and subject to appropriate mitigating actions, and that delivery of the People Plan remains under close review.

During 2025/26, a detailed sickness deep dive was undertaken to strengthen assurance on sickness absence and its impact on workforce sustainability. The deep dive highlighted ongoing challenges, particularly the persistence of long-term sickness absence, variation across Divisions and pressure on return-to-work compliance, alongside gaps in control that required further mitigation. The Committee is assured that targeted actions are in place, including strengthened line-manager training, enhanced HR sickness support, SALS and Occupational Health support, and alignment to People Plan workstreams, with progress subject to ongoing monitoring through Trust-wide metrics and Board Assurance Framework oversight.

In addition, the Committee received updates on the Organisational Design Collaborative, which supports delivery of the People Plan and Vision 2030 by aligning organisational structures, governance and ways of working. The Committee was assured that appropriate governance is in place and that the programme provides a structured approach to organisational change, supporting staff experience, leadership effectiveness and organisational resilience.

On this basis, the People Committee can confirm that there is an appropriate level of assurance in place regarding delivery of the People Plan during 2025/26, with clear priorities identified to support continued progress in 2026/27.

Thriving

During 2025/26, delivery of the People Plan placed increasing emphasis on developing and sustaining an organisational culture that enables staff and teams to thrive. The People Committee received regular assurance that cultural priorities were being progressed through the People Plan implementation, organisational development activity and leadership programmes, with explicit alignment to Board Assurance Framework risk 2.2 – organisational culture.

Freedom to Speak Up (FTSU)

Based on the regular updates received by the People Committee during 2025/26, the Committee is assured that effective arrangements remain in place to support staff to raise concerns safely and confidently through the Trust's Freedom to Speak Up framework. Quarterly FTSU reports provided visibility of activity levels, themes and trends, enabling appropriate oversight of speaking-up processes and assurance that concerns are managed in line with national guidance and Trust policy.

The Committee recognised a small number of ongoing challenges within this area. In particular, maintaining consistent visibility and accessibility of the FTSU service across all staff groups remains important, especially during periods of operational pressure and workforce change. Variability in reporting levels between quarters was noted, highlighting the need to continue building confidence and awareness among staff to ensure concerns are raised promptly and appropriately.

Mitigating actions are in place and under active review. These include continued promotion of the FTSU offer, strengthening Guardian capacity to ensure continuity and visibility through the appointment of a Deputy FTSU Guardian, and ongoing monitoring of trends and themes through routine People Committee reporting. The Committee was also assured that learning from concerns raised is used to inform organisational learning and improvement, reinforcing the Trust's commitment to an open, just and learning culture and supporting assurance against Board Assurance Framework risk 2.2 relating to organisational culture and staff confidence.

Internal Communications

Throughout 2025/26, the People Committee received regular Internal Communications updates as part of its oversight of delivery of the People Plan and the wider *Thriving* agenda. These updates provided assurance that clear, consistent and timely communication with staff remained a priority, supporting engagement, transparency and alignment with Vision 2030.

Internal Communications activity focused on strengthening two-way communication between senior leaders and staff, promoting People Plan priorities, and supporting organisational change through clear messaging and accessible channels. The Committee was assured that communications activity was increasingly informed by staff insight and feedback, enabling messaging to be targeted and responsive to emerging themes and workforce challenges.

The routine inclusion of Internal Communications updates on Committee agendas ensured sustained oversight of staff engagement and confidence, and reinforced the role of effective communication as a key enabler of organisational culture, wellbeing and staff thriving.

Staff Thriving Index

People Committee received updates on the development and introduction of the Staff Thriving Index, which represents a significant step forward in understanding staff experience beyond traditional workforce metrics. The Index is designed to provide insight into how staff are functioning

both at work and more broadly, supporting early identification of pressure points, enabling targeted support, and strengthening the Trust's ability to create the conditions for staff to thrive. Although the Committee was assured that the Thriving Index complements existing intelligence, including staff survey results, sickness absence data and wellbeing information, and supports a more preventative and learning-focused approach to organisational culture it recognised a number of challenges and areas for ongoing monitoring. As a new measure, the Committee noted the importance of ensuring consistent staff engagement with the Index to generate meaningful and representative data. There is also a need to continue developing the Trust's ability to triangulate Thriving Index insights with other workforce and quality indicators, and to clearly demonstrate how insight is translated into action and measurable improvement. The Committee will therefore continue to monitor uptake, data maturity and the impact of interventions informed by the Index, to ensure it strengthens assurance on organisational culture and contributes effectively to delivery of the People Plan and Board Assurance Framework risk 2.2.

Staff Survey 2025

The People Committee received the 2025 NHS Staff Survey results, supported by detailed Trust-wide and team-level breakdowns. The Committee noted that the Trust achieved a 51% response rate, representing a decline compared to 2024 and reflecting a wider sector-wide reduction in staff engagement levels during 2025. Despite this reduction, the Trust received 2,426 responses, the third-highest number of responses recorded, providing a robust dataset for analysis and action.

The Committee was assured that overall engagement trends broadly mirrored those seen across comparator acute and acute community trusts, with Alder Hey continuing to perform above sector comparator averages despite the reduction in response rate. The Committee recognised that the results highlighted both strengths and areas for improvement across People Promise themes, reinforcing the importance of targeted, localised action rather than reliance on Trust-wide averages alone.

To support learning and improvement, the Committee received updates on the roll-out of "Big Conversation" packs and the establishment of a Staff Survey Action Group, enabling teams to review their own results, engage in meaningful dialogue and develop locally-owned action plans. The Committee was assured that this approach supports staff voice, strengthens engagement and aligns staff survey learning to delivery of the People Plan and the Thriving agenda.

New Trust Values

A new set of values were agreed at Trust Board in April 2025 to support the delivery of Vision 2030 and development of a positive, inclusive and values-led organisational culture. The People Committee received updates confirming that work was progressing well, supported by early engagement and feedback activity which demonstrated positive staff response to the proposed values. A dedicated values working group was established to widen involvement and ensure that the values were informed by staff experience and organisational priorities.

Thriving Teams and Culture Reporting

During the year, the People Committee received updates on the Thriving Teams and Culture programme, providing oversight of work on values and behaviours, safety culture, thriving teams and leadership development. While recognising ongoing challenges in embedding consistent culture and targeting support for teams under pressure, the Committee is assured that appropriate governance and monitoring arrangements are in place, with progress and risks managed through established People Committee oversight and Board Assurance Framework risk 2.2.

