Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS EXTRAORDINARY PUBLIC MEETING

Wednesday 26th June 2024, commencing at 16:15

via Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**24/25/99**	**16:15 (2 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/100**	**16:17 (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 2023/24							
3.	**24/25/101**	**16:20 (10 mins)**	**Draft Annual Report and Accounts for 2023/24:** • **Ernst and Young External Audit Year-end Draft Report, 2023/24 – 'ISA260'.** • **Letter of Representations.**	E. Saunders/ J. Grinnell/ K Byrne D. Spiller D. Spiller	To approve the Trust's draft Annual Report and Accounts for 2023/24. To receive the External Audit year-end draft report for 2023/24. To receive the letter of representations.	**R/D**	Read report *(to follow)* Read report *(to follow)* Read enclosure *(to follow)*
4.	**24/25/102**	**16:30 (5 mins)**	**Committee Annual Reports 2023/24** - **Audit and Risk Committee.** - **Resource and Business Development Committee.** - **Safety and Quality Assurance Committee.**	 K. Byrne J. Kelly F. Beveridge J. Revill	To receive the annual reports of the sub-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 and Wellbeing Committee.** - **Research and Innovation Committee.**	S. Arora			
5.	**23/24/103**	**16:35 (5 mins)**	**Board Self-Certification of Compliance with the Provider Licence.**	E. Saunders	To approve: • NHS Improvement Provider Licence Self-Assessment • The declarations in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training. • The declaration in relation to general condition 6 (systems for compliance with licence conditions) and service condition 7 of the provider licence (continuity of services).	**R/D**	Read report
Items for information							
6.	**24/25/104**	**16:40 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
7.	**24/25/105**	**16:44 (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, 4th July 2024, 12:20pm, in Lecture Theatre 4, Institute in the Park.							

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday, 26th June 2024

Paper Title:	**Assurance Committee Annual Reports 2023/24**
Report of:	**Erica Saunders, Director of Corporate Affairs**
Paper Prepared by:	Jill Preece, Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	To present the Board with the annual reports from: ARC RABD SQAC PAWC R&I Committee
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐
Resource Implications:	None

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

Alder Hey Children's NHS Foundation Trust

Audit & Risk Committee Annual Report 2023/24

The Audit and Risk Committee

The Audit & Risk Committee (ARC) has primary responsibility for reviewing the effectiveness of the framework in place 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 of Directors 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 the Committee 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 2024/25.

Constitution

The membership of the Committee comprises three Non-Executive Directors. Its Chair has 'recent relevant financial experience'. The Chief Financial Officer / Managing Director and Director of Corporate Affairs together with the Director of Finance & Development and Associate Director of Nursing and Governance (ADN&G) are invited to attend the whole meeting, whilst the Chief Operating Officer is invited to attend for the risk related items. The Committee may request the attendance of the Chief Executive and any other officer of the Trust as needed. In addition, the Internal and External Auditors and Anti-Fraud Specialist are invited to each meeting. A schedule of attendance at the meetings is provided in Appendix 1 which demonstrates full compliance with the quorum requirements and regular attendance by Members and those invited to the Committee. The ARC members also have the opportunity throughout the year to meet in private with Internal Audit, External Audit and the ADN&G.

The Committee has an annual Work Plan with meetings timed to consider and act on specific issues within its Terms of Reference. Five 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 ARC Chair presents a Summary Report to the Board following each ARC meeting highlighting the documents received, 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.

Work undertaken in 2023/24 in accordance with Terms of Reference

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 regularly undertakes a self-assessment of its own performance and

regularly undertakes an assessment of key assurance providers (Internal and External Audit and the Anti-Fraud Service) and identifies any actions required.

This section provides an overview of the work undertaken by ARC in each of the main areas of its responsibility – Risk Management, Management Assurance of Key Risks (Programme Assurance, Emergency Planning Response & Resilience (EPRR), Data Quality, Cyber Security, Data Protection Act Compliance, Freedom of Information Act Compliance), Internal Audit, Anti-Fraud Service, Clinical Audit, Finance and Governance.

Risk Management

The Committee receives the following reports to each of its meetings (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) which includes updates on each of the risks from the Executive. Whilst ARC reviews the BAF in respect of compliance with the risk management framework, oversight of the individual risks is undertaken by the Board or one of the other Assurance Committees. ARC refers any areas of query or concern to those Committees for 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 analysis of the CRR, highlighting new risks, those with changed risk scores, longstanding (>12 months old) risks, closed risks and the number of risks that are overdue review or have overdue actions.
  - A summary of the "deep dives" that the RMF has undertaken in key risk areas. In 2023/24 these were non-compliance with national guidance regarding transferring and transcribing patient records following adoption, risks relating to the Major Trauma service, the increase in demand for assessment and diagnosis of Autism Spectrum Disorder since Covid-19, Digital risks, risks in relation to realising the vision for Springfield Park, the management of longstanding high-moderate risks and the medical device replacement programme.
  - The minutes from prior RMF meetings.
- An analysis of the Trust Risk Register (all Trust risks including those on the BAF and CRR) highlighting the number and percentage of risks by score, static and longstanding risks, those overdue review, without action plans or with actions overdue and provides an analysis of risks by severity and Division / Corporate Service. This high-level analysis enables ARC to understand the effectiveness of risk management across the Trust as a whole.

The Corporate Services Collaborative (CSC) undertakes detailed scrutiny of corporate service risks, reporting into the RMF.

The Annual Report on Risk Management provided by the RMF describes the activities that took place throughout the year to evidence that the management of risk is constantly reviewed, monitored, and reported with appropriate risk escalation. In presenting its Annual Report, the following assurance statements were provided by the RMF:

- Appropriate processes are in place for the management of risks and that progress against 2023/24 priorities have been made.
- Assurance of compliance against the key requirements of the Risk Management Strategy.
- There are robust systems of risk management for oversight of operational risk management in accordance with ARC Work Plan.
- In its delegated authority from ARC, RMF is fit for purpose and providing the Board with the assurances required.

Across the year, each of the Divisions (except Surgery whose presentation was received in April 2024) presented to the Committee on the risk management processes within their Division. This

provided an opportunity to understand in more detail how the Divisions oversee and manage risk on a day-to-day basis.

Assurance Committee Annual Reports are presented to ARC before onward presentation to Board. Within their Annual Report 2023/24 each Assurance Committee 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 these risks <Committee name> can confirm that management are effectively managing these risks and are taking timely steps to reduce their risk score."

The Trust's new incident and risk management system, InPhase went live with some modules in May 2023, following which, a number of issues were reported in relation to the risk module functions and obtaining data and reports. The Committee (along with SQAC) maintained oversight of the risk in relation to providing assurance reports to the Trust Board and Assurance Committees until full resolution. A Lessons Learned Report was received by ARC in April 2024 which summarised the issues arising and what could be done in the future to minimise similar issues. As a result of the challenges arising, ARC has formally requested oversight of the project management of InPhase "Phase 2" which comprises implementation of the remaining modules (Legal / Claims, NICE Guidance, Central Alert System, Mortality, Nursing Audits, Volunteering Management and FTSU – see item 5 in "Committee Developments and Priorities for 2024/25").

<u>Management assurances on key risks</u>
During the year the Committee received Annual Assurance Reports for 2023/24 activities and Forward Plans 2024/25 for key areas of risk. The following section summarises key information and assurances within these reports.

Programme Assurance
The Delivery Management Office (DMO) provides semi-independent assurance on the adherence to programme management standards; for programmes designated as strategically important. Assurance ratings are provided for each programme to support the change teams and Senior Responsible Officer, to rate the level of confidence that the programmes will achieve their intended benefits, within quality, cost, and timescale. It is designed to improve control and therefore the achievement of sustainable change. Assurance is evidence based and grouped into two areas:

a) **Adherence to programme management standards** e.g. stakeholder engagement, risk management.
b) **Delivery assurance** - whether the programme is on track to deliver its intended benefits, within timescales and resources, and meeting areas of need.

At the year-end, for the 6 programmes overseen by the DMO the following ratings were provided:

	Red (Standards not achieved)	**Amber** (Standards achieved in part)	**Green** (Standards achieved)
Programme management	0	3	3
Programme delivery	0	5	1
	0	**8**	**4**

Emergency Planning Response & Resilience Core Standards Assessment
A report was provided by the EPRR Manager regarding the Trust's overall emergency preparedness processes in line with legal and statutory requirements to meet the Civil Contingencies Act (2004), NHSE Emergency Preparedness Framework (2022) and NHSE EPRR Core Standards. The report outlined the work undertaken in governance, risk management, training and exercising for EPRR incidents, actual incidents experienced and EPRR staffing.

Each year the Trust is required to self-assess against EPRR Core Standards:

Following a check and challenge process* with NHSE NW and, in line with other Trusts in Cheshire and Merseyside, the Trust declared the 2023/24 EPRR Core Standard annual assurance submission "Non-Compliant". A robust Action Plan has been agreed with the ICB and is underway to realign the Trusts overall compliance. The Action Plan is monitored through the Emergency Preparedness Group (EPG) and good progress has already been made with many of the individual core standards although, due to the additional criteria to assure each Standard and the increasing interdependencies between them, it is expected that a Non-Compliant submission will also be made in 2024/25.

*This year the check and challenge processes were significantly more stringent looking into each individual Standard alongside a number of changes to national guidance relating to EPRR. The annual submission was agreed by the Board.

Data Quality (DQ)

DQ is the cornerstone of good quality reporting and equally poor data quality can lead to reports both being inaccurate and misleading for operations. The Trust's DQ Strategy "strive(s) to achieve the highest quality of data that is parallel to the outstanding care that we provide". The Chief Transformation & Digital Officer (CTDO) provided a detailed report summarising the Trust's DQ performance against a number of benchmarks:

The DQ Maturity Index (DQMI) offers a rounded assessment of an organisation's data quality through a number of datasets. For the latest position published (December 2023), the Trust had a DQMI score of 89.8, in comparison to a national average of 75.1 and is in line with our peer's performance.

Commissioning Data Set (CDS) DQ Dashboard:

- Performance of Admitted Patient Care submissions is to a high standard with 18 of 22 areas green.
- Performance for Outpatient data is to a high standard with 21 of 22 metrics green.

The 2023/24 Clinical Coding Data Security Audit found the Trust to be adhering to national clinical coding standards.

Cyber Security

ARC received a report from the CTDO providing assurance of the Trust's cyber security performance against NHSE national priorities as summarised below along with the Work Plan for 2024/25.

Priority		Status
1	Ensure secure, well tested backups are in place.	
2	Maintain a good patching regime	
3	Action high severity security alerts as quickly as possible when they are issued.	
4	Make sure that Microsoft Advanced Threat Protection is enabled across your device and server estate.	
5	Clear policies and processes around secure configuration and management of active directory	
6	Maintain supported systems	

Data Protection (DP) and the Data Security & Protection Toolkit (DSPT)

Alder Hey is registered as a data controller with the Information Commissioners Office (ICO) as required within the Data Protection (Charges and Information) Regulations 2018. ARC received a summary of key DP activities undertaken during 2023/24 to support compliance with DP principles outlined in the Data Protection Act 2018 and NHS specific requirements within the annual DSPT submission.

During the year two data security incidents occurred that were self-reported to the ICO. No further action was deemed necessary following rapid review and remedial actions implemented.

- Each year the Trust is required to provide a DSPT submission to NHSE. The DSPT baseline assessment for 2023/24 was submitted in February 2024, with the final submission due in June 2024. It is anticipated the Trust will submit a compliant return supported by an independent audit process by MIAA.
- 2,004 subject access requests were coordinated and disclosed achieving 99.51% compliance against statutory disclosure timeframes.
- There is 33% reduction in information governance / DP incidents reported since last year.
- In line with the DSPT information governance data security training requirement, the Trust has achieved the 95% threshold (98.29%).

In 24/25 the DSPT is replaced by the Cyber Assessment Framework (CAF) which will have a more stringent focus on technical and cyber controls. In preparation for this Mersey Internal Audit Agency (MIAA) have undertaken an assessment of CAF processes as part of the Internal Audit Plan.

Freedom of Information Act 2000 (FoIA) Compliance
An overview of FoIA activity during 2023/24 including summary of compliance with FoIA legislation was received from the CTDO.

- 650 FoIA requests were received and actioned in the year; a 6% increase from the prior year with requests becoming more voluminous, detailed, and complex. Overall, compliance of responses within the prescribed 20 working day timeframe achieved 93.38% (compared to 71.45% in 2022/23).
- There have been no formal complaints, information notices or enforcement action received via the ICO in relation to Alder Hey FoIA practices or compliance.

Analysis of the types of requests was provided as well as details of exemptions with reasons.

Internal Audit
The internal audit service is provided by MIAA in line with Public Sector Internal Audit Standards. Internal Audit provides an independent and objective opinion to the Accountable Officer, the Board and ARC on the degree to which risk management, internal control and governance are effective.

ARC approved MIAA's Internal Audit Plan for 2023/24. The Plan is structured to enable the Head of Internal Audit to provide an Annual Opinion which gives an assessment of the:

- Effectiveness of the range of individual assurances arising from risk-based internal audits. This assessment takes into account the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
- Design and operation of the underpinning Assurance Framework, risk management systems and supporting processes.
- Trusts response to Internal Audit recommendations, and the extent to which they have been implemented.

Throughout the year, MIAA provide a summary of the audit reports issued and management's response to address them. During 2023/24 11 audits (see Appendix 2) were completed all of which received a Substantial or Moderate opinion. There were no Full, Limited or No opinions. Whilst assurance on key programmes would usually fall within Internal Audits remit, NHS Digital were commissioned by the CDTO to undertake detailed pre and post implementation reviews of the Aldercare system. Reports were provided to ARC which outlined minor improvements.

The Internal Auditors also undertake a quarterly exercise to assess the implementation of agreed actions 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. 30 actions were reviewed and the status confirmed to be:

	Number	%
Implemented	20	67
Partly Implemented	8	27
Superseded	1	3
Not Implemented	1	3
Total	**30**	**100**

At the year-end there are 23 recommendations for which implementation is not yet due. Four of these are high risk and relate to the audits of Junior Doctors – Non-Consultant Spend, Medical Devices, On Call Payments and EPRR. Of those remaining none are critical risk, 11 are medium risk and eight are low risk.

The key conclusion from MIAA's work for 2023/24 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 Trusts objectives, and that controls are generally being applied consistently.

During the year ARC oversaw the completion, ARC Members and Attendees, of an effectiveness review of the internal audit service based on a 2013 KPMG questionnaire "Evaluation of the Internal Audit Function" and consideration of Client Satisfaction Questionnaires issued to management upon completion of each audit. Questions covered mandate and strategy, organisation and structure, stakeholders, leadership competencies and culture, risk assessment and planning, execution and reporting.

