Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS EXTRAORDINARY PUBLIC MEETING

Monday 27th June 2023, commencing at 10:00am

Lecture Theatre 4, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**23/24/68**	**10:00 (2 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/69**	**10:02 (3 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
Year End Closure for 2022/23							
3.	**23/24/70**	**10:05 (30 mins)**	**Draft Annual Report and Accounts for 2022/23:** • **Ernst and Young External Audit Year-end Draft Report, 2022/23 – '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 2022/23. To receive the External Audit year-end draft report for 2022/23. To receive the letter of representations.	**R/D**	Reports to follow
4.	**23/24/71**	**10:35 (25 mins)**	**Committee Annual Reports 2022/23:** - **Audit and Risk Committee.** - **Resource and Business Development Committee.** - **Safety and Quality Assurance Committee.** - **People and Wellbeing Committee.**	 K. Byrne J. Kelly F. Beveridge F. Marston	To receive the annual reports of the sub-committees that report into the Trust Board.	**A**	Read reports

Alder Hey Children's NHS Foundation Trust

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Innovation Committee.**	S. Arora			
5.	**22/23/72**	**11:00 (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.	**22/23/73**	**11:05 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
7.	**22/23/74**	**11:09 (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, 6th July 2023, 9:00am, in Lecture Theatre 4, Institute in the Park.							

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 27th June 2023

Paper Title:	**Assurance Committee Annual Reports 2022/23**
Report of:	**Erica Saunders, Director of Corporate Affairs**
Paper Prepared by:	Jill Preece, Governance Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary / supporting information:	To present the annual reports from: ARC RABD SQAC PAWC Innovation Committee
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

Alder Hey Children's NHS Foundation Trust

Audit & Risk Committee Annual Report 2022/23

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 management, 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 delivered throughout the year, key assurances that it can provide to the Board and proposed developments for 2023/24.

Constitution

The membership of the Committee comprises three Non-Executive Directors. Its Chair has 'recent relevant financial experience'. The Directors of Finance and Corporate Affairs together with the Deputy Director of Finance are invited to attend the whole meeting, whilst the Associate Director of Nursing and Governance (ADN&G) and Chief Operating Officer are 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 A 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 and 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. Six meetings were held during the year. One, in June was devoted to consideration of the External Auditors report on the Annual Accounts and ISA 260.

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

Work undertaken in 2022/23 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 identifies any actions required.

The following pages provide an overview of the work undertaken by ARC in each of the areas of its responsibility.

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)).

Board Assurance Framework (BAF) which includes updates on each of the risks from the Executive with overarching narrative provided by the Director of Corporate Affairs. 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 which provides assurance to Board as to the effectiveness of the management of those risks in its Annual Report (see below). ARC refers any areas of query or concern on BAF risks to the appropriate committee for investigation.

- A report from the RMF which provides:
  - a report on the Corporate Risk Register (CRR) (risks scored 15+) outlining the current risk themes, actions taken and any barriers to their mitigation. The report also includes extracts and analysis of the CRR, highlighting new risks, those with changed risk scores or that are longstanding, risks which are overdue for review, actions which are overdue and actions taken.
  - a summary of the "deep dives" that the RMF has undertaken in key risk areas. In 2022/23 these have covered the management of all longstanding (>12 months) high-moderate risks, risks relating to information governance, 10x medication errors, ASD / ADHD, the deployment of the Innovation Strategy 2030, the backlog of access to health disclosures in breach of Data Protection Act 2018, court and police disclosure timeframes and the high-moderate risks within the Division of Medicine.
  - The minutes from prior RMF meetings.
  - An analysis of the Trust Risk Register (all Trust risks including those on the BAF) highlighting the number and percentage of risks by score, static and longstanding risks, those overdue review or 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 assess the effectiveness of risk management across the Trust as a whole.

A Corporate Services Collaborative (CSC) was established during 2022/23 to review the performance of the service areas sitting within the corporate umbrella using a risk lens. The CSC reports into the RMF and is held to account in the same way as Divisions via a quarterly performance review. RMF reporting to ARC now includes information from the CSC.

The RMF presented its Annual Report on Risk Management for 22/23 to the April 23 ARC meeting. Chaired by the Director of Corporate Affairs, RMF brings together Divisional Directors and senior clinical and operational managers plus corporate colleagues from across the Trust. The Annual Report described the activities that have taken 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:

- assurance that appropriate processes are in place for the management of risks and that progress against 2022/23 priorities have been made.
- assurance of compliance against the key requirements of the Risk Management Strategy.

Assurance Committee Annual Reports are presented to ARC before onward presentation to Board. Within their Annual Report 22/23 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."

* with the exception of Innovation Committee.

Deep dives on risk management within the Divisions of Medicine and Surgery were presented to ARC. This provided an opportunity to understand in more detail how the Divisions oversee and manage risk on a day-to-day basis. The Committee was also updated on the outcome of the incident relating to iPads that were stolen from the Trust and the implementation of actions agreed following a review by MIAA. The Committee was also informed of the fire arrangements for new buildings - Catkin Centre and Sunflower House.

Ongoing development of Risk Appetite Statements & Tolerances

Throughout 2022/23 the ARC Chair has continued to support the Director of Corporate Affairs with the ongoing development of Risk Appetite Statements and Risk Tolerances. The Risk Appetite Statements have been reported to Board on a couple of occasions, initially as narrative statements and more recently with a proposed acceptable range of "risk scores" for each statement (Risk Tolerances).