Veteran Aware Report

The People Committee received the Veteran Aware – Year Two Progress Report for information and noted that the workstream aligns with the Trust's wider EDI agenda, People Plan and values-based culture. The report provided assurance on the Trust's ongoing commitment to supporting members of the Armed Forces community, including veterans, reservists, service leavers

and their families. The report confirmed that Alder Hey has established a clear governance framework for the Veteran Aware workstream, underpinned by an Armed Forces Working Group with defined Terms of Reference. This group reports into the Equality, Diversity and Inclusion (EDI) Steering Group, with escalation to the People Committee and ultimately the Trust Board, ensuring senior-level visibility and accountability.

The Committee was advised that named executive, clinical and management champions are in place, alongside active staff network leadership, supporting delivery of Veteran Aware commitments across the organisation. Progress during Year Two included the development of a new Armed Forces Community Policy.

Workforce Planning

Workforce Efficiencies

Regular updates on the Workforce Efficiencies Programme were received, including detailed reporting on Trust-wide workforce whole time equivalent (WTE) position and associated workforce controls. These updates provided assurance that workforce efficiencies are being actively managed through established governance arrangements, with WTE reported routinely through the Integrated Performance Report and external returns, and aligned to delivery of the People Plan and financial recovery requirements.

The Committee recognised that delivery of workforce efficiencies presents a number of challenges. In particular, the national and regional requirement to reduce NHS financial deficits continues to place pressure on workforce numbers, requiring careful balancing of WTE reduction, service sustainability and staff wellbeing. The Committee also noted that workforce controls remain partially assured, reflecting the complexity of implementing efficiencies at pace while maintaining safe staffing, clinical quality and staff engagement.

Mitigating actions are in place and subject to ongoing oversight. These include strengthened establishment control, alignment of workforce planning to the Target Operating Model, use of structured workforce efficiency schemes, and regular triangulation of WTE data with quality, safety and sickness absence indicators. The Committee is assured that workforce efficiencies continue to be progressed in a controlled and risk-aware manner, with clear escalation routes in place where risks to service delivery or staff wellbeing are identified.

Mutually Agreed Resignation Scheme (MARS)

During 2025/26, the People Committee received a formal update on the outcomes of the Mutually Agreed Resignation Scheme (MARS), which was implemented as part of the Trust's wider workforce efficiency and financial sustainability arrangements.

The Committee recognised a number of challenges associated with the scheme. In particular, there was a need to carefully balance the financial benefits of voluntary exits against the potential impact on workforce capacity, service resilience and the retention of critical skills and experience. The Committee also noted the importance of maintaining staff confidence and engagement during the operation of the scheme, particularly in the context of wider workforce efficiency measures.

Mitigating actions were in place and subject to People Committee oversight. These included clear eligibility criteria, application review processes to protect essential roles, and alignment of decisions to workforce planning and establishment controls. The Committee was assured that the scheme was managed in a controlled manner, with oversight of risks and escalation routes in place where potential impacts on service delivery or workforce sustainability were identified.

Apprenticeship Provision

The People Committee received assurance on the Trust's apprenticeship provision, confirming that robust arrangements are in place to support workforce development, succession planning and skills growth in line with the People Plan. The Committee was assured that the Apprenticeship Information, Advice and Guidance (IAG) Service continues to provide high-quality, impartial support to staff and managers, underpinned by continued compliance with the Matrix Standard, and

supported by an updated Apprenticeship Policy aligned to national funding rule changes. The Committee recognised ongoing challenges, including navigating national apprenticeship reforms, maintaining uptake and progression during a period of workforce and financial pressure, and ensuring apprenticeships remain aligned to future workforce need.

Voluntary Redundancy

The Committee approved and oversaw the implementation of a time-limited Voluntary Redundancy (VR) Scheme, aligned to the NHS England Model Voluntary Redundancy Scheme, as part of the Trust's wider workforce efficiencies and financial sustainability programme. The Committee was assured that the scheme was designed to support delivery of the Target Operating Model and workforce change plans by enabling voluntary exits in a fair, transparent and nationally compliant manner, while minimising the need for compulsory redundancies. The Committee recognised the inherent challenge of balancing workforce reductions with the need to maintain safe staffing, critical skills and service resilience, and therefore maintained close oversight through eligibility controls, alignment to workforce planning and regular reporting.

Occupational Health

Occupational Health updates providing assurance that arrangements are operating in line with Trust policy and best-practice guidance to support staff wellbeing and reduce sickness absence were routinely received. The Committee noted the successful mobilisation of a new Occupational Health provider from May 2025 following a procurement process, while recognising the ongoing challenge of ensuring timely access, consistent application and demonstrable impact on sickness absence and workforce sustainability. The Committee is assured that appropriate governance and monitoring arrangements are in place, with Occupational Health provision aligned to attendance management processes and subject to ongoing oversight.

Workforce Planning Audit

During 2025/26, the People Committee received assurance from the Workforce Planning Review (Internal Audit), which concluded that a good system of internal control is in place to support the development, approval and monitoring of workforce plans at Divisional and corporate level. While the audit identified areas for improvement, particularly in relation to consistency of application and longer-term workforce planning capability, the Committee is assured that workforce planning arrangements are aligned to the People Plan and Integrated Annual Plan, with audit actions agreed, mitigations in place and ongoing oversight maintained through the People Committee and Board Assurance Framework.

Health & Safety

Health and Safety Committee provided regular updates including dashboard reporting, providing oversight of statutory compliance and arrangements to protect staff. The People Committee maintained visibility of key workforce health and safety risks, including violence and aggression towards staff, mandatory training compliance and sickness absence, recognising the inter-relationship between these areas and staff wellbeing. While ongoing challenges remain in sustaining consistent compliance and assurance across a large and pressured workforce, the Committee is assured that appropriate governance, escalation and monitoring arrangements are in place, with risks managed through established reporting routes and reviewed as part of the Trust's wider workforce and wellbeing governance framework.

Nurse Workforce Report

During 2025/26, the People Committee received the Nurse Workforce Report 2024/25, which provided assurance that the Trust has appropriate systems and processes in place to maintain safe nursing staffing levels across inpatient and day-case services, in line with national guidance. The report set out nursing workforce activity during the year, including establishment, recruitment, retention and use of workforce data to support safe, sustainable and productive staffing, and

confirmed that nursing workforce reporting is subject to routine oversight through the People Committee, SQAC and the Trust Board.