The outcome of the review was reported to the April 2024 ARC meeting. Answers to all questions were "agree" or "strongly agree" and no fundamental weaknesses were identified. Narrative responses indicated that the service is professional, of high quality with sufficient challenge and partnership focused whilst (importantly) not being "cozy". The service was described as "understood by staff and taken as seriously as it should be". Some improvements to internal audit processes required of both MIAA and the Trust were agreed and implementation of these will be overseen by ARC in 2024 (see item 2).

Discussions in Committee relating to the Internal Audit Annual Plan for the last couple of years have recognised that the days currently allocated to internal audit work are becoming increasingly "tight", in part due to the extent of external requirements for mandatory audits (such as of the BAF, DSPT, Conflicts of Interest, Fit and Proper Persons processes and risk management) leaving little room for the Committee to direct resources to areas of Trust priority, and also due to the increase in size of the Trust. The Committee therefore agreed to benchmark the internal audit days to similar trusts in Cheshire & Merseyside. This will be undertaken in 2024/25 (see item 6).

Anti-Fraud Service

The Anti-Fraud Service (AFS) is also provided by MIAA. The service is a mixture of proactive (such as fraud awareness communications, provision of fraud alerts and bulletins) and reactive activities (such as fraud investigation, fraud exercises such as National Fraud Initiative data matching and procurement fraud prevention).

The Anti-Fraud Annual Workplan is approved by ARC at the start of the year. Regular updates on the work undertaken is provided along with an Annual Report on the delivery of the Workplan. During the year a "local proactive exercise" looking at identity validation and vetting of agency, bank and non-substantive staff was undertaken and was ongoing at year end.

The 2022/23 local proactive exercise was reported in 2023/24 and, whilst it did not highlight any fraudulent activity it did highlight potential gaps in the employment records for some historical recruitments. Therefore, the Committee requested that HR check compliance of all current staff

records against the NHS Safer Recruitment Standards. This exercise enabled significant reduction in gaps and in 2024/25 ARC will consider the residual risk arising.

In May 2023 the Trust experienced a bank mandate fraud whereby a perpetrator intercepted emails sent to the Trust from a new supplier who then set up a new email address similar to the supplier's email address (addition of an "s") and used this to provide fraudulent bank details. These details were accepted by the Finance Team and an invoice for £30,000 was paid. When the fraud was identified, £9,723 was recovered but it is unlikely that the Trust will recover the remaining £20,273. The fraud was investigated by the AFS and it was also referred to the Police. The Finance Team undertook a lessons learned exercise and identified that existing process documents were not sufficiently clear. Refresher training was provided for staff and the AFS agreed to provide a talk on this area to Finance and Procurement staff.

The AFS also investigated a false representation allegation relating to non-attendance at shifts and the employee concerned was dismissed.

During the year, the Trust worked with MIAA to review and update its fraud risks following a review of fraud risk by NHS Counter Fraud Authority. The AFS completed a fraud risk assessment liaising with the AND&G and risk owners and the outcomes were reflected on the Trusts risk register.

Each year the AFS assists the Trust to undertake the annual self-assessment against the "Government Functional Standard 013 for Counter Fraud." The Trust's overall rating for 2023/24 was "green".

Clinical Audit

ARC is responsible for the oversight of Clinical Audit activities but the detailed oversight is undertaken by SQAC on its behalf. The Committee received the Trust Clinical Audit Plan 2023/24 following its approval by SQAC. The Plan is designed to reflect mandatory national and regional audits, National Confidential Enquiries (NCE) and audits that the Trust has identified as areas of priority fulfilling the requirements of the NHS Quality Contract and Trust Quality Account. The overall outcome of the year's work is:

Delivery of the Trust clinical audit activity has been delivered in line with accepted practice with the exception of submission of data for:

- the nationally mandated audit for Epilepsy 12.
- the nationally mandated audit for Trauma Audit & Research Network (TARN)
- the NCE Child Health Clinical Outcome Review Programme. NCE into Patient Outcome and Death. Transition for Child to Adult Health Services Study) (Transition).

For the Epilepsy 12 audit and NCE we did not submit data due to lack of clinical capacity. This has been escalated to the Clinical Effectiveness and Outcomes Group (CEOG) to oversee improvements to ensure submission in 2024/25. Data was not submitted for TARN due to a cyber-attack on the TARN platform which was subsequently suspended by NHSE and so submission is outside the Trusts control.

During 2023/24 the CEOG was established to oversee all clinical audit delivery reporting into SQAC. CEOG is chaired by a senior clinician and it endorses the Trust Clinical Audit Plan prior to approval by SQAC and oversees its delivery. CEOG is also working with Divisions to formalise processes and oversight of Divisional & Corporate Services* Clinical Audit Plan. The introduction of CEOG has significantly improved the detailed oversight and delivery of clinical audit at Trust-wide level and the assurance it provides in this regard to both SQAC and ARC, and is now focussing on achieving the same within Divisions and Corporate Services*. CEOG is also looking at how assurance can be gained on the effectiveness of implementing the findings from clinical audits. ARC will continue to work with SQAC and CEOG to further develop the clinical audit process and their oversight (see item 8).

* The CSC also oversees the delivery of corporate services audits with the Trust Clinical Audit Plan.

External Audit

External audit services continue to be provided by Ernst & Young (EY). The following reports were received from External Audit relating to 2023/24:

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

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 Chief Financial Officer / Managing Director will sign these documents on behalf of the Trust before the accounts are finalised.

During 2023/24 ARC commissioned a questionnaire, completed by ARC Members and Attendees, to review the effectiveness of External Audit. There were no significant weaknesses identified and improvements relating to audit partner rotation, timetabling to minimise the number of potential issues highlighted towards the end of the audit process, highlighting delays in the audit process and potential cost overruns promptly and training for new ARC Members were agreed. ARC will review implementation of the agreed actions throughout 2024/25 (see item 2).

An unqualified opinion on the accounts for 2023/24 was provided to ARC for endorsement and presentation to Board in June 2024.

Finance

The following reports were provided by the Finance Team in relation to the Annual Report and Accounts process and to provide assurance on financial control matters:

- Annual Accounts 2023/24.
- Statement of Going Concern from the Finance Team advising why it is appropriate to prepare the Trust's Accounts on a going concern basis.
- Accounting Policies.
- Waiver Activity Report.
- National Cost Collection – briefing in advance of an audit of this process in 2024/25.

Following the transfer of the Trusts procurement team to a shared service - Health Procurement Liverpool (HPL) – a review of tender limits and waiver processes across the trusts serviced by HPL was performed. As a result, ARC approved an increase in the tender limits in the Standing Financial Instructions from £10k to £20k recognising that this limit had not been increased for inflation for a number of years and to bring it in line with other trusts. ARC also approved a small number of circumstances where a waiver is currently required but the process does not add value or change the outcome (for example, salary recharges, spend that is governed by grants and funding transfers to other organisations).

Governance

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

<u>ARC Governance:</u>

- ARC Terms of Reference and Work Plan.
- ARC Annual Report 2023/24.

In 2021/22 ARC Members and Attendees completed a self-assessment of ARC effectiveness by reference to the Healthcare Financial Management Association Audit Committee questionnaire within the Audit Committee Handbook. During 2023/24 ARC continued to oversee the two ongoing actions arising from this relating to developing risk appetite statements and tolerances and processes for Clinical Audit planning. Elements of both actions remain ongoing and will be monitored in 2024/25 (see items 1 and 8). During 23/24 the ARC Chair undertook a desktop exercise based on the "Committee Processes" checklist in the Audit Committee Handbook which identified some minor actions to add to those ongoing.

There are various external requirements and good practices which suggest that the effectiveness of ARC, Internal Audit and External Audit be reviewed annually. To date, the individual exercises have been spread across separate years. Recognising that a full review of each of these would be time-consuming and that it would be beneficial to review the effectiveness of the Anti-Fraud Service too, ARC agreed to define an approach to their regular review which balances the needs of external requirements but in a manageable way for the Trust. This will be completed and implemented in 2024/25 (see items 3 and 4).

Trust Governance

- Trust Annual Report 2023/24.
- Draft Annual Governance Statement.
- Annual Reports of the Trust's Assurance Committees.
- Gifts & Hospitality Register.
- Policies and Strategies Approved or Ratified:
  - Treasury Management Policy.
  - Risk Management Strategy.
  - Risk Management Policy and Procedure.
  - Risk Assessment Policy.
  - Policy for Engagement of External Auditors in Non-Audit Work.
  - Corporate Governance Manual.

The Annual Report for Non-Clinical Claims for 2023/24 was not provided to ARC in April 2024 due to staff unavailability. The Report is now expected in July 2024.

Developments in 2023/24

During the year:

- The risk management system transferred to InPhase.
- A Trust wide Clinical Effectiveness and Outcomes Group was established to oversee all clinical audit activity reporting into SQAC and ARC.
- Effectiveness reviews of the Internal and External Audit services were undertaken.

Assurance Statements

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 2024/25

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

1. Oversight of the continuing development of risk appetite and tolerances and their implementation throughout the Trust.
2. Monitor the implementation of the actions identified in the effectiveness reviews of Internal and External Audit.
3. Oversee completion of an effectiveness review of the Anti-Fraud Service and implementation of actions arising.
4. Agree a process to annually review the effectiveness of Internal Audit, External Audit, Anti-Fraud Service and ARC itself which balances meeting external requirements whilst not being onerous for the Trust.
5. Seek assurance of the project management processes for the phase 2 implementation of InPhase.
6. Benchmark the Internal Audit resources versus similar Trusts in Cheshire & Merseyside.
7. Work with the Governors that are aligned to ARC to enable them to gain assurance of the effectiveness of ARC.

Kerry Byrne, Audit and Risk Committee Chair
June 2024

Appendix 1 - Audit and Risk Committee – Record of Attendance 2023/24

The quorum necessary for the transaction of business: two Members

	2023				2024	TOTAL	
	Apr	June	July	Oct	Jan		
MEMBERS							
Kerry Byrne (Chair) Non-Executive Director	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	**5 / 5**	**100%**
Garth Dallas Non-Executive Director	✓	x	✓	✓	✓	**4 / 5**	**80%**
Jo Revill Non-Executive Director	✓	✓	✓	✓	x	**4 / 5**	**80%**
Quoracy achieved	**YES**	**YES**	**YES**	**YES**	**YES**	**5 / 5**	**100%**
ATTENDEES							
John Grinnell Managing Director / CFO	✓	✓	x	x	✓	**3 / 5**	**60%**
Emily Kirkpatrick (Associate Finance Director – Commercial, Control & Assurance)	✓	✓	✓	✓	✓	**5 / 5**	**100%**
Rachel Lea Director of Finance and Development	✓	✓	✓	✓	✓	**5 / 5**	**83%**
Erica Saunders Director of Corporate Affairs	✓	✓	✓	✓	x	**4 / 5**	**80%**
*** Adam Bateman** Chief Operating Officer	✓	N/A	✓	✓	✓	**4 / 4**	**100%**
**** Lisa Cooper** Divisional Director – Community	N/A	N/A	✓	N/A	N/A	**-**	**-**
**** Urmi Das** Divisional Director - Medicine	N/A	N/A	N/A	N/A	✓	**-**	**-**
**** Benedetta Pettorini** Divisional Director - Surgery	N/A	N/A	N/A	N/A	N/A	**-**	**-**
**** John Chester** Director of Research and Innovation	N/A	N/A	N/A	✓	N/A	**-**	**-**
Jackie Rooney Ass. Dir. of Nursing & Governance	✓	✓	**Deputy**	✓	✓	**5 / 5**	**100%**
External Audit (**Ernst & Young)**	HR/DS	HR	N/A	HR	DS	**5 / 5**	**100%**
Internal Audit **(MIAA)**	GB/KS	GB/KS	KS	GB/KS	GB/KS	**5 / 5**	**100%**
Anti-Fraud Service **(MIAA)**	✓	N/A	N/A	✓	✓	**3 / 3**	**100%**

External Audit (E&Y) Representatives:
Mr D Spiller (DS)
Mr H Rohimun (HR)

Internal Audit (MIAA) Representatives:
Mr. G Baines (GB)
Mrs K Stott (KS)

Anti-Fraud Service (MIAA) Representative:
Ms V Martin (VM)

* attendance only required for risk items
** attends once each year to present on risk management within their Division. Benedetta's attendance in January 2024 was deferred to April 2024.

Appendix 2 – Summary of Internal Audits for 23/24 Internal Audit Plan

Audit Title	Assurance Level
Access to Health Records	Substantial
Key Financial Controls	Substantial
Data Quality	Substantial
Project Management	Substantial
FTSU	Substantial
EPRR	Moderate
Data Security & Protection Toolkit	Substantial
Payroll	Substantial
On call payments	Moderate
Assurance Framework	Met Requirements
Cyber Assessment Framework	Substantial

Alder Hey Children's NHS Foundation Trust

Resources and Business Development Committee Annual Report 2023/24

The Resources and Business Development Committee

This report provides a summary of Resources and Business Development Committee activities and assurance that the Committee has carried out its obligations in accordance with its Terms of Reference and work programme for 2023/24 and identifies key actions to address developments in the Committee's role.

The Resources and Business Development Committee was established by the Board of Directors to be responsible for reviewing financial strategy, workforce strategy, performance, organisational business development, innovation and strategic IM&T issues, and the approval of business cases to limits delegated by the Board.

The principal devolution of the Board's responsibilities are as follows:

- Review and recommend business, operational and financial plans to the Board
- Ensure value for money is obtained by the Trust
- Monitor performance, assuring the Board that performance is being managed in line with plans
- Identify related areas of strategic and business risk and report these to the Board
- Oversee the development of the Trust's long-term financial strategy, its Business Development Strategy and its Investment Strategy

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.

Constitution

In accordance with the terms of reference which are reviewed annually the membership of the Committee comprises:

- Non-Executive Directors x 2 [one of whom shall be the Chair]
- Director of Finance
- Deputy Director of Finance
- Chief Operating Officer
- Chief People Officer
- Chief Information Officer
- Managing Director of Innovation

Expected to attend each meeting is: Director of Corporate Affairs, Associate Director of Finance, Director of Marketing and Communications, Development Director, Deputy Director of Business Development – Commercial, Director of Strategy and Partnerships.

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. A schedule of attendance at the meetings is provided in Appendix A which demonstrated that all meetings in-year were 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 2023/24

Assurance on five RABD Key Risks

- Regular assurance reports were received on the following:
    1) Immediate financial performance – outturn, capital and cash
    2) Cost Improvement Plan in the context of the National financial constraints
    3) Benefits realisation, governance and prioritisation of change programme to 2030
    4) Alderc@re implementation
    5) The Campus & Park developments

    Details of assurances received are listed below.