Throughout Q4 22/23 the proposed Risk Tolerances have been presented to each of the Assurance Committees (except Research & Innovation) for the types of risk within their remit. Each Committee is undertaking a review of the proposed Tolerances and to report back to Board as to whether they are acceptable or of any proposed changes. The ARC Chair will continue to support the Director of Corporate Affairs throughout 2023/24 to gain Board and Assurance Committee approval of the Risk Appetite Statements and Tolerances and to support their implementation.

Management assurances on key risk areas

During the year the Committee received Annual Assurance Reports for 2022/23 and Forward Plans 23/24 for key areas of risk. The following section summarises key information and assurances within these reports.

Programme Assurance

The Delivery Management Office 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 time scale. It is designed to improve control and therefore the achievement of sustainable change. Assurance is evidence based and grouped into two areas:

a) **Programme management standards** are being adhered 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:

- **100% of programmes (5/5)** were rated green for the **adherence to the governance** standards.
- **Two programmes** were rated as green for programme delivery and three were rated as amber.

Emergency Planning Response & Resilience (EPRR) Core Standards Assessment

A report was provided regarding the Trust's overall emergency preparedness efforts in line with legal and statutory requirements to meet the Civil Contingencies Act (2004), NHS England Emergency Preparedness Framework (2022) and NHS England 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:

The Trust remains substantially compliant (92% compliant) under the definition of the annual EPRR Core Standards, this is an overall satisfactory level and within compliance terms of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness Framework (2022). The assessment highlighted 3 areas for improvement:

- Training and exercising.
- Duty to maintain plans.
- Business Continuity management systems.

Data Quality

Data Quality 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 Data Quality Strategy aims to "strive to achieve the highest quality of data that is parallel to the outstanding care that we provide".

The Chief Digital Information Officer (CDIO) provided a detailed report summarising the Trust's data quality performance against a number of benchmarks:

The Data Quality Maturity Index (DQMI) offers a rounded assessment of an organisation's data quality through a number of datasets. For the latest position published (December 2022), the Trust has a DQMI score of 93.0, in comparison to a national average of 78.7 and, in 10 out of 13 months, received a score >90. Our DQMI score is in line with our peers (Sheffield Children's, Birmingham Women's and Children's, Great Ormond Street and Manchester University Trusts).

Commissioning Data Set (CDS) Data Quality Dashboard:

- Performance of Admitted Patient Care submissions is to a high standard with 20 of 21 areas green with "Registered GP Practice" being amber, therefore performing at the National standard.
- Performance for Outpatient data is to a high standard. 21 of 22 metrics are green except "Person Gender Current" which is 100% but flagging as amber due to performing at the same standard as the national position.

Clinical Coding Data Security and Data Protection Audit 2022/2023 shows Alder Hey to be adhering to (and in some cases exceeding) national clinical coding standards.

Cyber Security

ARC received a report from the CDIO providing assurance of the Trust's cyber security performance against NHSE national priorities as summarised below along with the forward workplan for 23/24.

	Priority	**Status**
1	Ensure secure, well tested backups are in place.	
2	Maintain a good patching regime	
3	Action high severity CareCerts (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 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 data protection activities undertaken during 2022/23 to support compliance with data protection principles outlined in the Data Protection Act 2018 (DPA 2018) and NHS specific requirements within the annual DSPT.

During 2022/23, the main data protection issue related to a legacy backlog of 1,484 access to health subject access requests which also included police, court, and NHS to NHS requests. A rapid review and improvement plan was implemented supporting the Trust to demonstrate compliance from January 2023. This legacy issue led to a large volume of complaints, PALS contacts and a single point of contact being assigned by the ICO. This risk was first scored at 16 has reduced to 6.

During the year 225 information governance / data protection incidents occurred, none of which met the threshold for reporting to the ICO. Learning is required to prevent recurrence or escalation to a breach.

- Each year the Trust is required to provide a DSPT to NHSE. The DSPT baseline assessment for 2022/23 was submitted in February 2023, with the final submission due in June 2023. It is anticipated the Trust will submit a compliant return.
- In line with the DSPT information governance data security training requirement, the Trust has achieved the 95% threshold.
- There were no reportable data protection incidents to the ICO during 2022/23.

Freedom of Information Act Compliance
An overview of Freedom of Information Act 2000 (FOIA) activity during 2022/23 including summary of compliance with FOIA legislation was received.

674 FOIA requests were received and actioned in the year; a 23.2% 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 71.5%.

Due to problems in meeting the 95% internal target an 11-point improvement plan was initiated in Q4 to enhance FOIA engagement, raise awareness of FOIA requirements, support teams to respond within prescribed timeframes and, by the year end, performance had improved and 9 of the 11 actions had been completed.

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

Confirmation of over 95% of Trust staff completing the mandatory DSPT IG data security training (which includes a high level of overview of FOIA) was provided.

Internal Audit
The internal audit service is provided by Mersey Internal Audit Agency (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. From time to time, and as directed by ARC, they also provide an independent and objective advisory service to help management improve a particular operational area. During 22/23 management commissioned an advisory piece of work on IT Hardware Asset Management following the theft of Trust iPads; the report from this review was formally received by the Committee which also received updates on the implementation of actions.