The Committee recognised a number of ongoing challenges requiring continued oversight. These included workforce supply pressures, particularly in specialist nursing roles, the need to sustain recruitment and retention in a competitive labour market, and the impact of sickness absence and turnover on workforce stability. The Committee also noted the importance of continued alignment between nursing workforce plans, financial constraints and service demand, to ensure that staffing remains safe while supporting delivery of the People Plan and Vision 2030

Overpayments

The People Committee received regular reports on the Trust's overpayment position, providing oversight of the scale, causes and management of payroll overpayments. The reports set out that overpayments primarily arise from delays or inaccuracies in the timely processing of changes within the Electronic Staff Record (ESR), and outlined the controls in place to monitor, recover and reduce overpayments.

The Committee recognised ongoing challenges in ensuring timely and accurate notification of contractual and workforce changes, particularly in a complex and fast-moving workforce environment. Mitigating actions reported included closer joint working between HR and Payroll teams, monthly review meetings, development of clearer guidance for managers, and continued review of policies and processes

Flu Vaccine Uptake

During 2025/26, the People Committee received an update on the Trust's flu vaccination programme. The report confirmed that 40% of the total workforce (1,782 staff) had received the flu vaccine, with 41% uptake among frontline staff (1,185 staff). The Committee noted that the Trust was joint second in the Cheshire and Mersey region for flu vaccination uptake at the time of reporting, providing assurance on the relative performance of the programme within the system.

Improving Working Lives for Resident Doctors

The Committee received an update on Resident Doctor Experience and Improving Working Lives (IWL), drawing from national surveys, education reviews, and local feedback at Alder Hey. Risks related to poor resident doctor experience and potential loss of training posts remain under review, with assurance currently only partial as improvement actions are ongoing.

A working group was formed to address issues identified in the report, focusing on rota design, workload, supervision, education, and reasonable adjustments.

Visa and Immigration Changes

The People Committee received an update on UK Immigration Policy Changes and their impact on the Trust's workforce, following a series of Home Office policy changes affecting the health and care sector, including staff at Band 3 and above, which came into effect from 9 April 2025. The report set out the potential implications for workforce supply, recruitment and retention, and confirmed that these changes present a material risk to the Trust's ability to maintain a sustainable workforce. The Committee requested and received detailed analysis on the number of affected employees, the visa categories impacted, and the potential workforce risks, alongside proposed mitigation actions. These included consideration of support mechanisms for affected staff, alignment with workforce planning and recruitment strategies, and continued monitoring of workforce impacts as national policy evolves. Actions were formally logged and tracked through the People Committee action log, with follow-up reporting required to ensure visibility and grip.

Belonging in the NHS

Equality, Diversity and Inclusion

During 2025/26, the People Committee received regular Equality, Diversity and Inclusion (EDI) reports providing oversight of strategic and operational activity to embed inclusive practice across the Trust. Key areas of focus included delivery of the Trust's anti-racism approach, progress against NHS EDI high-impact actions, implementation of mutual mentoring, and continued monitoring of workforce equality through WRES, WDES, Gender Pay Gap and EDS reporting. The Committee noted that EDI activity is supported by an established EDI Steering Group with regular reporting into the People Committee.

While challenges remain in achieving consistent impact across all Divisions and translating activity into measurable improvement in staff experience, the Committee confirms that EDI-related risks are actively managed through Board Assurance Framework risk 2.3, with clear action plans and ongoing People Committee oversight.

Gender Pay Gap

The People Committee received the Gender Pay Gap Report, which confirmed that, on average, female employees earn 25% less than male employees at Alder Hey. The Committee noted that this represents an improvement from the previous year, when the gap was reported as 27%, indicating modest progress in closing the gender pay gap. The report provided assurance that the gap is largely reflective of the wider NHS workforce profile, with a higher proportion of women employed in lower-banded roles and a greater concentration of men in higher-paid medical and dental roles with longer lengths of service.

The Committee considered the actions in place to address the gender pay gap, including alignment with the Trust's Equality, Diversity and Inclusion strategy, oversight through the EDI Steering Group, and integration with wider workforce initiatives focused on recruitment, progression and inclusive career development. The Committee also requested further narrative and context to strengthen understanding of the drivers of the gap and to support transparency in future reporting.

Governance

Extraordinary Meetings Held

During the year, three extraordinary People Committee meetings were convened to consider the Trust's workforce planning position for 2026/27 and 2027/28, including the role of the Target Operating Model (TOM) in enabling safe and sustainable delivery, and to approve the implementation of a Voluntary Redundancy (VR) Scheme.

NHSE Self- Assessment Report

The People Committee received the Compliance Report: Self-Assessment for Placement Providers (Education Return), which sets out the Trust's annual NHS England Self-Assessment against the national education standards for placement providers. The Self-Assessment is a mandatory process through which providers evaluate their compliance with NHSE education quality standards and submit an online return indicating where standards are met or unmet. The report confirmed Alder Hey's position as at November 2025 confirming no significant areas of concern against the national standards framework, with overall assurance assessed as Fully Assured, indicating that controls are suitably designed and operating effectively in practice. The responses within the Self-Assessment require Board-level sign-off and are provided to the People Committee to support oversight and assurance of the Trust's responsibilities as a placement provider

Committee Governance

The People Committee provides assurance that it has fulfilled its governance responsibilities for 2025/26 by approving the Committee Annual Report, ensuring continued ratification of all relevant

workforce policies, and formally endorsing the Committee Terms of Reference for the year. These actions demonstrate the Committee's ongoing commitment to robust oversight, policy compliance, and effective governance arrangements.

Sub-Committee / Working Groups

The Committee received the minutes from the following working groups:

- Local Negotiating Committee
- Joint Consultative and Negotiation Committee
- Education Governance Committee
- Health & Safety Committee
- Equality, Diversity & Inclusion Steering Group

Disclosure and Barring Service

During 2025/26, the People Committee received assurance on the Trust's three-year DBS renewals programme with 94.68% of colleagues having had a DBS check within the last three years. Despite the programme being Trust-mandated rather than a national requirement and presenting a cost pressure, the Committee supported its continuation, recognising its contribution to safer recruitment and safeguarding.

BAF Oversight & cross-cutting themes

During 2025/26, the People Committee provided focused and consistent oversight of the three principal Board Assurance Framework (BAF) risks delegated to it:

Ref	Risk	Score	Target
		I x L	
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	3x2
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	4x3	4x2
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	4x3	4x1

The Committee reviewed these risks at every meeting, supported by routine Executive updates, strengthened triangulation of Trust-wide and divisional workforce intelligence, and clearer alignment to People Plan priorities, workforce metrics, staff experience data and external assurance sources.