Quarterly meetings held face to face with deep dives on divisional performance

The Committee received quarterly detailed reports on activity, productivity and performance along with actions taken to improve the financial position for all divisions. Mitigation plans and forecast position for each division were received to provide assurance around future financial sustainability. These included capacity and demand exercises, enhanced recruitment scrutiny and divisional CIP workshops.

Of particular note was the adverse affects of ongoing industrial action during 2023/24 causing a significant negative variance within the surgical division for ERF income, which otherwise would have been met. A number of schemes have been identified to hold forecast position along with a medical spend improvement plan, introduction of a dedicated programme manager in order to run CIP as a programme in 2024/25 and the launch of a project to reduce high-cost drugs wastage on wards (detailed report in section below).

Financial and Operational Performance

- The Committee regularly monitored the agreed financial metrics in the Integrated Performance Report and received substantive updates with regard to specific issues identified.
- The Committee received an overview of the 2023/24 Financial Plan noting the £12m surplus requirement at May 2023 submission.
- The committee received the year-end financial position report for 2022/23, the cash balance position at M12 was reported at £83.5m and the Trust ended the year with a surplus of £16.729m. Our capital expenditure was £16.9m and the Trust delivered its cost improvement plan target of £17.3m.
- Monthly financial position reports were received in-year detailing surplus position, CIP posted to date, updates in respect of the wider Cheshire and Merseyside plans and overall control total. The position reported at 27th March 2024 was a surplus of £6.4m YTD (£2.1m short of plan due to in-year industrial action). In March 2024, the Trust was £1.16m income to offset some of the deficit caused by industrial action implying a forecast of £12.3m for year end. £17.7m of CIP was posted in-year and the Trust was on plan to spend its full CDEL allocation in-year.
- The Committee was kept informed of the impact in relation to industrial strike action including income loss and costs.
- RABD received a 5 Year Cash Flow Forecast noting the current balance, forecast for the year ahead assumptions on likely capital spend and I&E positions for the next 5 years (base case and downside assumptions).
- The Committee was kept well informed of Alder Hey's vision to create a 'health campus' on Springfield Park including the further development of the campus and reinstatement and enhancement of Springfield Park including key risks to delivery. Owing to the rise in

inflation costs, a revised cost plan for the Neonatal project was brought to the Committees attention and subsequently presented to Trust Board for approval. Significant milestones on the following projects were provided during the year: opening of Sunflower House in May 2023; handover of Springfield Park to LCC and provision of Gender Services.

- Position reports on the deployment of the Meditech Expanse upgrade under the AlderC@re Programme were received highlighting key risks to delivery and mitigations. The Alderc@re programme was implemented in September 2023. Assurance reports in respect of the main challenges in the immediate post go live period were received until post go live phase. The outputs of an NHSE assessment undertaken following go live were received. Positive feedback from the national team had been received along with two recommendations to take forward 1) set up an Expanse Operational Forum to include other organisations due to implement Meditech Expanse and 2) undertake due diligence and learning for future phases. The Committee was encouraged that one of our biggest risks for 2023/24 was now mitigated.
- The Committee was kept abreast of the progress against the Digital and Data Futures Strategy noting the associated challenges and mitigation plans. Updates on key areas of transformation, operational performance and progress with digital developments were provided in-year including Alder Hey Anywhere, digital maturity assessment and assurance in respect of DSPT compliance.
- Progress against the Trust's Green Plan was regularly reported to the Committee including updates on carbon emissions showing a reduction of 17% from 2021/22 to 2022/23.
- Following the continuing rise in inflationary pressures in the energy markets, RABD received and supported the proposed approach to energy procurement for 2023/24 in order to achieve low-cost energy through a managed procurement strategy.
- Quarterly Innovation and Commercial Activity reports were received outlining activity against the Innovation operational plan KPI: Business Development. The reports provided assurance against the monitoring of specific agreements, deal progression status and potential commercial revenue opportunities as a result of the organic products developed by Alder Hey Innovation. Due diligence and transparency reports relating to ongoing projects were also received by the R&I committee. Going forward these would be received by the Futures Committee and high level commercial activity reported to RABD by exception.
- Procurement updates were received on a quarterly basis highlighting the major milestones achieved since implementation of the shared service. Improvement projects included the implementation of a Product Evaluation Group to standardise and rationalise products, implementation of a resist, negotiate, explore strategy to challenge suppliers applying inflationary increases, applying a category management approach for strategic projects and development of a procurement board performance dashboard. The delivery of all schemes for 2023/24 was noted.
  2024/25 schemes were presented to committee noting the requirement for procurement support from other Trusts. The Committee challenged the ambition set out in the current schemes and requested a much more radical approach re collaborating and further efficiency gains.
- The Committee approved the HPL three-year Procurement Strategy.
- The committee received sight of the correspondence received from the ICB detailing a number of mandated expenditure controls required and the Trusts response to ensure each of the controls are implemented. A subsequent report was received by RABD providing assurance on actions taken in-year to comply with these controls and proposed steps for ongoing actions.

- RABD approved two bad debt write off reports of £12,013k and £348,366.40 following assurance that all efforts to recover monies had been exhausted and updated process to ensure that such costs are not re-incurred.
- RABD reviewed the costing plan and supporting information for the Trust's 2022/23 National Cost Collection submission.
- Quarterly Service Line Reporting data was received noting that SLR performance varied significantly across specialites. Work to improve cost and income allocations were noted for 2024/25 including costing of several productivity metrics, exploration of health inequalities/demographics, PLICS data and the establishment of the CHA Costing Benchmarking Group were noted. Greater involvement from divisions in terms of divisional analysis was also welcomed to improve productivity.
- Biannual assurance reports on the Trust's performance as an Operational Delivery Network (ODN) host were received. The Committee noted key updates, assurance that Alder Hey are discharging responsibilities as an ODN Host organisation and that ODNs continue to operate within their agreed budgets. Risks and issues within hosted ODNs were noted including their mitigations for resolution. It was noted that both Alder Hey and RMCH had submitted intentions to NHSE to obtain a hosting fee for the provision of services which we are hopeful of achieving. Going into 2024/25 ODNs will be excluded from CIP targets in 2024/25 in order to ringfence delivery of safe services.
- Regular overview reports detailing the activities undertaken by the Marketing & Communications Team were received. These included successful management of mission critical activity for the Trust, managing our reputation, hosting a number of high-profile visits, staff communications and engagement and using social media to grow interest and communicate with our stakeholders.
- The Committee received a follow up report on the actions implemented as a result of the HFMA Finance Sustainability Audit undertaken early 2023. Assurance was received that all areas were reported as green and that an ongoing review of the HFMA Sustainability checklist has been built into the Annual Planning Timetable as a point of reference for internal review. The Committee noted that, as a result of a number of initiatives implemented this year, the finance team were shortlisted for a series of national awards including the Public Finance Awards Finance Team of the Year as well as Finance Digital Project of the Year for the use of RPA.
- Monthly assurance reports were received by the Committee in relation to the Children's Health Park, highlighting planned preventative maintenance performance and progress against key issues such as energy consumption, green roof works and the corroded pipework.
- An update in relation to overspend on drugs during 2023/24 was presented to the March RABD. The Committee noted the reasons for this which include significant changes in the way commissioners fund drugs and national shortages causing inflationary cost pressures. Actions to mitigate the cost pressure were noted whilst noting that there doesn't appear to be any immediate resolution to the national shortages and that the cost pressure is likely to continue for at least the first half of 2024/25. Despite an improved position from the previous year, the committee requested further assurance by way of detailed analysis of outcomes aligned to spend, trends, CIP benefits, opportunities within pharmacy (horizon scanning) and additional controls.
- The draft 2024/25 Annual Plan was received ahead of Trust Board approval in April 2024. Key priorities were highlighted aligned with the 2030 Vision. Target metrics for 2024/25 were presented which will be tracked through the IPR next year. National guidance was still awaited at this stage, therefore stretch targets had been included. The proposed activity plan was noted to deliver an overall ERF value of 115%. The Trust was required to deliver an efficiency programme of £19.3m.

- The mobilisation plan for launching years 2 and 3 of Vision 2030 was received highlighting risks to deployment. The development of an Integrated Plan (IP) was welcomed as an assurance mechanism for delivery which will also support the achievement of the in-year financial efficiencies required for 2024/25. The Committee approved the formation of a 2030 Programme Board to monitor delivery of the IP which will report directly into RABD.

Governance

- The draft Terms of Reference and Work Plan for 2024/25 were received. The Committee agreed to receive the final version at its April 2024 meeting following discussion around a number of further changes required.
- The Committee continued to approve policies as required.
- The 2022/23 Committee Annual Report was received.

Board Assurance Framework

- RABD received assurance reports for Board Assurance Framework risks under its area of responsibility (risk 1.2, risk 1.3, risk 1.4, risk 3.1, risk 3.2, risk 3.4, risk 3.6 and risk 4.2). This process proved an effective mechanism for gaining assurance to controls and any required actions.
- RABD is responsible for oversight of the following BAF risks on behalf of the Trust Board:

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	4x3	2x3
1.4*	Access to Children and Young People's Mental Health	3x5	3x3
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	3x4	3x2
3.2	Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. ***Risk renamed in light of Vision 2030***	4x3	4x2
3.2	Strategy Deployment	3x4	4x2
3.4	Financial Environment	4x4	4x3
3.6	Risk of partnership failures due to robustness of partnership governance. ***Risk closed October 2023.***	3x2	3x2
4.2	Digital and Data Strategic Development and Delivery	3x4	2x4

** Joint responsibility with SQAC*

Throughout the year RABD was provided oversight of these risks by:

- *Risk 1.2 Children and young people waiting beyond the national standard to access planned care and urgent care*.
  - gaps in controls were regularly addressed through updates within the Integrated Performance Report. At M11 the position against national standards were:
    - patients waiting over 65 weeks had been reduced to just 8 patients. The Trust is expected to achieve this standard by year end.
    - ED performance stood at 83% for February 2024 against a national target of 80%.

- ambulance handover was slightly under the 90% target, but mitigation was in place. Assurance was provided that timely handover is being delivered.
- Performance in theatres has remained stable with low cancellations despite ongoing IA.
- Wait times for diagnosis in neurodiversity remain a challenge due to the huge demand on the service. Discussions are ongoing with Commissioners to look at integrating the pathway.

- *Risk 1.3 Building and infrastructure defects that could affect quality and provision of services*
  - Progress against the actions to address gaps in controls were monitored on a monthly basis by RABD through the assurance reports from the Building Services Team (referenced within report).
- *Risk 1.4 Access to Children and Young People's Mental Health*
  - gaps in controls were regularly addressed through updates within the Integrated Performance Report including key actions being taken forward to mitigate the increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks.
- *Risk 3.1 Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus*
  - Substantive reports were received each month on Alder Hey's vision to create a 'health campus' on Springfield Park (referenced within report).
- *Risk 3.2 Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.*
  - Progress against the actions to address gaps in controls were monitored by RABD through assurance reports on the Trust's performance as an Operational Delivery Network (ODN) host. 'Our Plan' concluded in 2024 and was replaced with Vision 2030.
- *Risk 3.2 Strategy Deployment*
  - In March 2024, the Committee approved the formation of a 2030 Programme Board to monitor delivery of the IP which will report directly into RABD.
- *Risk 3.4 Financial Environment.*
  - Monthly updates highlighting uncertainty on the 2023/24 forecast with the impact of industrial action and exit run rate and underlying position going into 2024/25 were received. A number of key actions and additional mitigations were set out and monitored closely by RABD including inflation increases and benefit cases.
- *Risk 3.6 Risk of partnership failures due to robustness of partnership governance*
  - Following a substantial audit report received from MIAA on Partnership Governance this risk was closed in-year.
- *Risk 4.2 Digital and Data Strategic Development & Delivery.*
  - gaps in controls were regularly addressed through the Digital, Data and Information Technology progress report with a particular focus on implementation of AlderC@re. This risk was reduced following safe deployment of the system.

- The Trust's risk appetite statement was agreed in February 2022 incorporating risk tolerances linked to the various defined risk categories including safety and quality, regulation and compliance, financial environment and innovation using a risk appetite framework based upon best practices promoted by the Good Governance Institute.

In 2022/23 RABD was asked to undertake a review of the risk tolerance scores for the BAF and corporate risk register risks within the categories under their remit, including current scoring, threshold descriptors where they exist and to determine what those may be where they do not. This work was placed on hold following the implementation of InPhase due to the limitations in the system.
During the latter part of 2023/24 this work resumed, and the next phase of this work, following agreement of the appetites and tolerances relating to RABD risks, is for the Audit and Risk Committee to consider the risk profile that this presents during the first quarter of 2024/25 and make any recommendations that arise to the Board when it next considers its overall appetite; this may include the adjustment of thresholds or differentiation of categories.

Based on the processes for overseeing these risks as summarised above, RABD can confirm that management are effectively managing these risks and are taking timely steps to reduce their risk score**.**

Business Cases approved

- Recovery of Surgical Services
- ENT and Dental
- Community Business Case – Clinical Health Psychology to support complex discharges (50% of the funding to allow for investment to sustain priority services)
- 3T research/clinical MRI scanner (onward running costs) for Trust Board ratification.

Further assurances
The Committee has continually challenged assurance processes when appropriate and has requested and received assurance reports from Trust management and various other sources, both internally and externally throughout the year.

Extraordinary Meetings Held
During the year, three extra-ordinary meetings were convened.
The first meeting was to discuss and agree business cases for the recovery of surgical services and ENT and Dental. The second meeting was held to seek support for the capital development of the NICU, PAU and Urgent Care Centres and also to receive an update on H2 financial and operational planning. The third meeting was held to discuss commercially sensitive matters in respect of the Campus.

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, with year-end performance ending positively.

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. RABD also agrees to the declaration reported to the Board in respect of the Annual Governance Statement.

The Committee holds key relationships with the Innovation 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 RABD 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 2024/25

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2024/25:

- The Committee will continue to focus and seek assurances regarding the top five risks/key priority areas in 2024/25 which would enable the Trust to deliver its clinical, operational and financial targets.
    - Immediate financial performance including system position
    - Capital Programme
    - Efficiency Programme
    - Benefits realisation, governance and prioritisation of change programme to 2030
    - The Campus & Park developments

- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- The Committee will continue to hold the Divisions to account for their performance and will seek to drive measurable improvements in efficiency and productivity.

John Kelly
Committee Chair
April 2024

RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE - RECORD OF ATTENDANCE 2023/24

The quorum necessary for the transaction of business: Chair or nominated deputy, one other NED, one Executive Director.