ARC approved MIAA's Internal Audit Plan for 2022/23. 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 internal control system, risk management and governance. This is based on the output of a range of risk-based audits contained within the Internal Audit Plan. The opinion takes account of the relative risk of these areas and management's progress in addressing identified control weaknesses.
- Design and operation of the underpinning Assurance Framework and supporting processes.

Throughout the year, MIAA provide a summary of the audit reports issued and management's response to address them. For any reports that are assessed as "Limited" or "No" Assurance a senior representative from the audit area is invited to the meeting to present their detailed action plan to address the findings. In 2022/23 the following audits were undertaken:

Morbidity & Mortality	High	Partnership Governance	Substantial
Consent	Substantial	Data Security & Protection Toolkit	Substantial
Conflicts of Interest	Substantial	IT Service Continuity & Resilience	Substantial
Data Quality	High	Health Procurement Liverpool**	Substantial
Junior Doctors - Non-Consultant Spend***	Moderate	Assurance Framework	Met Requirements
Workforce Planning** (position review)	Substantial	Cyber review – Medical Devices	Moderate
Improving NHS Financial Stability	N/a		

* This audit was requested by management following concerns identified within this area.

** This audit did not assess the Trust against good practice workforce planning processes as the Trust is aware that this is not yet in place. Instead, it looked at work done to date, and that planned, and provided an opinion on the adequacy of the planned work.

*** HPL provides a procurement service to the Trust. This audit was undertaken on behalf of a number of Trusts in the region who each contributed to a portion of its cost and received a copy of the report.

This year, and for the first time, ARC requested a third-party assurance report from ELFs who provide the Trust's payroll service. This is an independent assurance report, commissioned by ELFs and available to users of their service. There were no significant issues relating to payroll within the report.

The Internal Auditors also undertake a quarterly exercise to assess the implementation of agreed actions that have passed their implementation deadline reporting the outcomes to ARC. During the year ARC remained focussed on progress against overdue actions to encourage the timely closure of any gaps in the control environment. Progress was made in implementing some of the longstanding overdue actions from the Consultant Job Planning audit although some still remain outstanding. 34 actions were reviewed and the status confirmed to be:

	Number	%
Implemented	27	79
Partly Implemented	7	21
Not Implemented	0	0
Total	**34**	**100**

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

The key conclusion from MIAA's work for 2022/23 as provided in the Head of Internal Audit Opinion and Annual Report was that:

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

Anti-Fraud Service

The Anti-Fraud Service (AFS) is provided by MIAA. The work undertaken is a mixture of proactive - such as fraud awareness communications, provision of fraud alerts and bulletins and reactive - such as reviews of potential frauds, fraud exercises such as National Fraud Initiative data matching and procurement fraud prevention.

The planned work is submitted to ARC for approval in the Anti-Fraud Annual Workplan. Throughout the year regular updates on the work undertaken to prevent and detect fraud, including any investigations is provided along with an Annual Report on the delivery of the Workplan. During the

year a "local proactive exercise" looking at overtime payments was undertaken. The review did not highlight any fraudulent activity.

Investigations of potential fraud resulted in an overpayment identified (fraud loss) of £8,700 with debt recovery in progress, and a fraud prevention figure of £2,267. A further outcome was the dismissal of two employees who were the subject of two of the fraud referrals.

The AFS completed a fraud risk assessment liaising with the AND&G and risk owners throughout the year with the outcomes to be input the Trust's internal risk management scoring process.

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 2022/23 was "green".

Clinical Audit

ARC is responsible for the oversight of Clinical Audit but the detailed oversight is undertaken by Safety & Quality Assurance Committee (SQAC) on its behalf. Formal reporting to ARC from the Clinical Audit Team and SQAC was introduced in 2022/23. During the year the Committee received the Clinical Audit Work Programme for 2022/23. The Work Programme is developed in line with mandatory requirements for the forthcoming year and reflects mandatory National and Regional audits, Confidential Enquiries and Trust-wide priority audits, fulfilling the requirements of the NHS Quality Contract and Trusts Quality Account. The Clinical Audit Annual Report summarising the work undertaken and the findings is due to be presented to ARC shortly. It is expected to contain the following assurance statement:

Trust clinical audit activity (including local, national, and regional clinical audits) is progressing in line with accepted practice.

In addition to the mandatory audits (described above) the Trust also undertakes local clinical audits, the need for which is identified by Divisions and Corporate Services. ARC does not yet receive reporting on these audits. Throughout the year the ARC Chair has been working with the SQAC Chair, Chief Medical Officer, Chief Nurse and AND&G to further develop the processes for identifying, prioritising and reporting local clinical audits and the processes to check and report on embedding of lessons learned. For 23/24 a Clinical Effectiveness and Outcomes Group has been introduced to provide executive oversight of Clinical Audit. It is anticipated that these developments will result in increased reporting and assurance of Clinical Audit.

External Audit

External audit services continue to be provided by Ernst & Young (EY). The following reports were received from External Audit relating to 2022/23:

- 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 Director of Finance / Deputy Chief Executive will sign these documents on behalf of the Trust before the accounts are finalised.

An unqualified opinion on the accounts for 2022/23 is expected to be provided to the Board on 22nd June 2022.