BAF Risk 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

Workforce sustainability remained a central focus for the People Committee throughout the year, reflecting continued pressures relating to recruitment, retention, sickness absence, financial constraints and national workforce supply challenges. Across 2025/26, the Committee:

- Scrutinised Trust-wide and divisional workforce metrics, including vacancy rates, turnover, sickness absence, agency and bank usage
- Oversaw delivery of the Workforce Efficiencies Programme, including voluntary redundancy, MARS and establishment controls
- Monitored recruitment and retention initiatives, including apprenticeships, international recruitment and pipeline development
- Reviewed the sickness deep dive, return-to-work compliance and Occupational Health provision
- Maintained oversight of resident doctor experience, visa and immigration risks, and regulatory requirements impacting workforce supply

The Committee recognised that while mitigations were increasingly mature and supported by clearer governance and grip, the risk remained appropriate given sustained system-wide pressures and the scale of transformation required.

BAF Risk 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

The People Committee maintained oversight of organisational culture through the Thriving Teams and Culture programme, recognising the critical link between culture, staff wellbeing, retention and quality of care. During the year, the Committee:

- Received regular updates on Thriving Teams, Thriving Leaders and safety culture
- Oversaw development and consultation on the new Trust values
- Reviewed staff survey results, Thriving indices and culture intelligence
- Monitored leadership development, internal communications and wellbeing initiatives
- Considered the impact of organisational change and workforce pressure on staff experience

The Committee acknowledged ongoing challenges in embedding consistent values-based behaviours across all Divisions and translating culture insight into targeted interventions for teams under pressure. However, the Committee welcomed the increasing maturity of culture data, improved transparency in reporting and strengthened organisational development capability, and supported further refinement of the risk articulation for 2026/27.

BAF Risk 2.3 — Failure to successfully embed workforce equality, diversity and inclusion across the organisation

Equality, diversity and inclusion remained a key area of People Committee oversight, recognising both statutory responsibilities and the impact of inclusion on workforce sustainability and culture. During 2025/26, the Committee:

- Received routine EDI updates, including WRES, WDES, Gender Pay Gap and EDS reporting
- Oversaw delivery of the anti-racism approach and mutual mentoring programme
- Monitored the work of the EDI Steering Group, including workforce equality action plans
- Reviewed assurance relating to Veteran Aware, sexual safety and inclusive workforce policies
- Considered progress in embedding EDI within leadership, workforce planning and organisational development activity

The Committee recognised ongoing challenges in achieving consistent impact across all staff groups and translating activity into measurable improvement in experience and outcomes. The Committee concluded that governance arrangements were robust, actions were clearly articulated, and EDI risks were appropriately managed and monitored through BAF risk 2.3.

Cross-Cutting Assurance Themes Identified in 2025/26

Across all three People Committee-delegated BAF risks, several recurring themes were identified:

- Workforce Supply and Capacity Pressures

Persistent challenges in recruitment, retention and sickness absence, particularly in specialist roles, requiring sustained focus and long-term planning.

- Impact of Organisational Change and Financial Constraint

The need to balance workforce efficiencies with staff wellbeing, capability and service resilience remained a key area of scrutiny.

- Data Maturity and Triangulation

Continued improvement in the quality, consistency and use of workforce and culture data supported stronger assurance and decision-making.

- Leadership Capability and Cultural Consistency

Variability in leadership experience and capacity influenced staff experience and required targeted development and support.

- Equity and Inclusion as Enablers of Sustainability

EDI was increasingly recognised as integral to workforce sustainability, culture and engagement rather than a standalone agenda.

Assurance Statements

Based on the information provided, the Committee is satisfied that:

- the systems of control governing workforce sustainability, organisational culture, wellbeing and equality, diversity and inclusion are largely effective;
- workforce-related risks are well-identified, actively monitored and appropriately escalated through established governance routes;
- the organisation continues to mature its approach to workforce planning, culture and inclusion, with clear and measurable progress compared with previous years; and
- there is strong alignment between operational delivery, People Committee scrutiny and the Trust's strategic ambition as set out in the People Plan and Vision 2030.

The People Committee confirms that the Trust's workforce assurance framework is fit for purpose and provides appropriate assurance to support the declarations made to the Board within the Annual Governance Statement.

Based on the Committee's processes for gaining assurance on workforce sustainability, culture and inclusion as summarised above, Committee members can confirm that:

- the remit, governance arrangements and resources dedicated to workforce planning, organisational development and equality, diversity and inclusion are appropriate for the Trust to meet its statutory and regulatory obligations; and
- the Trust has maintained effective oversight of mandated workforce programmes, including workforce efficiencies, apprenticeships, staff wellbeing and equality reporting requirements.

The Committee summarises key risks, assurances and matters for escalation to the Board of Directors following each meeting, ensuring timely visibility and integrated Board-level oversight

Committee Priorities for 2026/27

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2026/27:

- **Strengthening Workforce Sustainability and Resilience**

To maintain focused oversight of workforce supply, capacity and affordability, including delivery of the workforce plan, sickness absence reduction, retention, international recruitment and the ongoing impact of national policy changes, ensuring workforce risks remain within appetite.

- **Embedding Thriving Culture and Values-Based Leadership**

To oversee the full implementation of the Trust's new values and the Thriving Teams and Culture programme, with particular emphasis on translating culture insight into targeted support for teams, leadership capability and improved staff experience.

- **Delivering Measurable Improvement in Equality, Diversity and Inclusion**

To strengthen assurance on the impact of EDI interventions, including anti-racism, workforce equality metrics, gender pay gap actions and Veteran Aware commitments, ensuring progress is evidenced through improved outcomes and experience.

- **Assuring Workforce Change and Efficiency Programmes**

To maintain close oversight of workforce efficiencies, organisational design and transformation programmes, ensuring changes are delivered safely, compassionately and in a way that protects critical skills, quality and staff wellbeing.

- **Improving Workforce Intelligence and Assurance Quality**

To continue improving the quality, triangulation and use of workforce, culture and wellbeing data to support clearer assurance, earlier identification of risk and more informed Board-level decision-making.

- **Strengthening Compliance with PDR and Mandatory Training**

To maintain oversight of PDR completion and mandatory training compliance, with a focus on monitoring outstanding actions and ensuring delivery groups complete agreed outputs in a timely and consistent way.

- **Strengthening Assurance from External Reviews**

To strengthen the Committee's use of external assurance, including findings from the NHS England quality visit in relation to PGME, so that recommendations are tracked through to completion and used to inform wider workforce and education governance.

Jo Revill, Committee Chair

May 2026

PEOPLE COMMITTEE – RECORD OF ATTENDANCE 2025/26

The quorum necessary for the transaction of business will consist of the Chair or nominated deputy, one other NED and the Chief People Officer.