Member/Date of Meeting	2023									2024			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MEMBERS														
John Kelly (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	12/12	100%
Fiona Marston (Non-Executive Director)	-	-	-	-	✓	✓	x	✓	x	x	x	✓	4/8	50%
Kerry Byrne (Non-Executive Director)	-	-	-	-	✓	-	-	-	-	-	-	-	1/1	100%
Shalni Arora (Non-Executive Director)	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Jo Williams (Non-Executive Director)	-	-	-	-	✓	-	-	-	✓	-	-	✓	3/3	100%
John Grinnell (Managing Director/CFO)	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Rachel Lea (Director of Finance and Development)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	11/12	92%
Adam Bateman (Chief Operating Officer)	✓	x	✓	✓	✓	✓	x	✓	x	✓	✓	✓	9/12	75%
Melissa Swindell (Chief People Officer)	x	x	✓	✓	x	✓	x	✓	✓	✓	✓	✓	8/12	67%
Claire Liddy (Managing Director of Innovation)	Deputy (mat leave)	Deputy (mat leave)	Deputy (mat leave)	x	Deputy (mat leave)	Deputy (mat leave)	x	x	x	x	n/a	n/a	6/12	50%
Kate Warriner (Chief Digital and Info. Officer)	Deputy	Deputy	✓	✓	✓	✓	✓	✓	Deputy	✓	✓	✓	12/12	100%
Quorum achieved	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	12/12	100%

ATTENDEES														
Erica Saunders (Director of Corporate Affairs)	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	9/12	75%
Mark Flannagan (Director of Marketing and Coms)	✓	✓	x	x	x	Deputy	x	Deputy	1 item	x	x	Deputy	6/12	50%
Dani Jones (Director of Strategy and Partnerships)	✓	Deputy	x	✓	Deputy	✓	Deputy	✓	Deputy	✓	✓	Deputy	11/12	92%
Jayne Halloran (Acting Development Director)	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Emily Kirkpatrick (Associate Director Commercial Finance)	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	11/12	92%
Claire Shelley (Associate Director Operational Finance)	✓	✓	✓	✓	✓	✓	x	n/a	n/a	n/a	n/a	n/a	6/7	86%

Alder Hey Children's NHS Foundation Trust

Safety & Quality Assurance Committee Annual Report 2023/24

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 Divisions and Clinical Directors who have the authority to implement the Trust's Quality Strategy and supporting Quality Aims within and across Divisions, supported by the central functions.

Constitution

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
- Director of Nursing
- Director of AHP's
- Deputy Chief Executive/Director of Finance
- Chief Operating Officer
- Director of Corporate Affairs
- Chief People Officer
- Director of Strategy & Partnerships
- Chief Digital Information Officer
- Divisional Directors x4
- Divisional Clinical Leads for Safety x3

Expected to attend each meeting: Deputy Chief Medical Director, Deputy Director of Nursing & AHPs, Associate Director for Nursing and Governance and the Director of Infection Prevention Control. To ensure that SQAC remains strategic and assurance led, it is also supported by the Clinical Effectiveness & Outcomes, Patient Experience and Patient Safety Groups which monitor quality assurance at an operational level and report in to SQAC. A schedule of attendance at the meetings is provided in Appendix A which demonstrates each meeting was quorate.

The Committee has an approved work plan which is used to review the establishment and maintenance of an effective system of quality governance, patient safety and risk management across organisations activities.

Principal Review Areas / Achievements in 2023/24

Quality Improvement

Monthly updates were received from the Patient Safety Strategy Board (PSSB) on each of the workstreams sitting within the patient safety programme. Successes noted in-year were:

- The introduction of the hospital optimisation programme which saw the implementation of a number of improvement actions to tackle the problems with providing highly responsive medical hospital cover 27/7/365.
- The provision of a patient safety and human factors training master class to equip staff with the knowledge and skills to recognise and respond to human factors risks.
- Updated format of the Patient Safety Strategy Board following a thorough review of the Terms of Reference and workplans for the Patient Experience, Patient Safety and Clinical Effectiveness and Outcomes Groups.
- Approval of a decision document relating to the neonatal and newborn screening programme, which highlighted that Alder Hey Children's NHS Foundation Trust is the first paediatric Trust to implement a programme of this type working in partnership with NHSE.
- Development of the pharmacy dashboard derived from the InPhase system to allow greater spotlight on medication safety, ten-times medication errors and TPN incidents. This dashboard was noted as exemplar.
- Introduction of the Patient Safety Partners (PSP), namely children and young people aged 16 and over enabling PSPs to be involved in their own safety through a programme of events in line with school holidays.
- Closure of two formal workstreams in-year (Medication Safety and PAU) into business as usual.
- A claims and litigation event to enable the further development of systems and processes to ensure that learning from litigation and insight are embedded into the Trust to maximise patient safety.
- relaunch of the Learning Disabilities Champions Network and number of LD champions which saw in increase by 10% by January 2024. Provision of Makaton training was delivered through the LD workstream.

Delivery of Outstanding Care

- In May 2023, SQAC approved the proposal to disband the Clinical Quality Steering Group (CQSG) to enable the formation of a Clinical Effectiveness & Outcomes Group, a revised and refreshed Patient Safety Group and a new Patient Experience Group to progress to an improved model of oversight and quality assurance.
- New style Divisional Assurance Reports were introduced during 2023/24 following the disbandment of the CQSG, ensuring a standardised approach across the Trust to quality and safety monitoring. The monthly reports highlighted 3 successes, 3 key challenges, provided assurance against regulatory requirements, incidents, complaints, FFT, management of risks, sepsis compliance, clinical audit compliance, people metrics and areas for escalation.
- Monthly reports from the Director of Infection Prevention and Control were received. During the year a deep dive of infection cases and targets was undertaken resulting in much improved reporting and enabling a proactive focus for the IPC Team over the next 12 months. In addition, a piece of work remains ongoing with NHSE and other paediatric Trusts regarding the differences between adults and children acquiring infections and that some preventative methods are not effective for very young infants. The Committee welcomed data on all hospital acquired infections and not just those reported to UKHSA. Going forward, it was agreed that water safety will be included in the monthly report.
- Bi-annual reports detailing the themes and trends from the Quality Assurance Rounds (QAR) were formally received noting the main successes and challenges including

actions to address these. Looking ahead into 2024/25 SQAC welcomed the reset of QARs to ensure more face-to-face opportunities transitioning to a hybrid approach. The revised hybrid approach to QARs aligned to the new CQC single assessment framework will commence from April 2024.

- The Committee received the Health Inequalities & Prevention (HIP) Steering Group report noting the huge amount of work undertaken to close thirteen of the fourteen commitments set in December 2021. Alder Hey had been requested to showcase this work at ICS level. Key goals and actions for the next twelve months were presented including the Development of Alder Hey's Health Inequalities and Anchor Plan to 2030 and investment in a new substantive role – Consultant in Paediatric Health Medicine – to provide clinical leadership to the HIP agenda. Collaborative working with Divisions was welcomed going into 2024/25 in terms of better understanding the data across specialities and activities.
- SQAC ratified the 2023/24 Winter Plan taking assurance from the robust plans to ensure adequate staffing over the winter period.
- The Committee supported the proposal for the Chief Pharmacist to become the Controlled Drugs Accountable Officer in line with other organisations.
- Monthly updates in relation to continued pressures within the Emergency Department (ED) were provided to the Committee along with ED mental health attendances highlighting actions taken to ensure CYP were being triaged and treated in line with national targets. These included a dedicated consultant (Mon-Fri), ensuring the right skill mix of staff, exploring pathway redesign, introduction of an ED Escalation Policy and continuation of the Urgent Treatment Centre which was introduced in January 2023. Year to date (February 2024) performance against national 4-hour target was 82.2%, 6% above the national standard. Median time to triage for February was 18 minutes against a national standard of 15 minutes. The Committee was assured that a deep dive was underway regarding median time to triage to establish time frames when this is most challenged; therefore, allowing focused improvements to be made.
- The Committee continued to receive detailed oversight reports from the Sepsis Steering Group and whilst welcoming the development of the ED and Inpatient Sepsis Dashboards, the Steering Group was asked to focus on finalising the remaining elements of the Inpatient dashboard with BI in order to provide greater levels of assurance.

  Following concerns of completeness, a deep dive review into the appropriateness of sepsis training for all relevant staff members was undertaken and assurance provided that this is all now correct and staff have been advised of the new arrangement. A basic sepsis training package has been developed for all staff who do not require the full package which is pending approval ahead of roll-out.
- A concluding Divisional Governance Report was presented to the May 2023 meeting highlighting the completion of all actions associated with the clinical governance review undertaken in 2022. The Committee expressed thanks to colleagues for the changes that had taken place over the last 2-3 years across the organisation.
- The Committee received the outputs from the task and finish group established to look at the backlog of diagnostic notifications in Meditech and were assured of the low risk of harm based on the low associated incident rate. Actions to rectify the situation were noted and commended including reconfiguration in the new system (Expanse) and development of reports and dashboards to monitor clinician compliance. The Committee agreed that this would be kept under review until we were assured that these were at a steady state and not increasing, hotspots within the surgical division will be looked at and brought back to the committee in 2024/25.
- Quarterly Mortality Assessment Reports were received broken down to show activity from the Hospital Mortality Review Group. The reports concluded that HMRG is providing

effective and comprehensive reviews in a timely manner, meeting the four-month target, and that there are no concerning trends that have been identified for patient deaths at Q3. SQAC welcomed these comprehensive reports providing high levels of assurance with refection and learning. The Committee took assurance from the appointment of two Paediatric Medical Examiners; a legal requirement from 1st April 2024. Going forward, the Committee welcomed the formation of a group with other paediatric hospitals regarding the mortality process.

- Quarterly Reports in respect of the Safe Waiting List management programme were received containing strong assurances on all workstreams sitting within the programme including:
    - follow up waiting list programme had been established because of some children coming to harm as a result of clinicians listing more patients for follow up that can be seen. A business case was approved in year to provide additional resource for 2024/25 to address the high-risk overdue backlog along with an external review of data quality.
    - All actions reported as complete from the RCA in Urology
    - An independent assessment of waiting lists following the implementation of Alderc@re on data quality which provided assurance that the reports are working as they should and an improvement in the metric relating to number of pathways with a DQ error from previous reported data.

  At the February 2024 meeting, it was confirmed that the SWL Management Programme had delivered the initial piece of work it set out to do and is now in optimisation phase. SQAC were therefore content not to receive regular updates into 2024/25 but welcomed the evaluation of follow up work to come back once complete.
- The Annual Project Assurance Report 2022/23 and Forward Plan for 2023/24 was presented to the Committee. In terms of assurance for 2022/23 the report highlighted the closure of two recovery projects to business as usual, 100% of programmes rated green for adherence to the governance standards and three programmes rated as green for overall programme delivery.

  The Committee noted that the Delivery Management Office (DMO) would be supporting delivery of the 2030 Strategy deployment and associated Governance and Assurance Framework and therefore approved the cessation of receiving quarterly DMO Reports.
- Regular Healthcare Transition Reports were received and whilst noting the successes and achievements in year a number of challenges were highlighted. Assurance was received that the transition process for complex patients is robust and under control (albeit challenging) but the process for 'normal' transition was inconsistent owing to challenges with data collection following the roll out of Alderc@re. An audit was being undertaken to understand issues around incorrect usage of transition appointment codes. In addition, a targeted approach to Healthcare Transition training was being looked at, in conjunction with the Academy, to ensure appropriate staff complete this competency.
- SQAC received the Ward Accreditation Report demonstrating assurance of standards of practice by measuring the quality of care delivered by wards and department teams. It was noted that the current accreditation criteria, scoring system and process is under review to align with the new CQC Single Assessment Framework. The Committee were encouraged to learn that there are now 24 wards and departments included in the ward accreditation scheme and that there had been lots of engagement from CYP this year.
- Safeguarding Quarterly Assurance Reports were received during the year outlining the governance arrangements in place to ensure the Trust meets its statutory safeguarding responsibilities. The absence of the Named Doctor for Safeguarding was noted however, which is a statutory requirement. SQAC noted that this had been added to the risk register and work continues to safely staff the service. The ongoing work regarding investment to improve capacity and address some of the staffing challenges was noted.

Safeguarding training compliance was escalated to SQAC in April 2023 which was sitting below the required 90% compliance target. A number of changes were implemented (approved via the Education & Training Governance Committee) to ensure the Trust is meeting its statutory and legal requirements and to protect children and young people from harm. This continues to be closely monitored on a quarterly basis.

- The matter regarding the restriction of capital funding for the replacement of medical equipment was brought to the Committees attention. SQAC noted that this was a consequence of IFRS16 and capital expenditure reduction by ICB controls. A deep dive into the risk surrounding this was being undertaken via the Risk Management Forum in March 2024. The Committee agreed that despite the cause of this risk being financial, SQAC would continue to receive updates in terms of the potential impact to patient safety. Assurance was provided that this matter is being closely monitored through the Trust Capital Subgroup who are maintaining oversight of the long-term view.
- SQAC was presented with a report regarding the governance systems and processes for the new Children and Young People's Gender Service (North), which commenced on 1st April 2024. The Gender Service Risk Register was noted and assurance taken from how new and escalating risks would be managed post go live.
- The Committee received an update report from the Safeguarding & Statutory Services Assurance Group noting the work undertaken on the trust risk register in relation to safeguarding categories. Monthly operational safeguarding meetings were introduced across divisions to share learning, review incidents, and provide appropriate assurance.
  The Committee supported the changes to mandatory safeguarding training in order to meet the required statutory and legal requirements and continues to monitor training compliance as a result of some hotspot problem areas.

<u>Clinical Governance Effectiveness</u>

- The Trust Wide Clinical Audit Annual Work Programme 2023/24 was approved by the Committee setting out the mandatory National and Regional audits, Confidential Enquiries and Trust wide priority audits in order to fulfil the requirements of the NHS Quality Contract and Trusts Quality Account. The Committee was informed that weekly meetings are now in place with divisions to monitor compliance. Later in the year, the draft Plan for 2024/25 was received following release of the regional audit requirements and Quality Contract confirmations. The Clinical Audit Team were asked to consider aligning the Audit Plan to Trust objectives.
  Throughout the year, the Clinical Effectiveness and Outcomes Group (CEOG) provided oversight of all audit activity by way of regular highlight reports demonstrating good engagement and positive discussion relating to progressing clinical audits and NICE Guidance. The Committee has gained assurance that there is a real sense of ownership within the Group in terms of learning from clinical audits. The Committee approved the CEOG Workplan and ToRs for 2024/25 and requested that a Chairs Highlight Report from the Group be submitted to the ARC for oversight and assurance.
- The Committee received regular update reports following the implementation of the new risk and incident management system, InPhase in May 2023 which presented a number of issues in terms of functionality and obtaining data. At year-end, it was reported that the majority of reports had been completed and were in use. In collaboration with LHCH a heatmap report was in development to allow real time data analysis of risks by division. Notwithstanding, there have been a number of lessons learned from implementing this new system which continue to be taken forward.
- SQAC received the National Safety Standards for Invasive Procedures (NatSSIPs) Report and noted the work being undertaken by a working group to review all current NatSSIPs working within the Trust in line with updated Standards released in January 2023.