Finance

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

- Annual Accounts 2022/23.
- Statement on Going Concern from the Finance Team laying out why it is appropriate to prepare the Trust's Accounts on a going concern basis.
- Nil Net Assets Review. Following an issue raised in the 21/22 accounting exercise the Finance Team undertook a review of all items recorded on the asset register with a net nil asset value to determine if they were still in operational use. Where this was found not to be the case, they were removed from the asset register and the Committee was provided with assurance on updated processes to ensure that a build-up of unused / disposed of assets on the asset register does not recur.
- Waivers of Financial Regulations in relation to procurement. (Procurement is now provided to Alder Hey by Health Procurement Liverpool).

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:

ARC Governance:
- ARC Terms of Reference and Work Plan.
- ARC Annual Report 2022/23.
- Regular review of the Committee self-assessment actions and their progress. The Committee continued to monitor the small number of ongoing actions which related to oversight of Clinical Audit, further developing risk appetite and tolerances, and risk management training.

Trust Governance
- Trust Annual Report 2022/23.
- Draft Annual Governance Statement.
- Annual Reports of the Trust's Assurance Committees 2022/23.
- Gifts & Hospitality Register.
- Policies and Strategies Approved or Ratified:
  - Risk Assessment Policy.
  - EPRR Policy – incorporating:
    - Escalation Plan.
    - Heatwave Escalation Plan.
    - HAZMAT CBRNE Incident Management Plan.
    - Business Continuity Plan.
    - Local Business Continuity Plan.
    - Cold Weather Plan.
    - Critical Incident Plan.
  - Board Assurance Framework Policy.
  - Risk Management Strategy Policy.
  - Company Representatives Policy.

Developments in 2022/23

During the year:
- Management established the CSC to review the performance of Corporate Service teams through a risk lens. The CSC reports into the RMF which provides assurance to ARC of the effectiveness of risk management in these areas to a degree that was not previously possible.
- The Assurance Committees agreed to undertake detailed scrutiny of the Trust's proposed Risk Tolerances. Once the final Tolerances are agreed ARC will oversee their implementation into the risk managements process.

- The Assurance Committees continued to provide oversight of the BAF risks within their remit. This year they provided an assurance statement as to the effectiveness of their management by the executive.
- Discussions were undertaken with MIAA to agree a different approach to be taken to the key financial controls given that external audit undertake significant amounts of substantive testing and no longer place reliance on internal audit's work. This change will release 10-15 days of audit time which can be focussed on an additional audit of an area of priority.
- Reporting of Clinical Audit to ARC commenced this year and will continue to be further enhanced throughout 23/24.
- Management assurances were provided to the Committee on a number of areas of risk.
- Following the introduction of an additional "risk only agenda" meeting previously, the Committee has replaced the September and November meetings going forward with a single meeting in October.

Assurance Statement

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

- They agree to the declaration reported to the Board of Directors in respect of the Annual Governance Statement.
- The Assurance Framework is fit for purpose.
- Systems for risk management identify and allow for the management of risk.
- There are robust governance arrangements.
- There are sound systems of financial control.
- The Trust operates a robust internal control environment.
- Trust clinical audit activity (mandatory local, national, and regional clinical audits) is progressing in line with accepted practice.

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 2023/24

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. The ARC Chair will continue to support the Director of Corporate Affairs throughout 2023/24 to gain Board and Assurance Committee approval of the Risk Appetite Statements and Tolerances and to support their implementation operationally.
2. Seeking assurance from the ADN&G as to the effectiveness of risk management training throughout the Trust.
3. Continuing to support the ADN&G to further strengthen Clinical Audit processes and reporting.

Kerry Byrne, Audit and Risk Committee Chair
June 2023

AUDIT AND RISK COMMITTEE – RECORD OF ATTENDANCE 2022/23

The quorum necessary for the transaction of business: two members
* Risk agenda items only

Member/Date of Meeting	2022					2023	TOTAL	
	Apr	June	July	Sept	Nov	Jan		
MEMBERS								
Kerry Byrne (Chair) Non-Executive Director	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	6 / 6	100%
Anita Marsland Non-Executive Director	✓	✓	N/A	N/A	N/A	N/A	2 / 2	100%
Garth Dallas Non-Executive Director	✓	✓	✓	✓	✓	✓	6 / 6	100%
Jo Revill Non-Executive Director	N/A	N/A	N/A	N/A	✓	✓	2 / 2	100%
Quoracy achieved	YES	YES	YES	YES	YES	YES	6 / 6	100%
ATTENDEES								
John Grinnell Director of Finance/Deputy CEO	✓	✓	✓	✓	✓	✓	6 / 6	100%
Rachel Lea Deputy Director of Finance	✓	✓	x	✓	✓	✓	5 / 6	83%
Ken Jones Associate Finance Director	✓	x	✓	N/A	N/A	N/A	2 / 3	67%
Emily Kirkpatrick Ass. Dir. Commercial, Control & Assurance	N/A	N/A	N/A	N/A	✓	✓	2 / 2	100%
Erica Saunders Director of Corporate Affairs	✓	✓	✓	✓	✓	✓	6 / 6	100%
Louise Shepherd Chief Executive	✓	N/A	N/A	N/A	N/A	N/A	1 / 1	-
*** Adam Bateman** Chief Operating Officer	✓	x	✓	✓	✓	✓	5 / 6	83%
*** Cathy Umbers** Ass. Dir. of Nursing & Governance	✓	N/A	N/A	N/A	N/A	N/A	1 / 1	100%
***Jackie Rooney** Ass. Dir. of Nursing & Governance	N/A	N/A	✓	x	✓	✓	3 / 4	75%
Ernst & Young External Audit	✓	✓	✓	✓	✓	✓	6 / 6	100%
MIAA Internal Audit	✓	✓	N/A	✓	✓	✓	5 / 5	100%
MIAA Anti-Fraud Service	✓	N/A	N/A	✓	N/A	✓	3 / 3	100%