	May 2025	July 2025	Sept 2025	Nov 2025	Jan 2026	March 2026	TOTAL	
MEMBERS								
Jo Revill (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	6/6	100%
Fiona Beveridge (Non-Executive Director)	x	✓	✓	✓	✓	x	4/6	67%
Garth Dallas (Non-Executive Director)	✓	✓	x	✓	✓	✓	5/6	83%
Melissa Swindell (Chief People Officer)	Deputy	✓	✓	✓	✓	✓	6/6	100%
Adam Bateman (Chief Operating Officer / Deputy Chief Executive)	x	✓	✓	x	✓	x	3/6	50%
Nathan Askew (Chief Nursing, AHP and Experience Officer)	✓	x	x	✓	✓	x	3/6	50%
Alfie Bass (Chief Medical Officer)	✓	x	x	x	x	x	1/6	17%
Erica Saunders (Chief Corporate Affairs Officer)	✓	x	✓	✓	✓	✓	5/6	83%
1 x Senior representative from Surgical Division	✓	✓	✓	✓	✓	x	6/6	100%
1 x Senior representative from Medical Division	x	✓	✓	✓	✓	✓	5/6	83%
1 x Senior representative from Community & Mental Health Division	✓	x	✓	✓	✓	✓	5/6	83%
1 x Senior representative from Clinical Research Division	✓	✓	x	x	✓	x	3/6	50%
Quorum achieved?	YES	YES	YES	YES	YES	YES	6/6	100%

	May 2025	July 2025	Sept 2025	Nov 2025	Jan 2026	Mar 2026	TOTAL	
ATTENDEES								
Sharon Owen (Deputy Chief People Officer)	✓	✓	✓	✓	✓	✓	6/6	100%
Jo Potier (Associate Director of OD)	✓	✓	✓	✓	✓	✓	6/6	100%
Katherine Birch (Academy Director)	x	✓	x	✓	✓	x	3/6	50%
Angie Ditchfield (Head of Equality, Diversity and Inclusion)	✓	x	✓	✓	✓	✓	4/6	67%
Julie Worthington (Staff Side Chair)	x	x	x	x	✓	x	1/6	17%



Growth and Opportunities Committee Annual Report 2025/26

Introduction

The Growth and Opportunities (GO) Committee presents its Annual Report for the period **1st April 2025 to 31st March 2026**. This report provides assurance to the Board of Directors that the Trust has effective governance, oversight and strategic focus in place to enable sustainable growth, innovation and opportunity in support of **Vision 2030** and improved outcomes for children, young people and families.

The Committee was established by the Board of Directors to oversee and monitor the implementation of the strategic initiative known as "Pioneering Breakthroughs." This initiative is designed to address needs identified by children and young people under the theme "Bring Me The Future." The Committee's remit replaces and subsumes the responsibilities previously held by the *Futures Committee*, providing a fresh focus on the evolving requirements of its target groups.

A core function of the GO Committee during its first year was the development of a structured approach to identifying and prioritising the Trust's most significant growth opportunities and challenges. Early meetings focused on:

- defining the scope and ambition of "Growth & Opportunities"
- clarifying how the Committee would add value alongside other Board Committees
- agreeing the role of the Committee as a strategic, forward-looking forum

Horizon scanning discussions covered system leadership, research and innovation portfolios, education and workforce development, and the Trust's role as a local, national and international leader in child health.

Growth and Opportunities Committee

Formally constituted during the 2025/26 period, the GO Committee supersedes the former Futures Committee. It adopted an expanded scope and enhanced assurance responsibilities. In its inaugural year, the Committee has acted as the principal mechanism for horizon scanning, strategic development, and oversight across a range of domains: research, innovation, education, digital enablement, partnerships, and external income generation. These activities underpin the Trust's commitment to delivering sustainable growth and opportunities for its beneficiaries.

The Committee operates under the broad aims of providing assurance to the Board that:

- growth and innovation activity is strategically aligned to Vision 2030;
- opportunities are prioritised effectively and delivered in a controlled, value-driven way; and
- risks associated with innovation, investment and new models of care are identified, mitigated and escalated appropriately.

The Committee provides advice and assurance on matters relating to:

- research and innovation
- digital and data-enabled transformation
- education, training and workforce capability development
- partnerships (local, national and international)
- private patient and income-generating activity
- system leadership and external influence

The conduct of this remit was achieved firstly through the Committee being appropriately constituted and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

Membership during 2025/26 comprised a balance of Non-Executive Directors, Executive Directors and senior clinical and operational leaders, providing appropriate expertise across strategy, innovation, finance, partnerships and delivery. The Committee was chaired by a Non-Executive Director and supported by Executive leadership spanning strategy, science, digital, operations and partnerships.

The Membership comprises:

- Non-Executive Directors x 3 [one of whom shall be the Chair]
- Chief Executive
- Chief Strategy and Partnerships Officer
- Chief Scientific Officer
- Chief Operating Officer/Managing Director of Futures
- Clinical Director of Innovation
- Director of Research
- Director of Alder Hey Academy
- Director of Global Health
- Director of AHPs
- Chief Digital and Transformation Officer
- Chief Finance Officer

Expected to attend each meeting are the Head of Research Operations, Deputy Director of Finance, Associate Director of Strategy and Partnerships, Associate Director – Digital Transformation, Head of L&D, Policy Lead/Advisor to the CEO, Chief Executive of the Alder Hey Charity, Transformation Programme Lead and the Deputy Director of Marketing and Communications.

The Committee met regularly throughout the year and was consistently quorate. Attendance and engagement were strong, reflecting the importance of the Committee's remit within the Trust's overall governance framework. A schedule of attendance at the meetings is provided in Appendix A which demonstrates each meeting was quorate. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Principal Review Areas / Achievements in 2025/26

Ambition

Horizon Scanning - Our top opportunities and challenges

Horizon Scanning was central to the GO Committee's forward-looking role, providing structured insight into emerging opportunities and risks for the Trust.

Discussions focused on Alder Hey's system leadership and growth opportunities, external drivers (system change, partnerships and national direction), and the constraints affecting delivery pace. The Committee also considered how the Trust can shape, not just respond to, changes across health, research, education and innovation.

Leading the Way for the Children's System discussions focused on opportunities available through the 10 Year Health Plan, reinforcing whole-system thinking, collaboration beyond the Trust, and alignment between internal ambitions, system priorities and national policy change. This provided a system-wide view of paediatric care, helping the Committee test feasibility, sustainability and alignment with Trust values and Vision 2030.