- SQAC was presented with the outputs from the Clinical Coding Data Security and Protection Audit 2022/23 and took assurance from the standard of coding and achievement of an overall attainment level of Standards Met for Data Security and Protection Toolkit purposes. There had been a vast improvement in three areas of the audit, compared to last year's DSPT audit. The most noticeable and significant improvement was in the accuracy of the capturing and coding of secondary procedures, however a number of recommendations have been taken forward to ensure clinical coding accuracy.
- The Committee received quarterly reports from the Drugs and Therapeutics Committee following the disbandment of CQSG, noting the deep dive into medication incidents and good management of risks. Going forward, SQAC requested more detailed updates highlighting good practice and team successes from a pharmacy viewpoint.
- Assurance was provided to SQAC in relation to oversight and learning following the Trust's participation in the National Confidential Enquiries programme.
- The Committee regularly monitored compliance against National Institute for Health and Care Excellence (NICE) Guidance and actions taken to meet expected standards and ensure patient safety. SQAC noted the continued improvement in terms of compliance and implementation of a clear system for ensuring completion of works within a reasonable timeframe.
- Commissioning for Quality & Innovation (CQUIN) reports were received quarterly (previously stood down during Covid), indicating that all nine CQUINs are on trajectory with the exception of two which are subject to discussion with Specialised Commissioning. The quarterly reports were also subject to RABD oversight in terms of the financial aspect linked to non-delivery of the CQUINs.
- The Committee received the Trust Quality Account for 2022/23.
- The Committee was kept abreast of the governance arrangements in place to transfer from the Serious Incident Framework to the Patient Safety Incident Response Framework – the new approach to responding to patient safety incidents for the purpose of learning and improving patient safety.

<u>Well Led</u>

- SQAC is responsible for oversight of the following BAF risks on behalf of the Trust Board:

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*	Access to Children and Young People's Mental Health	3x5	3x3

** Joint responsibility with RABD*

- Despite not being able to run the full BAF report from the new InPhase system for the first half of the year, SQAC continued to receive Executive updates against each of the BAF risks which had evolved during the year to reflect the risks to delivery of the 2030 Strategy. In addition, assurance was provided that scores, gaps in assurance and mitigations continued to be managed in-year.
- The Trust's risk appetite statement was agreed in February 2022 incorporating risk tolerances linked to the various defined risk categories including safety and quality, regulation and compliance, financial environment and innovation using a risk appetite framework based upon best practices promoted by the Good Governance Institute.
  In 2022/23 SQAC was asked to undertake a review of the risk tolerance scores for the BAF and corporate risk register risks within the categories under their remit,

including current scoring, threshold descriptors where they exist and to determine what those may be where they do not. This work was placed on hold following the implementation of InPhase due to the limitations in the system.
During the latter part of 2023/24 this work resumed, and the next phase of this work, following agreement of the appetites and tolerances relating to SQAC risks, is for the Audit and Risk Committee to consider the risk profile that this presents during the first quarter of 2024/25 and make any recommendations that arise to the Board when it next considers its overall appetite; this may include the adjustment of thresholds or differentiation of categories.

- A review of the linked corporate risks will be undertaken early in the new financial year.

Specific items to highlight in relation to oversight of these risks include:

- *Risk 1.1 Inability to deliver safe and high-quality services*:
  - assurances regarding industrial action were provided to SQAC regularly highlighting the level of impact and disruption along with mitigations to ensure patient safety was maintained**.**
  - gaps in controls addressed through updates on projects being overseen by the PSSB. These reports are usually first on the agenda for discussion/assurance.
  - Regular reports on:
    - actions taken by the Sepsis Steering Group and performance against the sepsis KPIs
    - NICE Guidance implementation
    - patient experience
    - Expanse implementation risks and mitigation
    - levels of medication safety incidents.
- *Risk 1.2 Children and young people waiting beyond the national standard to access planned care and urgent care:*
  - gaps in controls addressed are through the following regular reports: Safe Waiting List management programme including clinical review of long wait patients, winter plan and monthly updates to address pressures within the Emergency Department and performance against national waiting times,
- *Risk 1.4 Access to Children & Young People's Mental Health:*
  - gaps in controls addressed through regular reports on mental health attendances at the Trust's Emergency Department with reports now being presented utilising the SBAR methodology as well as monitoring of performance against referral and treatment KPIs in the Integrated Performance Report.

Based on the processes for overseeing these risks as summarised above, SQAC can confirm that management are effectively managing these risks and are taking timely steps to reduce their risk score**.**

- The Committee continued to approve policies as appropriate/required.
- Terms of Reference were comprehensively reviewed to ensure a focussed oversight role of key issues relating to the safety of our patients and their families.

<u>External inspections undertaken and assurances received</u>

- During the year SQAC has received the following reports from external sources:

- Mental Health Act (MHA) (1983) monitoring visit. Following the opening of Sunflower House in May 2023, the CQC made an unannounced visit to conduct a focussed MHA records review and monitor the use of MHA compliance with the Code of Practice. The report from the visit was positive with CQC confirming that they had no concerns and did not raise any actions.
- The 2022/23 External Visits / Accreditation Report was received setting out the record of all external agency visits, inspections and accreditations including action plans and where these are monitored locally. Assurance was received from divisions that the Management of External Agency Visits, Inspections and Accreditations Policy is being adhered to.

Responsive

- Quarterly patient and family feedback reports were received. SQAC welcomed the restart of the Parent Forum, both as a way to consult with patients and to receive feedback from them to help shape the work of patient experience.
- The Year End 2022/23 Complaints, PALS & Compliments Report was received, demonstrating ongoing improvement in terms of responsiveness. Additional actions for 2023/24 were noted including a change in the process by which experience is reviewed. In addition, the work undertaken within the surgical division in relation to process was noted as good practice and has resulted in all four complaints received within the division being withdrawn since the new process was implemented.
- Quarterly Complaints Reports were presented to the Committee showing good compliance against the three working-day acknowledgement standard and complaints being responded to within 25 days. Further work to resolve PALS enquiries within five days is ongoing to ensure more timely resolution.
- SQAC received regular reports from the Patient Experience and Engagement Group which demonstrated a strong overall performance towards achieving our strategic aim of outstanding care. What was clear from these reports is the wide range of opportunities for CYP to have their voices heard. The Committee commended the phenomenal amount of work undertaken by the group with a real focus on volunteers.
  It was noted that due to staff sickness the PLACE assessment did not go ahead in-year.
- SQAC received and noted the updated Patient Experience Improvement Framework and Domain 1 of the EDS 2022 assessment *'commissioned and provided services'* (Domains 2 & 3 will be reported to PAWC). The Committee welcomed the new assessment and audit process enabling teams to take forward actions and make improvements.

Annual Reports

- Annual reports were provided throughout the year to provide assurance to the Committee. These included those from / relating to:
  - Safeguarding Children
  - Research
  - Clinical Ethics Committee
  - Organ Donation
  - DIPC
  - CQSG – final report
  - Patient & family feedback
  - Clinical Audit 2022/23
  - Drugs & Therapeutics Committee

Further Assurances

- The Committee has continually challenged assurance processes when appropriate and has requested and received assurance reports from Trust management and various other sources, both internally and externally throughout the year, including:
  - Divisional focussed deep dives including analysis of, and actions required for improvement:
    - Friends and Family Test
    - ENT cancellations
    - Sepsis mandatory training compliance
    - Outstanding NICE compliance
    - Medication Safety
    - Line infections (Sept 22-Sept 23) within Medicine
    - Sepsis Deep Dive within the Emergency Department
    - Paediatric Assessment Unit Pilot Analysis
    - Review of ED mental health presentations (including referral to Crisis Care) together with post code analysis of end users detailing what the Trust is doing to address this issue.
  - A detailed report following the deep dive into the high number of complaints which related to ASD and ADHD services and took assurance from the extensive improvement plan, learning from complaints, recruitment to vacancies for key clinical roles, digital improvements to Meditech and training for the ASD processes. Discussions with commissioners regarding required investment for the service to support reduction in waiting times are ongoing. The Committee received the findings of the Root Cause Analysis (RCA) undertaken in relation to a patient who sadly died unexpectedly following surgery. The RCA panel concluded that despite the complication that had occurred during surgery being extremely rare, there had been missed opportunities to identify and treat the complication which would likely have resulted in a different outcome. A number of immediate actions were put in place to prevent such incidents occurring again.
  - The Committee received the findings of the RCA undertaken in relation to a patient who sadly died as a result of delayed septic screening. A number of recommendations from this review were noted which will be taken forward and shared as appropriate to prevent such an incident from recurring.
  - A deep dive of complaints themes and trends over the last 5 years was undertaken, noting the consistent main themes reported over the five years. A number of actions came out of this review to ensure that going forward divisions consistently aggregate and triangulate the learning from formal complaints and informal PALs concerns, together with incidents, investigations, FFT and claims, to focus improvement work.
  - A report highlighting progress with restoration of the Trust's reporting capabilities following transition to Alderc@re in September 2023 was received. Despite the programme of work not delivering as quickly as expected, the report provided assurance around short term mitigations until reports could be re-written and validated.
  - A report detailing the safety incidents associated with the upgrade of Meditech V6.08 to Expanse/Aldercare 2023 was presented to the Committee. SQAC noted the number of incidents reported which continues to demonstrate a good reporting culture, themes/trends of the reported incidents and were assured by the lessons learned for areas of improvement.
  - Quarterly updates from the Children & Young People Engagement Leads were received by SQAC showing a good level of engagement and highlighting the importance of involving the voice of CYP particularly regarding strategy development.

- An improving trend in compliance against NICE Guidance was noted during the year, and assurance taken from the robust system in place to oversee the receipt, review and implementation of NICE guidance that is relevant to the Trust.
- In relation to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) programme, SQAC was assured that the Trust remains compliant with submissions. Participation with the programme is mandatory and part of the Quality Accounts submission.

Items to bring to the Board's attention
There are no matters to highlight.

Assurance Statements

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. SQAC also agrees to the declaration 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 with the exception of:
    - Submission of data for the nationally mandated audit for Epilepsy 12 (due to lack of clinical capacity).
    - Submission of data for the nationally mandated audit for Trauma Audit and Research Network (TARN) (due to unavailability of the external TARN platform).
    - Submission of data for the National Confidential Enquiry "Child Health Clinical Outcome Review Programme. National Confidential Enquiry into Patient Outcome and Death. Transition from Child to Adult Health Services Study" (due to lack of clinical capacity).

CEOG is working with the Divisions to enable these submissions in 2024/25.

The Chair of SQAC is a member of the People and Wellbeing 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 2024/25

- Further develop the reporting of Clinical Effectiveness and the Patient Experience group to mirror the utilisation of the Brilliant Basics approach, currently demonstrated through the Patient Safety Board.
- Continue to hold the Divisions to account for quality performance and will seek to drive measurable improvements in key quality indicators form 'ward to board'

- Maintain an overview of the Quality Assurance Round process to provide an in depth understanding of the issues facing each service and department; and
- Oversee the delivery and governance of the Patient Safety Strategy and associated aims in the context of the Trust's overall strategic direction and re-stated ambition to achieve an overall 'Outstanding' rating from CQC.
- Continue to seek improvements in relation to NICE guidance and clinical audit compliance, particularly implementation of learning.
- Further embed the Patient Safety Incident Response Framework processes and develop learning from patient safety events.
- Start to ensure that patient safety and quality data reviewed in Divisions and through other processes in operation across the Trust enables enquiry into health inequalities in support of the strategic priority in this area.

Professor Fiona Beveridge
Committee Chair
April 2024

APPENDIX A

SAFETY & QUALITY ASSURANCE COMMITTEE - RECORD OF ATTENDANCE 2023/24

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 continued to be held virtually via Microsoft Teams.

Member / Date of Meeting	2023									2024			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Fiona Beveridge (Chair) (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	**NO MEETING HELD**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	**11/11**	**100%**
Kerry Byrne (Non-Executive Director)	**x**	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	**10/11**	**91%**
Dame Jo Williams (Non-Executive Director)	**-**	**-**	**-**	**-**		**-**	**-**	**-**	✓	**-**	-	**-**	**1/1**	**100%**
Jo Revill (Non-Executive Director)	**x**	✓	✓	✓		✓	**x**	✓	**x**	✓	✓	✓	**8/11**	**73%**
Alfie Bass (Chief Medical Officer)	✓	**x**	**x**	✓		✓	✓	✓	✓	✓	**x**	✓	**8/11**	**73%**
Nathan Askew (Chief Nursing Officer & AHP/HCP Lead)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	**x**	**10/11**	**91%**
Pauline Brown (Director of Nursing)	**x**	**x**	**x**	**x**		**x**	**x**	**x**	✓	x	x	x	**1/11**	**9%**
John Grinnell (Deputy Chief Executive/Director of Finance)	**x**	**x**	✓	✓		✓	✓	**x**	✓	✓	✓	✓	**8/11**	**73%**
Adam Bateman (Chief Operating Officer)	✓	✓	✓	✓		✓	✓	✓	**x**	✓	✓	✓	**10/11**	**91%**

Member / Date of Meeting	2023									2024			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	NO MEETING HELD	x	✓	✓	x	✓	✓	✓	9/11	82%
Melissa Swindell (Chief People Officer)	✓	✓	x	✓		✓	✓	✓	✓	✓	✓	✓	10/11	91%
Dani Jones (Director of Strategy & Partnerships)	✓	x	x	x		x	x	x	x	x	x	x	1/11	9%
Kate Warriner (Chief Digital Information Officer)	Deputy	Deputy	Deputy	Deputy		Deputy	Deputy	Deputy	✓	Deputy	Deputy	Deputy	11/11	100%
Benedetta Pettorini (Divisional Director, Surgery)	✓	Deputy	Deputy	Deputy		Deputy	Deputy	Deputy	Deputy	Deputy	Deputy	Deputy	11/11	100%
Urmi Das (Divisional Director, Medicine)	✓	✓	Deputy	Deputy		✓	✓	✓	Deputy	✓	✓	✓	11/11	100%
Lisa Cooper (Divisional Director, Community & Mental Health)	✓	✓	Deputy	✓		Deputy	✓	✓	Deputy	✓	✓	✓	11/11	100%
John Chester (Divisional Director, Research)	Deputy	✓	✓	Deputy		Deputy	Deputy	Deputy	x	Deputy	Deputy	x	9/11	82%
QUORUM ACHIEVED	NO	YES	YES	YES		YES	YES	YES	YES	YES	YES	YES	11/11	100%

Member/Date of Meeting	2023									2024			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
ATTENDEES														
Deputy Chief Medical Director	x	x	x	x		x	x	x	x	x	x	x	0/11	0%
Phil OConnor (Deputy Director of Nursing & AHPs)	x	x	x	x		x	✓	x	x	x	x	✓	2/11	18%
Jackie Rooney (Associate Director for Nursing and Governance)	✓	x	✓	x		✓	✓	✓	✓	✓	✓	✓	9/11	82%
Beatrice Larru (Director of Infection Prevention Control)	x	✓	x	✓		x	✓	x	✓	✓	x	✓	6/11	55%

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee Annual Report 2023/24

The People and Wellbeing Committee

This report provides a summary of People and Wellbeing Committee activities and assurance that the Committee has carried out its obligations in accordance with its Terms of Reference and work programme for 2023/24 and identifies key actions to address developments in the Committee's role.