Ernst & Young Representatives:
Mr D Spiller (DS); Mr H Rohimun (HR)

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

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

Alder Hey Children's NHS Foundation Trust

Resources and Business Development Committee Annual Report 2022/23

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 2022/23 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 2022/23

Assurance on six RABD Key Risks

- Regular assurance reports were received on the following:
    1) Cost Improvement Plan
    2) Cash (forecast) & Capital (5-year plan and service developments). Financial Strategy – Key Financial Areas (ICS questions)
    3) Benefits Realisation
    4) Campus & Park Update
    5) Alderc@re
    6) Productivity

  Details of assurances received are listed below.

Financial Performance

- The Committee received details of the 2022/23 Financial Plan noting the key risks to Alder Hey (CIP, activity and run rate) and the challenging position for the financial year ahead including regular progress updates.
- Monthly cash position reports were presented to RABD during 2022/23, the cash balance position at month 11 was reported at £86.1m.
- Progress on the 2022/23 Capital Plan was received in-year including a refresh of the 5-year capital plan. At month 11, capital spend was reported at £10.4m against a planned £11.4m.
- The Committee received assurances on actions taken to improve the financial position for both surgical and medical divisions. Mitigation plans and benefits realisation reports were presented detailing current position, overspend and forecast position for future financial sustainability.
- Bi-monthly updates on the systems of control to support the challenging achievement of the CIP requirements for 2022/23 were presented to RABD. Project schemes were allocated project management support based on impact, risk and value and assurance was provided to RABD in relation to the completion of EIA / QIAs to ensure no adverse impact on quality, safety and inclusion/diversity. In year CIP was fully met.
- A paper detailing a set of ten questions released by the ICS for Boards to consider was presented to RABD. Although this did not require formal submission, it was agreed to continually assess against these to provide assurance in relation to how well and understood finances are within the organisation.
- Approval of Trust debt write-offs RABD agreed a de minimis level of £500 for future debt write offs.
- Following the rising inflationary pressures in the energy markets RABD received and supported the proposed approach to energy procurement for both the PFI main hospital and the residual Alder Hey campus. This was subsequently approved by the Trust Board.
- RABD Received details on development opportunities for non-NHS business from 2023 onwards.
- The 2023/24 Financial Plan was received including funding assumptions, an initial assessment of Alder Hey's performance against the national objectives and targets and support in place to support Divisions with priorities. CIP was noted as the highest risk to deliver noting a target increased to £17.6m.
- RABD received the Integrated Annual Plan 2023/24 noting eight priorities, immediate deliverables for next 12 months and key risks to performance and activity delivery.

Operational Updates

- The Committee was kept informed of the impact in relation to industrial strike action including income loss and costs.

- 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. A revised cost plan for the Neonatal project was brought to the Committees attention and subsequently presented to Trust Board for approval.
- Maintained an oversight on all major investments and service development opportunities including the new urgent treatment centre facility to reduce overcrowding in A&E.
- The Committee was kept abreast of the progress against the Digital Futures Strategy 2022-2025 noting key areas of transformation, operational performance and plans for Digital Futures 2022.
- The Committee regularly monitored the agreed financial metrics in the Integrated Performance Report and received substantive reports with regard to specific issues identified.
- Oversight of the marketing strategy, including brand management, market positioning, marketing activity, market research and competitor analysis.
- Monthly assurance reports were received by the Committee in relation to the Children's Health Park, highlighting PPM performance and progress against key issues such as energy consumption, green roof works and the corroded pipework.
- The Committee received a highlight report of the revenue generation and business development activities in Innovation from 2021/22 and commercial activity opportunities for 2022/23.
- Position reports on the deployment of the Meditech Expanse upgrade under the AlderC@re Programme were received highlighting key risks to delivery. The Alderc@re programme is now set for delivery in Summer 2023.
- 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 are managing resources effectively. Risks and issues within hosted ODNs were noted including their mitigations for resolution.
- Progress against the Trust's Green Plan was regularly reported to the Committee via the clinically focussed Green Steering Group. A number of workstreams have been established to implement this work including travel; waste; energy and procurement.
- The Committee received regular assurances reports on the Safe Waiting List Management programme and actions implemented to reduce wait list pressures because of Covid-19. These provided the Committee with a comprehensive overview and proposals for improvements/changes to the processes and management of waiting lists.
- Procurement updates were received on a quarterly basis. Following implementation of the new Health Procurement Liverpool structure the Committee received progress updates against the 2022/23 workplan containing 177 schemes across the four HPL organisations.
- RABD approved the recommendation to renew the framework hosting agreement with Procure Partnerships Framework Ltd for a further 4-year period to start from January 2024.
- An update on the first 6 months of the 2022/23 innovation financial strategy deployment and performance against the agreed KPIs in the Operational Plan was received highlighting a number of lessons learned which will be used in business planning going forward.
- The Innovation & Commercial Activities Monitoring report was received noting the appointment of an independent consultant to work with the team to develop a commercial prospects pipeline tracker with a 3-year revenue generation opportunity look forward. This new report will be presented at Innovation Committee and RABD from 2023/24 financial year onwards.