Horizon Scanning discussions also helped to inform future agenda priorities and deep dives, supported development of GO metrics and KPIs focused on strategic value, and strengthened links between growth ambitions, capacity, risk, and integrated planning.

The GO Committee recognised Horizon Scanning as critical to enabling:

- proactive rather than reactive governance;
- informed strategic conversation at Board level; and
- a consistent narrative between opportunities, challenges, metrics and delivery plans.

The Committee agreed Horizon Scanning should remain a recurring feature of the work programme as the GO framework matures.

GO Metrics & KPIs

During the year, the Committee received regular updates and provided oversight of the development and refinement of the GO Metrics and KPIs, offering assurance that the emerging framework is proportionate, outcome-focused and aligned to the Trust's strategic priorities.

Discussions across the inaugural, December 2025 and February 2026 meetings confirmed the principles for measuring success under the GO framework, including that metrics should evidence impact rather than volume of activity, align to strategic outcomes, system leadership and sustainability, and complement (rather than duplicate) existing finance, performance and transformation measures. The Committee emphasised the need for a small, focused and meaningful dataset, strengthened the narrative on outcomes and benefits realisation (including indirect contributions to productivity, workforce capability and external influence), and tested the linkage to highlight reporting, integrated planning and executive accountability. By February 2026, alongside consideration of the Integrated Plan, the Committee was assured that the GO metrics were maturing into a practical governance tool to support prioritisation, horizon scanning and investment decisions, with further refinement to continue in 2026/27.

Top Opportunities and Challenges

During 2025/26, the Committee discussed *Top Opportunities and Challenges* to shape strategic focus and prioritisation across the GO portfolio. Key opportunities identified included strengthening Alder Hey's research and innovation ecosystem, expanding education and training offer, leveraging digital automation to improve productivity, and developing partnerships across the paediatric system, private patient activity and global health to enable sustainable growth aligned to Vision 2030. At the same time, the Committee recognised challenges relating to organisational and system capacity, workforce and leadership capability, reliance on external partners, and the need to balance ambition with deliverability and assurance. These discussions informed the development of GO metrics, helped align opportunity-led work with integrated planning, and supported the Committee's role as a forward-looking, horizon-scanning forum providing early assurance to the Board.

Leading the Way for the Children's System

The GO Committee received regular updates regarding Alder Hey's leadership role within the children's system. This work is centred on Alder Hey acting as a system leader for children and young people, collaborating closely with partners across health, local authorities, and communities. The overarching aim is to improve outcomes for children and young people, as well as to reduce inequalities across the system.

Efforts are focused on shifting care earlier and bringing it closer to home, primarily through prevention initiatives, neighbourhood-based models, and digital innovation. Alder Hey is committed to supporting more integrated pathways throughout the paediatric system. By serving as a convener and enabler, Alder Hey shapes shared priorities and supports system-wide change, rather than delivering these initiatives in isolation.

Updates further emphasised the Trust's role in system leadership and shaping the broader integrated children and young people system model, including how an Integrated Health Organisation contract could offer benefits for children and young people. This reflects Alder Hey's commitment to developing collaborative approaches and supporting the integration of care across the entire paediatric system.

The Committee was assured that Alder Hey is fulfilling its leadership responsibilities in a collaborative and enabling manner. The Trust remains focused on improving outcomes, reducing health inequalities, and supporting a transition towards prevention, neighbourhood-based care, and digital-first models. Oversight mechanisms are in place to ensure that this work aligns with national policy directions, system partner priorities, and the Trust's Vision 2030. In addition, there is recognition of the complexity, capacity, and delivery risks present across the wider system. Overall, the Committee was assured that Alder Hey's approach promotes effective system working and is progressing with appropriate governance and strategic oversight.

Paediatric Open Innovation Zone

During 2025/26, the Committee received assurance on the Paediatric Open Innovation Zone (POIZ) launch plan, recognising it as a key enabler of the Trust's growth, research and innovation ambitions. The Committee noted that POIZ is intended to provide a structured platform to accelerate paediatric innovation, strengthen collaboration with academic, industry and system

partners, and support the translation of innovation into improved outcomes for children and young people.

(POIZ) is expected to deliver a number of strategic benefits, including:

- Accelerating translation of innovation into patient care, by providing a structured mechanism to progress paediatric research, innovation and digital solutions from concept through to safe implementation and impact for children and young people.
- Strengthening Alder Hey's position as a national and international leader in paediatric innovation, supporting the Trust's ambition to shape the future of child health through partnership with academia, industry and system partners.
- Creating a coherent platform for collaboration, bringing together clinical, academic, commercial and system expertise to reduce fragmentation and support a more joined-up approach to innovation activity.
- Supporting sustainable growth and financial resilience, through the attraction of external investment, development of new partnerships, and creation of economic value aligned to NHS and public benefit.
- Building internal capability and leadership in innovation, ensuring that clinical and operational teams are supported to engage with innovation safely, ethically and effectively, and that benefits are measurable and governed.
- Contributing to wider system and place-based objectives, including economic development, skills growth and job creation, while maintaining a strong focus on improving outcomes and experience for children and families.

The Committee welcomed the phased approach to launch and engagement, alignment with the Trust's Annual Plan and Vision 2030, and the emphasis on establishing strong governance, clinical leadership and performance metrics to ensure impact, value and sustainability as the programme is implemented and scaled. Monitoring of the Plan will continue into 2026/27.

Institute of Child Health & Wellbeing

During 2025/26, the Committee received and considered an update on the next steps for the Liverpool Institute of Child Health & Wellbeing, recognising the Institute as a central pillar of the Trust's research, innovation and system leadership ambitions. The Committee noted progress towards establishing the Institute as a focal point for paediatric research excellence, with a clear emphasis on strengthening academic partnerships, consolidating leadership and governance arrangements, and aligning research priorities with population health needs and health inequalities. The next phase of development is intended to support increased research capacity and capability, attract external funding and investment, and accelerate the translation of evidence-based innovation into practice, while ensuring alignment with Vision 2030 and the wider GO framework.

Grant Opportunity 2026

The GO Committee received an update on Grant Opportunity 2026 as part of the Research and Innovation programme. The Committee was assured that work is underway to position the Trust to maximise external grant funding opportunities aligned to strategic priorities, including research excellence, innovation, and system leadership.

The update highlighted that grant opportunities are being considered alongside existing capacity and capability within the Trust, recognising the need for appropriate governance and workforce support to ensure delivery is sustainable and does not compromise core services.