People and Wellbeing Committee (PAWC) is responsible for providing strategic direction and board assurance in relation to all workforce matters, and making recommendations, as appropriate, on workforce matters to the Board of Directors, in support of the delivery of high-quality patient and family centred care. In particular ensuring that the strategic objectives relating to people as set out in the Trust's People Plan are met:

- Looking after each other
- Creating a sense of belonging
- Learn and grow for the Future
- Embrace new ways of working

The principal devolution of the Board's responsibilities are as follows:

- To oversee the development and implementation of the Trust's People Plan, to assure the Trust Board that the strategy is implemented effectively and supports the Trust's vision and values.
- To monitor strategic workforce risks and report these to the Trust Board via the Board Assurance Framework.
- To obtain assurance that Equality, Diversity and Inclusion plans are being effectively implemented and ensure that the Trust is meeting its legal obligations in this regard.
- To monitor compliance against strategic Health & Safety requirements, to ensure that the Trust is meeting its statutory obligations in relation to Health & Safety, and that plans are effectively implemented.
- To ensure mechanisms are in place to support the development of leadership capacity and capability within the Trust, including talent management.
- To ensure robust and proactive plans are in place to support the personal and professional development of all staff.
- To ensure effective arrangements to support partnership working with Trade Unions.
- Ensure that processes are in place to support the mental and physical health and wellbeing of Trust staff. Monitor and review the Trust's Occupational Health Service, receiving reports where required.
- Ensure delivery of an improved strategy for internal communications and monitor progress against this strategy.

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.

Constitution

In accordance with the terms of reference, the membership comprises:

- 1 Non-Executive Director [Chair]
- 2 Non-Executive Directors
- Chief People Officer
- Chief Operating Officer
- Chief Nursing Officer
- Chief Medical Officer
- Director of Corporate Affairs
- Director of Marketing & Communications
- 1 x Senior representative from each Division

The following are expected to attend each meeting: Deputy Chief People Officer, Associate Director of Organisational Development, Alder Hey Academy Director, Equality and Diversity Lead and the Chair of Staff Side.

Principal Review Areas / Achievements in 2023/24

People Plan 2030

- Following launch of the Trust's Vision 2030 Strategy, PAWC received monthly progress reports against delivery of the People Plan element embedded within this. Year 1 targets and measures were closely monitored throughout the year including risks to delivery against the three strategic areas: Thriving @ Alder Hey, Professional Development Hub and Future Workforce. Five workstreams were established to ensure that the fundamental changes required to support our people are delivered.
    1. Thriving Leaders
    2. Health & Wellbeing – now moved into business as usual.
    3. Preceptorship – significant progress made against the metrics to enhance staff experience and increased sense of belonging.
    4. Accessible and Diversified Recruitment
    5. Induction and Orientation

  The Committee was encouraged by progress against the year 1 targets. Monthly updates will continue into 2024/25 as year 2 targets and metrics are taken forward for delivery.
- Divisional workforce metrics were presented monthly by senior representatives from each division (surgery, medicine, research, community and corporate) through their wider knowledge of the Trust via the Integrated Performance Report. In addition to receiving updates against the workforce KPIs and actions to address areas of concern, divisions were asked to report on the outputs from local 'BIG conversations' held following results of the staff survey including themes. The Committee was encouraged by actions in response to some of the matters raised by staff locally, including holding a health and wellbeing week across the Trust and celebration days which have both been extremely successful and well received by staff.
- A deep dive into Personal Development Review (PDR) data was undertaken following a number of changes made to the process to improve compliance and ensure all staff have a meaningful PDR. The Committee learned that despite the improvements made, this didn't give the increase in compliance the trust had hoped for. The position as at 15th March 2024 was reported as 71.2% against a Trust target of 90%. A number of further actions have been implemented including the introduction of group PDRs for those who have same/similar objectives should they wish. Monthly reporting to Execs, divisions, and corporate leads and

insight from the Brilliant Basics Team to apply A3 thinking to the process. This area will remain under the Committees purview into 2024/25.

- Towards the end of the financial year, a deep dive into mandatory training was undertaken. In March 2024, the Trust reported a 92.04% compliance rate against a target of 90%. Despite this positive picture, the deep dive revealed a number of hotspot areas for immediate focus and attention. The Committee was assured by the number of actions in place to address areas of non-compliance including meetings with subject leads prioritised by hotspot area; a refresh of data within ESR to capture face-to-face course activity; review of competency required per staff member and monthly communications to managers following bi-weekly review of the data.
- Updates against the Trust's Internal Communications Plan were received during the year noting:
    - staff engagement – Alder Hey News and Ask the Execs viewing figures.
    - media interviews and engagement.
    - filming undertaken during the year.
    - communications produced to help reduce numbers at our A&E department during the recent Junior Doctors Industrial Action.
    - audience reached via our social media channels.
    - achievement of the first phase of engagement in respect of Vision 2030 with phase 2 now underway.
- Quarterly Staff Turnover Analysis Reports were received in order to understand the year-on-year increase in turnover rates and agree appropriate measures and interventions to reduce the position to Trust target (13%) and support the Alder Hey Attraction and Retention Plan. Improvement actions were received by the Committee including a new and improved leavers and exit process along with a revised questionnaire was launched in-year and can be easily found on the Trust intranet to improve completion rates and provide meaningful data to allow for a review of trends, themes and hotspot areas.
- The Committee received an update on the Nurse Retention Project initiated to support newly appointed nurses by way of a bespoke preceptorship programme. The Committee welcomed this project as way to really understand why some staff leave within the first twelve months of employment and how we can support and keep staff in post.

<u>Belonging in the NHS</u>

- Quarterly Freedom to Speak Up / Raising Concerns reports were received during the year providing rich data on the number of contacts by professional groups, themes, status of cases and assurance around escalation processes for concerns that relate to patient safety and quality. The continuing recruitment of FTSU Champions remains a priority for the network to ensure representation across all areas of the Trust and specifically our consultant body and our REACH, ACE and LGBTQ+ networks. The outputs from the audit undertaken by MIAA were welcomed which achieved substantial assurance. Going forward into 2024/25, it was agreed to receive monthly raising concerns updates.
- The Staff Survey 2023 initial results were received noting a 60% response rate (*54% for the previous year*) compared to 45% nationally. A number of key positives were presented to PAWC including improvement in every single theme and sub-score compared to the 2022 results, Alder Hey outscored comparator Trusts in every single theme and 20 of the 21 sub-scores, staff recommending Alder Hey as a place to work increased to 71.5% and staff recommending Alder Hey as a place for treatment increased to 88.82%.
  That said, the Committee noted that some questions had deteriorated in score from previous year including staff experiencing discrimination due to ethnic background. A deep dive into this data will be undertaken and actions agreed to take forward into 2024/25.
- PAWC received the contents of the Gender Pay Gap Report 2023 summarising that on average, female employees earn 27% less than male employees. Assurance was provided that this was reflective of the NHS which has a higher proportion of females in lower banded roles and a predominantly male workforce in the higher banded medical and dental

professions. In 2022, female employees earned 29% less than male employees which shows that there has been some improvement in closing the gap.

- The Committee received an update on the progress made towards becoming an anti-racist organisation applying the guidance and support from the North West BAME Assembly Anti Racist Framework. An initial self-assessment was undertaken to identify any gaps and a robust action plan formulated that will help us achieve a bronze status in the next 12 months.
- The Committee received and approved the Workforce Race Equality Scheme (WRES) report noting good progress in two of the nine WRES indicators, disappointingly the remaining seven indicators showed immobility and/or regression. The action plan in response to these concerns was received and ongoing work to improve the experience of our staff noted.
- The Workforce Disability Equality Scheme (WDES) Report was received and approved noting that the Trust had made improvements in 4 out of the 10 indicators of disability equality during 2022/23. The action plan in response to these concerns was received and ongoing work to improve the experience of our staff was noted.
- The Committee received an overview of the responses to the People Pulse Surveys showing that despite Alder Hey outperforming its comparators across the majority of the metrics the overall response rate had dropped dramatically in 2023 compared to 2022 (down 48%). The committee noted that this aligned closely with the start of the industrial action but it was not possible to determine the exact cause of the dip in responses.
- The Committee was encouraged to receive a proposal for SALS to recruit a Research Assistant and Clinical Psychologist following receipt of funding from the Clinical Research Division's seedcorn fund. A piece of work will take place to conduct detailed analysis of SALS and SALS Pals data over a nine-month period between 2023 and 2024. The aim of this work is to better understand and evidence the individual, group and organisation level impacts of our interventions, and by doing so contribute to the development of the evidence base regarding what works in staff support at this very critical period for the NHS workforce. The Committee expects to see the results of this work in the summer of 2024.
- The Committee welcomed the formation of a working group to review our approach to recognition and celebration for employees and relaunch of a daytime, face-to-face celebration event (quarterly). This was done following feedback from a staff and a previous reduction in the offer during the Covid-19 pandemic. Further work regarding the long service offer is continuing.
- The Committee was kept abreast of the forthcoming pension changes noting the increased flexibility for staff towards the end of a members' career.
- Regular progress reports against delivery of the new NHS Equality, Diversity and Inclusion (EDI) Improvement Plan were received outlining a number of initiatives and actions including the establishment of a Menopause Group, collaborative working across the ICS to promote EDI, implementation of the Anti Racist Framework and closer working with the FTSU Team to support staff and provide the best experience for our colleagues.
- PAWC was presented with the new Equality Delivery System (EDS22), formed following a review of the previous EDS2 by NHSE to incorporate system changes and take into account system architecture. The Trust continues to review performance for people with characteristics protected by the Equality Act 2010. The Committee noted the ratings and evidence within the EDS2, 8 of which were 'achieving', 7 were 'developing' and 3 'excelling'.
- The Committee received an update on the SALS Pals project which was established in 2020 to prevent burnout, stress and mental ill-health. The project is currently supported by NHSE/I who funded a pilot of paid wellbeing champions. PAWC welcomed plans to expand the service following the end of the current pilot. A business case would be developed and presented at Executive Level for approval.

Workforce Planning

- Following ratification of the Apprenticeship Policy, PAWC received an update on the number of apprenticeships offered across all areas of the Trust, and particularly the number of apprentices recruited as new employees. The Committee noted the Trust's achievement in maintaining the Matrix Accreditation for the Information, Advice and Guidance aspect of our Apprenticeship Service during the year. The risks to delivering these opportunities going forward were highlighted in terms of potential changes at national policy level that may come into force over the next 12 months. These would be monitored as appropriate and mitigations sought where possible.
- The Committee was provided with position updates in relation to ongoing Industrial Action and was assured around the safety of our children and young people specifically in relation to workforce numbers.

Governance

- An update on the Trust's three-year DBS renewals programme was received. The position reported in November 2023 showed that there are 93.4% of colleagues who have had a DBS check within the last 3 years. Assurance was provided that anyone appearing outside of this would be reviewed on a risk basis i.e., clinical colleagues prioritised.
- The Committee was presented with a report detailing the Trust overpayment position, including the main reasons for overpayment and actions to improve the position. A marked improvement in the overpayment position, with the volume of overpayments reducing by 24% in 2023/24 was noted.
- PAWC received the outputs of the exercise the HR team performed to check HR records against the NHS Safer Recruitment Standards following a related fraud case. The audit confirmed that whilst there were no gaps found in the right to work in the UK, professional registration, work health assessments (occupational health), and DBS check records, areas where the audit did find some gaps related to evidence on file of qualifications and references. The concluding report will be received by the Committee early 2024/25.
- Approved the Committee Annual Report 2022/23
- PAWC continued to ratify all relevant workforce policies.
- PAWC welcomed sight of the Nursery Ofsted report noting an overall 'Good' rating.
- Approved the Committee Terms of Reference for the year 2023/24
- The Committee was kept appraised on progress with the E-roster project and the related cost savings. A number of associated service improvements underway was also presented to PAWC including review of bank usage, enhanced short term support focused on effective rostering and implementation of the SelfCare system to enable roster managers to easily redeploy colleagues between wards/areas, providing accurate, easily accessible daily staffing level summaries, and supports simplified roster management.

Health & Safety

- Annual report 2022/23
- Annual non-clinical claims report
- Health & Safety updates were received for quarters 1 & 2 (2023/24) noting the activities delivered by the team including first aid training for staff, ongoing site inspections, practical manual handling training and risk assessment training.