Committee Assurances

- RABD received deep dive 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	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.	4x3	4x2
3.4	Financial Environment	4x4	4x3
3.6	Risk of partnership failures due to robustness of partnership governance	3x2	3x2
4.2	Digital Strategic Development and Delivery	4x4	4x1

** Joint responsibility with SQAC*

Throughout the year RABD has 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 the Safe Waiting List management programme reports.
- *Risk 1.3 Failure to address ongoing building defects with Project Co.*
  - 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.
- Risk 1.4 Access to Children and Young People's Mental Health
  - A deep dive presentation was received at the November 2022 meeting detailing the risks to delivery and 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.*
  - A deep dive presentation was received at the December 2022 meeting noting the current position along with short and long-term mitigations. Monthly assurance reports from the Building Services Team and Campus & Park updates focusing on the current areas of capital risk.
- *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 on a biannual monthly basis by RABD through assurance reports on the Trust's performance as an Operational Delivery Network (ODN) host.
- *Risk 3.4 Financial Environment.*
  - A deep dive presentation was received at the January 2023 meeting highlighting the impact of the changing NHS financial regime and uncertainty regarding income allocations beyond 2023/23 and beyond. A number of key actions and additional mitigations were set out to be monitored closely by RABD including inflation increases, obtaining value for money on all procurement processes and a refresh of the Long Term Financial Plan to inform future decisions.

- *Risk 3.6 Risk of partnership failures due to robustness of partnership governance*
  - A deep dive presentation was received at the March 2023 meeting resulting in a decrease in the risk score reflecting the substantial assurance received from the MIAA Partnership Governance Audit. The findings of the report noted "*a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently*".
- *Risk 4.2 Digital Strategic Development & Delivery.*
  - gaps in controls were regularly addressed through the Digital and Information Technology progress report including key areas of digital transformation.

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**.**

- Following agreement of the Board's risk appetite statement, RABD reviewed the suggested risk tolerances for its related risks with a view to trialling them within the divisions prior to trust-wide roll-out.
- Terms of Reference were comprehensively reviewed to ensure a focussed oversight role of key issues relating to financial, operational and contractual performance.
- Continued to approve policies as required.
- 2021/22 Committee Annual Report.

Business Cases approved

- Safe Staffing Nurse Recruitment
- Outpatient Department Staffing Investment
- Mental Health Investment

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:
  - A detailed breakdown in expenditure for drugs to demonstrate drug pressures by type. The committee was assured by the formation of a task and finish group to look into drug expenditure.
  - A recovery trajectory report following a reported 65.9% compliance against the 99% waiting times standard of diagnostics to completed within 6 weeks. Assurance was provided that the trust forecast recovery against a 6 weeks diagnostic target to be achieved by March 2023.
  - A deep dive into procurement following the move to the new Health Procurement Liverpool structure the Committee detailing further insight into the individual functions, support for departments and divisions and in-year savings projections.
  - A detailed report on pay expenditure in relation to agency staff; assurance was provided in relation to the continuing work to support the reduction of spend in this area for non-clinical posts and price caps.
  - Trust forecast outturn financial position reporting the internal risk and potential scenario analysis around a best case/ most likely/ and worst case including divisional scenarios.

Extraordinary Meetings Held

During the year, two extra-ordinary meetings were convened. The first meeting was to discuss and agree the financial strategy in relation to the development of the Neonatal Unit and Sunflower House Development, the second meeting was held to provide assurance to Committee members around value for money relating to a land sale and the future of the Trust's nursery provision.

For information

Commercial Governance Standing Operating Procedure approved at Innovation Committee.

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 2023/24

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2023/24:

- Going forward RABD has taken on the role of Investment Committee and will monitor performance through regular monthly updates and quarterly updates on the Treasury Management Performance.
- The Committee will continue to focus and seek assurances regarding the top five risks/key priority areas in 2023/24 which would enable the Trust to deliver its clinical, operational and financial targets.
    - immediate financial performance – outturn, capital and cash
    - The Cost Improvement plan in the context of the National financial constraints
    - Benefits realisation, governance and prioritisation of change programme to 2030
    - Alderc@re implementation
    - 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.
- Ensure the commercial activities of the Trust are undertaken appropriately and are compliant with necessary legislation whilst also demonstrating adequate financial returns.

Ian Quinlan
Committee Chair
April 2023

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RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE - RECORD OF ATTENDANCE 2022/23

The quorum necessary for the transaction of business: Chair or nominated deputy, one other NED, one Executive Director. All meetings were held virtually via Microsoft Teams.