The Committee noted that grant income forms an important component of the Trust's wider GO framework, supporting financial sustainability and the delivery of Vision 2030 ambitions, alongside commercial income, partnerships, and innovation programmes. The update was noted as providing appropriate strategic oversight and assurance.

International and Private Patients

The GO Committee received assurance on the Trust's approach to International and Private Patient activity, noting that this is being developed in a controlled and phased manner aligned with Vision 2030 and the Trust's financial sustainability ambitions. The Committee was assured that appropriate governance arrangements are in place to ensure private and international activity supports, and does not compromise, NHS services, with clear separation of activity, robust oversight and compliance with regulatory requirements. International opportunities are being pursued selectively to strengthen Alder Hey's global reputation and partnerships, with due regard to capacity, capability and patient safety. Overall, the Committee was assured that this area is being progressed in line with the Trust's values, strategic priorities and core purpose.

Observerships

The GO Committee received assurance regarding the Trust's Observerships programme. This initiative offers a time-limited opportunity for international healthcare professionals and senior leaders specialising in paediatrics and child health to visit the Trust, enabling them to observe clinical practice and organisational approaches in action.

The Committee noted that robust arrangements are in place to facilitate structured learning, promote professional development, and encourage external engagement. These processes are underpinned by appropriate governance and oversight, ensuring that all observership activities adhere to required standards.

Furthermore, the Committee was assured that the programme aligns closely with the Trust's strategic ambitions in the fields of education, research, and global engagement. Participation in the scheme is managed to safeguard patient safety, maintain operational capacity, and uphold the delivery of core NHS services. The Observerships programme was acknowledged as a key contributor to Alder Hey's reputation as a centre of excellence and as an important factor in enhancing wider system influence. All observership activities are carried out in accordance with Trust values, policies, and regulatory requirements.

Robotic Surgery

GO Committee received an update on the proposed development of a paediatric robotic surgery programme at Alder Hey; an area that remains under-developed nationally, with fewer than five established centres. The Committee was assured that this represents a significant strategic opportunity, aligned with national policy direction and recent regulatory approvals, to improve clinical outcomes for children through less invasive surgery, faster recovery and shorter hospital stays. A phased approach to implementation was outlined, with initial focus on selected surgical specialties, subject to appropriate governance, workforce planning, and investment approval. The

Committee noted that the proposal aligns with the Trust's Vision 2030 ambitions for innovation, clinical excellence and talent attraction, and was assured that further development will be progressed with robust oversight and assurance.

Assurance

Programme Update - Highlight Reports

Futures: Research, Innovation, Education and Digital

The Committee received regular updates on the Futures programmes, noting continued progress in strengthening research and innovation capability, expanding education and workforce development activity, and advancing digital enablement. The updates highlighted a continued focus on delivering innovation at scale, supporting clinical and academic leadership, embedding digital tools to improve productivity and patient experience, and aligning research and education activity with strategic priorities and system needs.

Private Patients

The Private Patients update set out progress in developing a controlled and ethical approach to private patient activity, aligned with the Trust's financial sustainability ambitions. The Committee noted ongoing work to clarify the future direction of private patient services, with a focus on robust governance, clear separation from NHS activity, and ensuring that any growth supports reinvestment in NHS care, the workforce and innovation.

Global Health

The Global Health update provided assurance regarding the Trust's international activity, including the development of strategic partnerships, governance arrangements and defined objectives for global engagement. The Committee noted progress in positioning Alder Hey as a system leader in paediatric global health, while ensuring that activity is pursued selectively and sustainably and supports the Trust's values, reputation and core clinical priorities.

The Committee was assured that these programmes continue to progress in alignment with the Trust's strategic priorities and Vision 2030, supported by appropriate governance, oversight and delivery arrangements. Collectively, the updates evidenced continued focus on strengthening research and innovation capability, supporting workforce development and digital enablement, progressing ethical and sustainable private patient activity, and developing global health partnerships and influence. Across all programmes, the Committee noted that progress is monitored, risks are identified and managed, and activity remains aligned with the Trust's values, core purpose and contribution to system-wide improvement.

Global Health Terms of Reference

The Board was provided with assurance through the presentation of the Global Health Terms of Reference, which formally set out the governance, accountability and oversight arrangements for the Trust's Global Health activity. The Terms of Reference define the purpose, scope, decision-making responsibilities and reporting lines of the Alder Hey Children's Global Health Programme Board, ensuring that international activity is delivered in a consistent, transparent and well-governed manner. This provides assurance that Global Health activity is aligned with Vision 2030, national policy direction and the Trust's values, and that risks, resources and benefits are subject to appropriate scrutiny and control.

Communications and Branding

Throughout the year, the Committee received an update on Communications and Branding, which highlighted the need to clarify and strengthen Alder Hey's brand and external messaging in line with the Trust's evolving strategic ambitions. The update recognised the importance of presenting a consistent and credible narrative across growth activity, partnerships, global engagement and innovation. It was noted that a focused stakeholder sprint is being taken forward to review and refresh brand positioning and messaging, involving charity and global/international representatives, to support clearer engagement with system partners, industry and external stakeholders.

Strategic Collaborations and Partnerships

The GO Committee received assurance through the Strategic Partnerships report, which set out progress in developing a more structured, strategic and system-focused approach to partnerships in support of Vision 2030. The Committee was assured that arrangements are being put in place to strengthen governance, oversight and assurance across the Trust's portfolio of strategic, system and industry partnerships, with increased focus on partnership maturity, value, risk management and alignment to organisational priorities. The report provided assurance that partnerships are being progressed in a controlled and transparent manner, recognising capacity considerations and ensuring that activity delivers tangible benefits for children and young people and supports long-term sustainability.

Items to bring to the Board's attention

There are no matters to highlight.

Assurance Statements

Through the governance and oversight arrangements described in this report, the Committee has obtained assurance that the Trust's Research and Innovation functions are being progressed in alignment with the Trust's strategic priorities and are supported by appropriate governance, oversight and delivery arrangements.

On the basis of the updates received during 2025/26, the Committee is satisfied that the assurance framework is operating effectively, with appropriate oversight of delivery, performance and risk across the GO portfolio.

The Chair of the GO Committee also sits on the Finance, Transformation and Performance Development Committee, supporting effective linkage and additional scrutiny of financial and commercial considerations associated with research, innovation and related growth activity.

A Summary Report is presented to the Board following each GO Committee meeting highlighting the documents received at the meeting, key risks and positive areas discussed and any matters to escalate to the Board or other Committee. Final minutes are also submitted to Board once approved.