Sub-Committee / Working Groups reporting to PAWC

The Committee received the minutes from the following working groups:

- Local Negotiating Committee
- Joint Consultative and Negotiation Committee

- Health & Wellbeing Steering Group
- Education Governance Committee
- Health & Safety Committee

Committee Assurances

- PAWC is responsible for oversight of the following BAF risks on behalf of the Trust Board:

Ref	Risk	Score	Target
		IxL	
2.1	Workforce Sustainability and Development	3x5	3x2
2.2	Employee Wellbeing	3x3	3x2
2.3	Workforce Equality, Diversity & Inclusion	3x5	4x1

In November 2024 these risks evolved to reflect the risks to delivery of the 2030 Strategy

Ref	Risk	Score	Target
		IxL	
2.1	Workforce Sustainability and Development	3x4	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	3x3	2x2
2.3	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	4x3	4x1

- Despite not being able to run the full BAF report from the new InPhase system for the first half of the year, PAWC continued to receive Executive updates against each of the BAF risks receiving assurance that scores, gaps in assurance and mitigations continued to be managed in-year.
- During the year, the Committee monitored progress against mitigating actions identified to reduce the risk to its target rating through the various reports identified above as part of normal committee business.
- Specific items to highlight in relation to oversight of these risks include:
    - *Risk 2.1 Workforce Sustainability and Development*
        - A deep dive presentation was received at the March 2024 meeting with particular attention to the gaps in controls. Additional mitigations were highlighted to the committee including the Establishment Control Project – due to close shortly and the commencement of the Wider Workforce Planning Project.
    - *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 (previously Employee Wellbeing)*
        - A deep dive presentation was received at the March 2024 meeting detailing several further actions that had been identified to further mitigate this risk including the newly established Thriving Leadership Programme looking at the restorative and learning culture within the organisation.
    - *Risk 2.3 Workforce Equality, Diversity & Inclusion*
        - A deep Dive presentation was received in January 2024, detailing actions identified to further mitigate risk including the approval of funding to support an EDI Adviser to support the Head of EDI.

Based on the processes for overseeing these risks as summarised above, PAWC can confirm that management are effectively managing these risks and are taking timely steps to reduce their risk score**.**

- The Trust's risk appetite statement was agreed in February 2022 incorporating risk tolerances linked to the various defined risk categories including safety and quality, regulation and compliance, financial environment and innovation using a risk appetite framework based upon best practices promoted by the Good Governance Institute.
  In 2022/23 PAWC was asked to undertake a review of the risk tolerance scores for the BAF and corporate risk register risks within the categories under their remit, including current scoring, threshold descriptors where they exist and to determine what those may be where they do not. This work was placed on hold following the implementation of InPhase due to the limitations in the system.
  During the latter part of 2023/24 this work resumed, and the next phase of this work, following agreement of the appetites and tolerances relating to PAWC risks, is for the Audit and Risk Committee to consider the risk profile that this presents during the first quarter of 2024/25 and make any recommendations that arise to the Board when it next considers its overall appetite; this may include the adjustment of thresholds or differentiation of categories.

Assurance Statements

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.

Through the various mechanisms set out above, the Committee has gained assurance that the delivery of the Trust People Strategy was on track and all key workforce risks were being managed.

A Summary Report is presented to the Board following each 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 2024/25

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2024/25:

- Focus on monitoring the implementation of the refreshed People Plan, as part of the Trust Vision 2023 Strategy
- Focus on the key areas which would enable the Trust to deliver this vision:
- Thriving @ Alder Hey
- Professional Development Hub
- Workforce Planning
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- The Committee will oversee the delivery of the work of the EDI Steering Group to ensure a strategic coherence in all matters related to Equality, Diversity and Inclusion and its determination to embed the work across the Trust.

Jo Revill, Committee Chair
April 2024

PEOPLE & WELLBEING COMMITTEE – RECORD OF ATTENDANCE 2023/24

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

All meetings were held virtually via Microsoft Teams.

	May 2023	July 2023	Sept 2023	Nov 2023	Jan 2024	March 2024	TOTAL	
MEMBERS								
Fiona Marston (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	6/6	100%
Jo Revill (Non-Executive Director)	**n/a**	**n/a**	**n/a**	**n/a**	✓	✓	2/2	100%
Fiona Beveridge (Non-Executive Director)	✓	✓	✓	✓	✓	✓	6/6	100%
Garth Dallas (Non-Executive Director)	✓	✓	✓	✓	✓	✓	6/6	100%
John Kelly (Non-Executive Director)	✓	✓	✓	✓	**x**	✓	5/6	83%
Melissa Swindell (Chief People Officer)	✓	✓	✓	✓	**x**	✓	5.6	83%
Adam Bateman (Chief Operating Officer)	**x**	✓	**x**	**x**	✓	✓	3/6	50%
Nathan Askew (Chief Nursing Officer)	✓	✓	**x**	**x**	**x**	**x**	2/6	33%
Alfie Bass (Chief Medical Officer)	✓	✓	**x**	**x**	**x**	**x**	2/6	33%
Mark Flannagan (Director of Marketing & Communications)	✓	**x**	**x**	**x**	**x**	**x**	1/6	17%
Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	**x**	✓	5/6	83%
1 x Senior representative from Surgical Division	✓	✓	✓	✓	**x**	✓	5/6	83%
1 x Senior representative from Medical Division	✓	✓	✓	✓	✓	✓	6/6	100%
1 x Senior representative from Community Division	✓	✓	✓	✓	✓	x	5/6	83%
1 x Senior representative from Research Division	✓	✓	✓	✓	✓	✓	6/6	100%
Quorum achieved?	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**6/6**	**100%**

	May 2023	July 2023	Sept 2022	Nov 2023	Jan 2024	Mar 2024	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 (Equality & Diversity Lead)	✓	✓	x	x	✓	✓	4/6	67%
Julie Worthington (Staff Side Chair)	✓	x	x	x	x	x	1/6	17%

Alder Hey Children's NHS Foundation Trust

Research and Innovation Committee Annual Report 2023/24

The Research and Innovation Committee

The Research and Innovation Committee was established by the Board of Directors to assist in overseeing and monitoring execution of the Trust's strategic direction in relation to research and innovation.

The Committee operates under the broad aims of overseeing delivery and periodic reviews of the Trust's Research and Innovation Strategic Framework and related activities, to provide assurance to the Board that delivery in these areas supports the Trust's strategic priorities.

The Committee has the authority on behalf of the Board to:

- Guide the development of a cohesive approach to the distinct but interlinked activities of Research and Innovation, ensuring that the Trust maximises the opportunities presented by its facilities, clinical expertise, partnerships and networks.
- Make decisions rapidly to initiate, prioritise or de-prioritise specific projects and initiatives that fall within the duties set out below, ensuring that an agile, flexible and business-like approach is retained, particularly in connection with commercial opportunities.
- Seek and commission external advice as deemed appropriate to the successful delivery of these agendas.

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

In accordance with the terms of reference which are reviewed annually the membership of the Committee comprises:

- Non-Executive Directors x 3 [one of whom shall be the Chair]
- Chief Executive
- Director of Research & Innovation
- Managing Director of Innovation
- Director of Research
- Deputy Chief Executive/Director of Finance
- Chief Medical Officer
- Chief Nursing Officer
- Director of Marketing and Communications
- Chief Digital and Information Officer
- Director of Corporate Affairs
- Academy Director

Expected to attend each meeting are the Clinical Director of Research, Clinical Director of Innovation, Deputy Managing Director of Innovation and Head of Research Operations.

The following would attend, on an occasional basis, as required by the agenda: Divisional Directors, Head of Nursing (Research) and Innovation Consultants.

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. 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 2023/24

Strategy

- At its April 2023 meeting, the Committee received a presentation that depicted how research and innovation functions fit into the Vison 2030 Strategy noting the work ongoing and required to move from the current focus to the new strategic initiative 'Futures', within the Area of Need 'Bring me the Future'.
- The Committee held regular discussions around the development of the Research Strategy 2024-2030 ahead of its publication in April 2024 and supported the work to ensure alignment to the Trust's 2030 Strategy particularly with regards to setting out bold and far-reaching priorities and the importance of working in partnership to achieve our goals. The involvement of children and young people in the development of the strategy was noted as key to implementation and achievement. A communications plan will now be developed and received at the April 2024 meeting.
- The Committee received a presentation on the evolution of the Innovation Strategy and stressed the importance of linking the recommendations of the Consultancy Project that was conducted on Alder Hey's Research and Innovations and the Futures Strategy, developing a Partnership Strategy and having additional business development staff to enable the Trust to engage with partners and bring in new investment. R&I Committee took assurance from the workshops held for the Trust's staff within its Divisions, setting out the principles for capturing benefits and the process that need to be implemented at the start of each project which would be integral for delivery of the Strategy. A Trust wide investment framework was also welcomed by the Committee.
- R&I Committee received and supported the proposal in relation to a one year strategic commercial partnership with Strasys Ltd intended to accelerate our ambitions and create value from our knowledge and expertise. Quarterly updates on this partnership were received.
- The Committee received a presentation on the proposed LifeArc funded UK centre for rare kidney diseases and welcomed the fantastic work to develop a rare disease ecosystem to commence in Liverpool. Work will now take place to align deliverables to the Trust's Research Strategy. Following an in-depth discussion on the expansion of such screening it was agreed to invite members of the Children's Hospital Alliance into this discussion to better support growth of studies to look at providing diagnosis of rare diseases during childhood, rather than when a patient presents in early adulthood.

Operations

- The Committee received the Research Performance Report for 2022/23 and Annual Planning Report 2023/24. Key highlights from 2022/23 were noted including Divisional performance against workforce metrics, plans to improve productivity, operational improvements during the year (new study activity and growth of commercial activity) and celebration events. The Committee took assurance from the establishment of the monthly Clinical Governance Forum and Divisional alignment to the Trust Strategy.

In terms of moving into 2023/24 the Committee welcomed the collaborative work that is being undertaken from a research and innovation perspective and plans to further improve productivity.

- The Committee received the Innovation Performance Report for 2022/23 and Annual Planning Report 2023/24. Key highlights from 2022/23 were noted including successes and lessons learnt from year one of the Innovation Strategy, achievement of the majority of KPIs and quarterly milestones, attraction of significant grants, celebration of 7 awards, product deployment of the Was Not Brought AI solution, Alderhey@nywhere hybrid platform prototype development with Microsoft and measurable benefits to patient care.
  A number of budget recommendations were made in the report for 2023/24 and a workshop scheduled to agree benefits and costs.
  Assurance was taken from the lessons learnt in planning activity for 2023/24 and corrective action in a number of areas regarding the pipeline and commercial activity that needs to be built on further going into 2023/24. The three main areas of focus will be: engagement to continue the building of a quality pipeline and innovation culture; delivering projects to 'business as usual' and ensuring they are deployed to care; and spread and adoption of the current products for financial sustainability.
- The Committee received the 2022/23 financial year to date update and draft outturn 2023/24 for the Clinical Research Division and Innovation noting the direction of travel towards Futures and need for an alternative financial model going forward.
- R&I Committee was provided with an update on the grants in development during Q4 2022/23 noting that of the six applications, two had been successful and one invited to stage 2. The others were awaiting an outcome.
- In terms of Innovation Strategic inward investment, the Committee was updated on the Strategic Outline Case (SOC) for investment and the recent Investment Zone opportunity within the Liverpool City Region Combined Authority. Alder Hey has been allocated £4.5m over an initial five-year period from spring/summer 2024.

<u>Finances</u>

- Discussion regarding the governance process for signing off grants that are contentious or deliver corporate risk was undertaken at Committee. Following discussion, it was agreed that the Research Management Board (RMB) and the Innovation Management Board (IMB) would liaise with the respective teams to address any grants that are material, have performance impact or risks associated with them and then escalate those that require R&I Committee oversight.
- Innovation management accounts were received at each meeting. The financial overview for month 9 reported a cost pressure of £0.13m primarily driven by a lack of budget for the RPA team. It was noted however that the RPA team have delivered £0.5m of savings/cost avoidance for divisions in year, in terms of time saved or cost avoided for RPA processes implemented in year. In terms of funding streams, at month 9 £146k was remaining, this was reported as worst-case forecasting and Innovation would look to offset by curtailing non-pay spend.
- Research management accounts were received at each meeting. The financial overview for month 9 reported an underspend of £0.3m. The total research forecast position for 2023/24 by activity was received including commercial, CRF & CRN, RCF, Management, Non-commercial and Charity & LHP.

<u>Performance</u>

- Quarterly Research Performance Reports were received, noting achievements across key workstreams within the CRD and particularly the successful bid which has provided the

Trust with the funding to purchase a third MRI scanner, with protected time for clinical research. Assurance was received that research performance is on track, with exceptions and associated action plans noted.

- Quarterly Innovation performance reports were received during the year on progress against the 2023/24 plan including KPIs, HR metric performance, summary of risks, Innovation pipeline, active projects, innovation growth. Whilst assurance was taken from the successes in-year, the Committee noted that achievement of operational KPIs remained a challenge given the competing priorities with large strategic pieces of work. Executive support is in place to support prioritisation going forward.
- The Committee was kept appraised of the development of an EDI Strategy within the Research Division to support recruitment that is representative of the organisations patient population, equality to access of studies and making sure that research is delivered in the local communities.
- In response to feedback that the Innovation pipeline is too disparate, the Committee received a deep dive portfolio review of the entire innovation pipeline in order to offer assurance that the pipeline and associated resources are being managed. The Committee took assurance from the level of detail provided and requested updates on a bi-annual basis.

Risk

- The Research and Innovation Committee is responsible for oversight of the following BAF risk on behalf of the Trust Board:

Ref	Risk	Score	Target
		IxL	
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	3x3	2x2

In November 2024 this risk evolved to reflect the risks to delivery of the 2030 Strategy:

Ref	Risk	Score	Target
		IxL	
4.1	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	3x4	2x4

- Despite not being able to run the full BAF report from the new InPhase system for the first half of the year, R&I continued to receive Executive updates against each of the BAF risks receiving assurance that scores, gaps in assurance and mitigations continued to be managed in-year.
- During the year, the Committee monitored progress against mitigating actions identified to reduce the risk to its target rating through the various reports identified above as part of normal committee business.
- The Innovation Committee received an update on the Acorn Partnership position (and related live spinout companies) – a commercial venture between Alder Hey, Deep Bridge Capital and We-Are-Nova Limited. In addition to exiting Acorn Partnership in 2022, in February 2023 it was agreed that the Trust would exit from any remaining companies under this arrangement. Conversations remain ongoing in terms of exit options.

Based on the processes for overseeing these risks as summarised above, R&I can confirm that management are effectively managing this risk and are taking timely steps to reduce its risk score**.**

Committee Governance

- Approved the Innovation Committee Annual Report for 2022/23.
- Received the initial iteration of the Terms of Reference for a new Futures Committee which it is proposed will subsume the current responsibilities of Research and Innovation Committee.
- Approved the Data Access Committee Terms of Reference.
- The Committee was provided with an update on the tracking and transparency of commercial activities per the approved Commercial Partnership & Governance SOP. The report provided updates against activity within the Innovation operational plan, KPI growth and Business Development. The Committee was provided with assurance regarding the commercialisation activities of Alder Hey Innovation, including potential and actual sales revenue opportunities and an update on specific co-creation agreements and the status and progression of other partnerships.
- The Committee received the findings of the consultancy project that was conducted on Alder Hey's Research and Innovations and the Futures Strategy noting a number of conclusions and recommendations. In summary the review concluded that Alder Hey can deliver on the Futures Strategy by reorganising and refocussing on research and innovation activities.