Member/Date of Meeting	2022									2023			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MEMBERS														
Ian Quinlan (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	X	✓ (Chair)	11/12	92%
Anita Marsland (Non-Executive Director)	x	x	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/3	33%
Shalni Arora (Non-Executive Director)	✓	✓	✓	x	x	✓	✓	✓	x	✓	✓ (Chair)	✓	9/12	75%
John Kelly (Non-Executive Director)	N/A	N/A	N/A	N/A	N/A	x	✓	✓	✓	✓	✓	✓	6/7	86%
Jo Williams (Non-Executive Director)	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
John Grinnell (Director of Finance/Deputy CEO)	✓	✓	✓	x	✓	✓	x	✓	x	✓	✓	✓	9/12	75%
Rachel Lea (Deputy Director of Finance)	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	11/12	92%
Adam Bateman (Chief Operating Officer)	✓	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓	10/12	83%
Melissa Swindell (Chief People Officer)	✓	✓	✓	x	x	✓	x	✓	✓	✓	✓	✓	9/12	75%
Claire Liddy (Managing Director of Innovation)	✓	✓	x	x	✓	✓	✓	✓	✓	✓	N/A	N/A	8/10	80%
Emma Hughes (Deputy M.D. of Innovation)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	2/2	100%
Kate Warriner (Chief Digital and Info. Officer)	✓	✓	✓	x	✓	✓	✓	x	✓	x	✓	✓	9/12	75%
Quorum achieved	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	12/12	100%

Member/Date of Meeting	2022									2023			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
ATTENDEES														
Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X	10/12	83%
Mark Flannagan (Director of Marketing and Coms)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	11/12	92%
Dani Jones (Director of Strategy and Partnerships)	✓	✓	✓	✓	✓	✓	X	✓	X	✓	X	✓	9/12	75%
Sue Brown (Associate Development Director)	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/2	100%
Jim O'Brien (Associate Development Director)	N/A	N/A	X	✓	X	X	X	X	✓	✓	X	X	3/10	30%
Emily Kirkpatrick (Associate Director Commercial Finance)	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Claire Shelley (Associate Director Operational Finance)	✓	✓	X	✓	X	✓	✓	✓	✓	✓	✓	✓	10/12	83%

Alder Hey Children's NHS Foundation Trust

Safety & Quality Assurance Committee Annual Report 2022/23

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/HCP Lead
- Director of Nursing
- Director of AHPs
- 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 Quality Steering Group (CQSG) which monitors quality assurance at an operational level and reports 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 2022/23

Quality Improvement

- For April and May 2022 assurance reports were received on the top 3 Quality Priorities agreed to drive the agenda ensuring a strategic focus on quality and safety (medication safety; deteriorating patients and parity of esteem). A 20% reduction in the number of administration and/or prescribing errors was achieved for 2021/22 along with a reduction in medication incidents that caused harm from 53 to 38.
- In June 2022 the Committee endorsed the establishment of a Patient Safety Strategy Board (PSB) to monitor the implementation of the Patient Safety Strategy. Monthly updates were received from the PSB on each of the above workstreams demonstrating good progress on each of the individual priorities. Reporting through the PSB utilising the brilliant basics methodology both Medication Safety and Deteriorating Patients demonstrate an effective use of the QI tools and techniques and should be used as an exemplar for the other workstreams to follow. In addition, there is a programme 'stock take' underway which will now begin to outline gaps in individual workstream governance, allowing for a more targeted approach to address gaps in governance, delivery and/or utilisation of the QI approach.

Delivery of Outstanding Care

- Exemplary assurance was provided to SQAC in relation to the Ockenden Report (independent review of maternity services provided by the Royal Shrewsbury and Telford NHS Trust). Whilst Alder Hey is not responsible for maternity care, the recommendations were considered in respect to our clinical services and a full Trust level action plan was taken forward to ensure learning from the review, including several recommendations on neonatal care.
- Monthly reports from the Director of Infection Prevention and Control were received including updates on delivery of the winter vaccination and covid booster vaccination programmes. Zero tolerance rates for both MRSA and C. difficile were achieved (as at February 2023). A rise in the number of Gram-Negative BSI cases was noted in February 2023 – see further assurances section.
- The themes and risk report from the Quality Assurance Rounds were formally received highlighting the main five successes relating to services showing best practice, positive feedback from Friends & Family Test, good governance structures, good multi-disciplinary teamwork, resilience and staff going above and beyond.
- A detailed overview of the case, findings and associated learning was received in relation to the review of the Major Trauma Care Pathway following a catastrophic injury involving a fireplace. Whilst noting that sadly the final outcome of this case would not have been any different from any changes in the pathway of care provide by Alder Hey clinicians, the Committee took full assurance from all areas for improvement being addressed.
- The Committee received the Health Inequalities & Prevention Steering Group report noting the thematic information, clear governance arrangements and learning.
- Thorough updates were received on the work undertaken in relation to those young people who do not meet the criteria for complex transition and compliance with NICE Guidance on Transition from Children's to Adult Services for Young People Using Health or Social Care Services (NG43). We previously received updates (and good assurance on those CYP who are classed as "complex transition". Having received this assurance it led to the Committee asking for a review of "non-complex" which we continue to focus on.
- Winter planning and safer staffing reports were presented to the Committee in order to provide assurance around robust plans for nurse staffing over the winter period. The Committee specifically noted the level of innovation with regards the plan.