Committee Priorities for 2026/27

Building on its first year of operation, the GO Committee has identified the following missions to work towards in 2026/27:

1. Create a single, integrated CYP system for Cheshire and Merseyside
2. Diversification of revenue streams
3. Brand amplification
4. Advancement of child health

Mark Jennings
Committee Chair
April 2026

GROWTH AND OPPORTUNITIES COMMITTEE - RECORD OF ATTENDANCE 2025/26

The quorum necessary for the transaction of business:

Chair or nominated deputy, one other NED, Chief Strategy and Partnerships Officer and one other Executive Director.

Member/Date of Meeting	2025		2026	TOTAL	
	Oct	Dec	Feb		
MEMBERS					
Mark Jennings (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	3/3	100%
Garth Dallas (Non-Executive Director)	✓	✓	x	2/3	67%
John Kelly (Non-Executive Director)	✓	✓	✓	3/3	100%
John Grinnell (Chief Executive)	✓	✓	✓	3/3	100%
Dani Jones (Chief Strategy & Partnerships Officer)	✓	✓	✓	3/3	100%
John Chester (Chief Scientific Officer/Director of Research)	✓	✓	✓	3/3	100%
Adam Bateman (Chief Operating Officer/Managing Director of Futures)	x	✓	✓	2/3	67%
Iain Hennessey (Clinical Director of Innovation)	✓	x	✓	2/3	67%
Dan Hawcutt (Clinical Director of Research)	✓	✓	✓	3/3	100%
Katherine Birch (Director of Alder Hey Academy)	✓	✓	✓	3/3	100%
Rafael Guerrero (Director of Global Health)	✓	✓	x	2/3	67%
Veronica Greenwood (Director of AHPs)	x	✓	✓	2/3	67%
Kate Warriner (Chief Transformation and Digital Officer)	✓	✓	x	2/3	67%
Rachel Lea (Chief Finance Officer)	x	✓	✓	2/3	67%
Quorum achieved	YES	YES	YES	5/3	100%

Member/Date of Meeting	2025		2026	TOTAL	
	Oct	Dec	Feb		
ATTENDEES					
Sarah Leo (Head of Operations – Research, Innovation & Futures)	✓	✓	✓	3/3	100%
Andy McColl (Deputy Director of Finance)	✓	✓	✓	3/3	100%
Colin Beaver (Deputy Director of Marketing and Communications)	✓	✓	✓	3/3	100%
Abby Pendergast (Deputy Director of Strategy and Partnerships)	✓	✓	✓	3/3	100%
Leila Brown (Associate Director – Digital Transformation)	x	x	x	0/3	0%
Gill Foden (Head of L&L and Widening Participation)	x	x	x	0/3	0%
Melissa Ashe (Policy Lead / Advisor to the CEO)	✓	✓	✓	3/3	100%
Fiona Ashcroft (Chief Executive of Alder Hey Charity)	✓	x	✓	2/3	67%
Natalie Palin (Director of Transformation)	✓	x	✓	2/3	67%

BOARD OF DIRECTORS
Tuesday, 23rd June 2026

Paper Title:	NHS Provider Licence – Annual Self Certification
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☐ Regulation ☒
Action/Decision Required:	To note ☐ To approve ☒
Summary/ supporting information:	As part of the regulation and oversight of NHS provider organisations, Foundation Trusts are required to make an annual self-certificated declaration relating to compliance with NHS Provider Licence conditions. The Trust is required to submit an annual declaration of its compliance with Condition CoS7: <i>Availability of Resources in the Provider Licence</i> . This report outlines the Trust's compliance with the regulation.
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 Impact:	None identified

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

Risk number	Risk description	Score
1.1	Inability to deliver safe and high-quality services	3x3

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

In previous years, as part of the declaration process, the Board of Directors was required on an annual basis to self-certify as to current and future compliance with conditions of the licence. In 2023, NHS England updated the requirement for Foundation Trusts to self-certify against specific sections, with updated guidance for Foundations Trusts to self-certify against compliance with condition *CoS7: Availability of Resources in the Provider Licence*.

The Corporate Governance and Finance Teams have undertaken an assessment against CoS7 (a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (CRS)) and can confirm compliance. There is no longer a requirement to submit this evidence to NHS England, providers must ensure that the self-certification is signed off by the Board of Directors. NHS England typically conducts sample audits on selected providers to ensure the self-certification arrangements have been completed appropriately.

2. Compliance 2025/26

Licence Condition	Supporting Evidence	Confirmed/ Not Confirmed
CoS7 – Availability of resources	- Monthly Financial Reports to Finance, Transformation and Performance Committee and Board. - Board and Committee oversight of financial plan delivery, including scrutiny of variances, forecast outturn and delivery of cost improvement plans. - Review and approval of the Annual Plan and supporting financial assumptions. - Oversight of workforce, operational and quality performance through the Monthly Integrated Performance Report. - Board Assurance Framework and corporate risk management arrangements, including oversight of principal risks that could affect delivery of Commissioner Requested Services. - Internal control, assurance and escalation processes, including routine reporting through Board committees. - Audit and Risk Committee oversight of internal audit findings, control	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Licence Condition	Supporting Evidence	Confirmed/ Not Confirmed
	effectiveness and the adequacy of assurance arrangements. • Board oversight of cash, liquidity and capital expenditure through regular financial monitoring and decision-making arrangements. • 2025/26 Annual Accounts prepared on a going concern basis. • Income and expenditure budgets have been set on robust and agreed principles, with Divisions expected to deliver high-quality healthcare within the resources available, subject to delivery of agreed efficiencies.	

3. Recommendation

The Board of Directors is asked to approve the proposed confirmation of compliance with condition CoS7: Availability of Resources in the Provider Licence.

Erica Saunders
Chief Corporate Affairs Officer
June 2026

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 Continuity of services condition 7 - Availability of Resources (designated CRS only)

- EITHER:**
- 1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. **Confirmed** Please fill details in cell E22
- OR**
- 1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. Please Respond
- OR**
- 1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Please Respond

Statement of main factors taken into account in making the above declaration
In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust Board has reviewed the cash balances and resources available and has concluded that the Trust has adequate resources. The Board has also considered the Trust's financial governance framework and a range of scenarios in assessing the organisation's ability to respond to any unforeseen financial challenges. On this basis, the Board considers it appropriate to prepare the accounts on a going concern basis.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Name Dame Jo Williams
Capacity Chair
Date 23 June 2026

Signature

Name John Grinnell
Capacity Chief Executive
Date 23 June 2026

Further explanatory information should be provided below where the Board has been unable to confirm declarations.