Supporting documents/items

- Research Management Board Minutes
- Innovation Management Board Minutes

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 Research and Innovation functions are operating effectively and in line with relevant standards and legislation.

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.

The Chair of the Research and Innovation Committee is a member of the Resources and Business Development Committee enabling links with commercial and partnership agreements to be dealt with in a multi-factorial way.

A Summary Report is presented to the Board following each Research and Innovation 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.

Shalni Arora
Committee Chair
April 2024

Alder Hey Children's NHS Foundation Trust

RESEARCH & INNOVATION COMMITTEE - RECORD OF ATTENDANCE 2023/24

The quorum necessary for the transaction of business:
Chair or nominated deputy, one Executive Director, Director of R&I (or delegate)

Member/Date of Meeting	2023			2024	TOTAL	
	April	July	Nov	Jan		
MEMBERS						
Shalni Arora (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	**4/4**	**100%**
Fiona Marston (Non-Executive Director)	✓	✓	**n/a**	✓	**3/3**	**100%**
John Kelly (Non-Executive Director)	✓	✓	✓	✓	**4/4**	**100%**
Louise Shepherd (Chief Executive)	✓	✓	**x**	✓	**3/4**	**75%**
John Chester (Director of Research and Innovation)	✓	✓	✓	✓	**4/4**	**100%**
Claire Liddy (Managing Director of Innovation)	**n/a**	**n/a**	✓	**n/a**	**1/1**	**100%**
John Grinnell (Managing Director/CFO)	✓	**x**	✓	✓	**3/4**	**75%**
Alfie Bass (Chief Medical Director)	**x**	**x**	**x**	**x**	**0/4**	**0%**
Nathan Askew (Chief Nursing Officer)	✓	**x**	✓	✓	**3/4**	**75%**
Mark Flannagan (Director of Marketing and Communications)	✓	**x**	**x**	**x**	**1/4**	**25%**
Kate Warriner (Chief Digital and Information Officer)	✓	✓	✓	✓	**4/4**	**100%**
Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	**x**	**3/4**	**75%**
Katherine Birch (Academy Director)	**x**	**x**	**x**	**x**	**0/4**	**0%**
Quorum achieved	**YES**	**YES**	**YES**	**YES**	**4/4**	**100%**

Member/Date of Meeting	2023			2024	TOTAL	
	April	July	Nov	Jan		
ATTENDEES						
Dan Hawcutt (Clinical Director of Research)	x	✓	x	✓	2/4	50%
Iain Hennessey (Clinical Director of Innovation)	✓	x	✓	✓	3/4	75%
Emma Hughes (Deputy Managing Director of Innovation)	✓	✓	x	x	2/4	50%
Sarah Leo (Head of Research Operations)	n/a	n/a	✓	✓	2/2	100%

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday, 26th June 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☐ To approve ☑
Summary/ supporting information:	The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All NHS Foundation Trusts and NHS Trusts are required to self-certify whether or not they have complied with the conditions.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Impact:	None identified

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

Alder Hey Children's NHS Foundation Trust

1. Introduction

As part of the regulation and oversight of NHS provider organisations, Foundation Trusts are required to make an annual self-certified declaration relating to compliance with NHS Provider Licence conditions.

Th purpose of self-certification is for providers to evidence that they are compliant with this condition of the licence. There is no requirement to submit this evidence to NHS England (NHSE), but providers must ensure that the self-certification is signed off by the Board of Directors. NHSE typically conducts sample audits on selected providers to ensure the self-certification arrangements have been completed appropriately.

2. NHS Provider Licence Self-Assessment - Update as at June 2024

Licence Condition	Current position	Assurance	Gap	Action
Section 1 – Integrated Care				
IC1 – Provision of Integrated Care	The Trust actively works with its partners to foster and enable integrated care and is involved in projects aimed at developing new ways of working, new models of delivery and reducing health inequalities. Significant partnership work has continued in-year, detailed in the Trust's Annual Report.	• Reports to BoD. • Annual Report. • 2030 Strategy. • Integrated Performance Report. • Reports to CoG.	None currently identified	None from a compliance perspective
IC2 – Personalised Care and Patient Choice	This condition requires licensees to notify their patients when they have a choice of provider either under the NHS	• Reports to RBD re contract performance.	None currently identified	Patient information leaflets updated as required to

Licence Condition	Current position	Assurance	Gap	Action
	Constitution or conferred locally by commissioners. It requires providers to tell patients where they can find information about the choices they have in a way that is not misleading. Any information provided to AH patients would be on the basis of clinical need. No inducements are offered to referring clinicians by the Trust under any circumstances. Patients are informed of their NHS Constitution right to choosing alternative providers for those waiting longer than 18 weeks from RTT.	• The Trust website sets out the service directories for each service. • The Trust complies with patient's right to choose and the NHS Choice Framework. • Patient information leaflets accessible via the Trust website.		include aspects on choice where appropriate
Section 2 – Trusts Working in Systems				
WS1 – Cooperation	The Trust complies with its legal duties to cooperate with NHS bodies, including the Cheshire & Mersey Integrated Care Board and local authorities for the purposes of: • Developing and delivering system plans • Delivering individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans • Delivering agreed people and workforce plans • Delivering and improving NHS services	• Integrated Performance Report. • Annual Report. • Reports to BoD. • Reports to CoG. • Reports to RABD. • Reports to People Committee.	None currently identified	

Licence Condition	Current position	Assurance	Gap	Action
WS2 – The Triple Aim	The Trust continues to work in partnership with people and communities to deliver the triple aim of better health and wellbeing, improved quality of services and the sustainable use of resources.	• BoD Reports. • CoG Reports. • SQAC Reports. • RABD Reports.	None currently identified	
WS3 – Digital Transformation	Alder Hey's first Digital Futures Strategy was published in 2019. In June 2021, Alder Hey collaborated with Liverpool Heart and Chest Hospital to form an integrated digital service; iDigital. The new Digital and Data Futures Strategy launched 2022.	• Digital and Data Futures Strategy. • Reports to RABD. • 2030 Strategy. • Reports to BoD. • Global Digital Exemplar accreditation from NHSE.	None currently identified	
Section 3 – General Conditions				
G1 - Provision of information	All monitoring submissions to NHSE provided by deadline via the portal. Additional documents provided on request.	• DoF and Development checks financial returns before submission and reports to RABD. • Annual Report and Accounts audited and scrutinised by Audit Committee then BoD.	None currently identified	None – the Trust remains compliant with this condition.
G2 – Publication of information	Trust reports placed in the public domain in accordance with NHSE requirements, e.g. Annual Report and Accounts.	• Hard copies of Annual Report and Accounts. available on request. • Trust website. • Trust Publication Scheme.	None currently identified	None – the Trust remains compliant with this condition.

Licence Condition	Current position	Assurance	Gap	Action
G3 - Fit and proper persons as Governors and Directors	Trust arrangements reflect • CQC regulation 5 (applies to directors only) • NHSE Fit and Proper Person Test (FPPT) Framework, and • Fit and Proper Persons Policy • Annual NHSE FPPT submission	• Annual declaration process for existing Directors. • Robust arrangements in place for new appointments to the Board including enhanced DBS checks and other robust pre-employment checks. • Existing directors undertake DBS refresh every three years. • Annual checks for insolvency and disqualification. • Governors subject to DBS checks. • Annual social media checks.	None currently identified	None outstanding – CQC satisfied with current arrangements following last inspection
G4 – NHS England guidance	Guidance consistently and stringently followed	• Reports to Board Committees e.g., Annual Plan, Annual Report and Accounts, Integrated Performance Report (NHS Oversight Framework). • Last Well Led review completed in 2019. • FTSU self-review tool received by Trust Board April 2024.	None currently identified	Continue to track new guidance through appropriate committee on publication

Licence Condition	Current position	Assurance	Gap	Action
G5 – Systems for compliance with licence conditions and related obligations (i.e. NHS Acts and Constitution)	Systems and processes are currently set up to ensure compliance with provisions of the Licence and other mandatory requirements; risk set out in BAF. Constitution reflects current legislation.	• Annual review – Licence Compliance undertaken. • Integrated Performance Report links to NHS Oversight Framework. • Monthly Board and assurance committee oversight of BAF.	None currently identified	Compliance with Licence conditions formally reviewed by the Board as part of its annual work plan.
G6 – Registration with the Care Quality Commission	Currently registered without conditions for all relevant services.	Overall rating 'good' (July 2020).	None currently identified	Continue with regular engagement meetings with CQC; ensure NHSI informed of all key issues.
G7 – Patient eligibility and selection criteria	This condition requires licensees to set and publish transparent patient eligibility criteria and to apply these in a transparent manner.	Explicit eligibility criteria are not currently published for individual AH services, however they are covered in a range of activities: • Patient Access Policy that complies with NHSI guidance and best practice. • Declarations of compliance with specialist service specifications; • Information on individual services provided on trust website; • Clinical discussions at MDT level including where any ambiguity exists for example with regard to age limits (16 – 18) and where adult	Individual eligibility and selection criteria not currently published together in one place due to nature of services – all children under 16 eligible depending on clinical need.	Statement re. equality of service access within Annual Reports from 2022/23.

Licence Condition	Current position	Assurance	Gap	Action
		transition services are not established		
G8 – Application of S.6 (Continuity of Services)	All previous Mandatory Services migrated to Commissioner Requested Services as of 1st April 2013. One service derogated as part of Spec Comm assessment of trusts against service specifications	NHSE (Spec Comm) contract monitoring meetings.	Derogation in place for the following service: Major Trauma	SDIP to be put in place for service with plan to achieve compliance
Section 4 – Trust Conditions				
NHS1 – Information to update the register	Trust reports placed in the public domain in accordance with NHSE requirements.	• Current Constitution on website. • Amendments to Constitution reported to NHS England within 28 days of being adopted. • 2022/23 Annual Report and Accounts including auditors reports on website.	None currently identified	None – the Trust remains compliant with this condition.
NHS2 – Governance arrangements	The Trust has robust corporate and financial governance arrangements that are compliant with all relevant guidance including that issued by NHSI.	• Constitution. • Standing Orders. • Assurance Committee Terms of Reference (reviewed annually). • Board Assurance Committees are subject to an annual review to ensure they are discharging their duties defined in their Terms of Reference.	None currently identified	None – the Trust remains compliant with this condition.

Licence Condition	Current position	Assurance	Gap	Action
		• Annual Governance Statement. • Internal and External Audit Reports to ARC. • Head of Internal Audit Opinion.		
Section 5 – NHS Controlled Providers Conditions				
CP1 – Governance arrangements for NHS-controlled providers	NHS-controlled providers are providers who are: 1. Not NHS trusts or NHS foundation trusts 2. Required to hold a provider licence 3**.** Ultimately controlled by one or more NHS trusts and/or foundation trusts.	N/A	None currently identified	N/A
Section 6 – Continuity of Services				
CoS1 – Continuing provision of Commissioner Requested Services	All services currently delivered as per contract/agreed specification issued by ICB.	• Reports by exception to Board. • Contract performance review meetings with Commissioners.	See G8 above	See G8 above
CoS2 – Restriction on the disposal of assets	Trust has an up-to-date asset register	• Register maintained by the Finance team. • The Trust complies with requirements regarding disposal of assets.	None currently identified	None currently identified
CoS3 – Standards of corporate governance, financial management and quality governance	Trust has robust systems and standards of corporate governance, quality governance and financial management.	• Annual Report. • SQAC Reports. • RABD Reports. • Integrated Performance Report.	None currently identified	Track any updates and changes to guidance

Licence Condition	Current position	Assurance	Gap	Action
		• Board Assurance Framework. • Risk Management Strategy.		
CoS4 – Undertaking from the ultimate controller	NHSI defines the 'ultimate controller' as being anybody that could instruct the licensee to carry out particular actions, i.e. the parent company of a subsidiary that has been licensed by Monitor. If there is no single body that could instruct the licensee in this way, the licensee does not have an ultimate controller and there is no need for an undertaking under this condition. Monitor has clarified that governors and directors of FTs are not regarded as ultimate controllers and will not need to provide undertakings.	N/A	None currently identified	N/A
CoS5 – Risk pool levy	In the event of a provider entering special administration, the costs of administration will be met by a central fund known as the risk pool. This condition requires the licensee to contribute to the funding of the pool if NHSI requests it.	N/A	None currently identified	N/A
CoS6 – Co-operation in the event of financial or quality stress	This condition applies when a licensee is concerned about the ability to continue to provide commissioner requested services due to quality stress	Integrated Performance Report scrutinised by RABD and BoD.	None currently identified	Trust financial position and risks to delivery continues to be subject to regular review and update.

Licence Condition	Current position	Assurance	Gap	Action
	or a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or the ability of the Licensee to carry on as a going concern.			
CoS7 – Availability of resources	This condition sets out the Board certification requirement which aims to provide NHSE with reassurance that the Board has given consideration to the resources to be dedicated to the provision of CRS over the coming 12-month period.	• Monthly Financial Reports to RABD and Board. • Integrated Performance Report. • Annual Accounts prepared on a going concern basis. • 2024/25 Annual Plan.	None currently identified	The Trust has forward plans in place that meet this condition.
Section 7 – Costing Conditions				
C1 – Submission of costing information	This condition requires Licensees to: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information as necessary	• Suite of quarterly reports to Divisions including service line, consultant, procedure and patient level cost and income performance. • Reports to RABD. • NHSE costing information, methodologies and governance is rated as above the England average.	None currently identified	

Licence Condition	Current position	Assurance	Gap	Action
C2 – Provision of costing and costing related information	Licensee shall submit the mandated information required per Costing Condition 1	• Trust submits National Cost Collection data to NHSE in line with timetable and guidance.	None currently identified	
C3 – Assuring the accuracy of pricing and costing information	Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance	• In terms of ensuring the accuracy of costing, we are continually improving our costing model in line with the National Costing Standards and guidance. • We submit a Costing Assessment Tool annually which assesses our compliance with the guidance against these costing standards, and in our most recent submission for 22/23 data we received a score of 92% - an improvement compared to the previous year and positioned us above the national average of 89%.	None currently identified	

Licence Condition	Current position	Assurance	Gap	Action
Section 8 – Pricing Conditions				
P1 – Compliance with the NHS payment scheme	Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England	• The Trust agrees contracts and charges under national terms and conditions. Charges are based on PbR published tariffs and follow counting and coding principles. • The Trust engages constructively with commissioners through routine monthly submissions and contract meetings. This enables opportunity to identify and resolve any queries to ensure compliance.	None currently identified	

3. Recommendation

The Board of Directors is asked to approve the proposed confirmation of compliance against the NHS Provider Licence.

Erica Saunders
June 2024