- Monthly updates in relation to pressures within the Emergency Department were provided to the Committee highlighting numerous innovative actions taken to ensure we deliver safe care to the patients that attend our ED. These include: the establishment of an Urgent Care Improvement Board, review of Escalation Policy, recruitment of additional Consultants and establishment of the new urgent treatment centre. SQAC commended the exceptional work within the ED@itsBest programme ongoing innovation and ability to link into the system addressing the Urgent Care Plan and helping to shape it.
- The Committee continued to receive detailed oversight reports from the Sepsis Steering Group and whilst the plethora of actions being taken to improve both training compliance and further development of the dashboard was noted further development of the sepsis dashboard was requested by SQAC to provide sufficient assurance going forward.
- Quarterly reports regarding mental health attendances at the Trust's Emergency Department were received with actions for reviewing the current pathway. This has enabled the (significantly increased) interactions between ED and the Crisis Care Team to be demonstrated.
- Quarterly mortality reports were received detailing a review of statistical analysis in PICU, detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.
- Quarterly reports from the Hospital Mortality Review Group (HMRG) were received including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims. One of the most significant changes noted was the introduction of the Medical Examiner (ME) process in the Trust in April 2023 enabling families to have a voice, improving accuracy of death certificates and ensuring every death is reviewed.
- Assurance reports in respect of the Safe Waiting List management programme were received in-year. These provided the Committee with a comprehensive overview on the progress on implementing lessons learned from previous RCAs; data quality incorporating review of current risks, outcomes of RCA's and proposals for improvements/changes to the processes and management of waiting lists within Meditech 6.08 and future migration to Expanse.
- SQAC received the Never Event Muscle Biopsy Root Cause Analysis Report noting that whilst this was a no harm event, a thorough case investigation was undertaken to identify the root cause. A full action plan was developed to address the recommendations from the review to ensure lessons learned, improved governance and patient safety going forward. SQAC was assured in terms of the divisional pathway review that had taken place in readiness for all new research patients which had been shared widely through the Trust and patient safety meeting.
- The Committee received a report detailing the actions taken to address the impact of medicine shortages, a national issue that has arisen due to Brexit, Covid-19 and the government applying a levy nationally which has resulted in suppliers withdrawing from market. SQAC were assured of the processes to address drug shortages, find alternatives and keep our patients safe. Senior pharmacy staff are involved in the neonatal and paediatric Chief Pharmacists network where any supply issues or discontinuation would be raised with relevant stakeholders. A report was subsequently presented to the Resources and Business Development Committee to highlight drug spend and potential financial risk to the Trust.

<u>Clinical Governance Effectiveness</u>

- Key issues reports were received from the Clinical Quality Steering Group (CQSG) which continues to monitor quality assurance at an operational level reporting in to SQAC.

- The Committee regularly monitored the agreed quality metrics in the Trust Integrated Performance Report and received substantive assurance reports on any specific issues identified from the Divisions.
- Following the BBC panorama investigation (October 2022), into the abuse of patients in the care of another NHS trust, the Committee received a report demonstrating assurance regarding the quality and safety of our services and the safeguarding methods in place to safeguard children, young people and families against failings in care. This review identified that robust systems and processes are in place to safeguard the children, young people and families in our care as well as areas for improvement. SQAC received and noted the content of the assessment and the actions required for improvement, which would be monitored through SQAC.
- The Committee was kept abreast on the procurement of the new risk and incident management solution scheduled for 'go live' April 2023.
- SQAC supported, in principle, the establishment of a clinical effectiveness group to have oversight of the Trust's internal annual clinical audit plan ensuring compliance with and adherence to all NICE guidance and clinical audit outcomes. In addition changes will be made in Q1 2023-24 to the current patient safety and patient experience groups which will each report directly into SQAC, removing the need for the current CQSG forum.
- Assurance was provided to SQAC in relation to oversight and learning following the Trusts 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 overdue reporting for some areas which requires significant improvement and will continue to focus on this area in 2023/24.
- SQAC retained its oversight of the Trust's clinical audit function during the year. The Committee is responsible for commissioning a Clinical Audit Work Programme and receiving the results of this work to provide oversight of clinical quality Trust-wide and within Divisions, reporting in to Audit & Risk Committee. During the year, SQAC received regular reporting from the Clinical Audit Function on work planned and completed, actions arising and the timeliness of implementation of the actions. Whilst the positive findings from the MIAA Audit Performance Review were noted, at quarter 2 2022/23 only 73% of the audits were progressing and on schedule compared with 87% for the previous quarter. Further detailed reporting was requested by SQAC including themes and a flow chart identifying key information in terms of reporting mechanisms.
- The Committee received the Trust Quality Account for 2021/22.
- The Committee was kept well-informed of the new requirements in relation to the National Patient Safety Incident Response Framework (PSIRF) and its implementation at Alder Hey.
- The Committee received and supported the proposals around implementing a standardised approach to Divisional reporting with a view to rolling this out from April 2023 onwards.

<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*

- During the year, SQAC received deep dive presentations for each of the BAF risks which gave the Committee the opportunity to gain further understanding of the risks and the controls in place to mitigate them, along with the current gaps in controls and ongoing actions. As the risk areas fall within SQAC's remit, various reports on aspects of the risks, controls and actions were received throughout the year as part of normal committee business.

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

  - *Risk 1.1 Inability to deliver safe and high-quality services*:
    - a deep dive presentation was received at the October 2022 meeting noting the significant work undertaken to review gaps in controls and identify further mitigations to reduce the risk.
    - gaps in controls were addressed initially through reports relating to the 'quality priorities', and latterly through updates on projects being overseen by the PSB. These reports are usually first on the agenda for discussion/assurance. Regular reports on mental health attendances at the Trust's Emergency Department, on the ED performance against national waiting times, on actions taken by the Sepsis Steering Group and performance against the sepsis KP, and levels of medication safety incidents, were also received.
  - *Risk 1.2 Children and young people waiting beyond the national standard to access planned care and urgent care:*
    - a deep dive presentation was received at the December 2022 meeting resulting in an increase in the risk score reflecting the current demand, various industrial actions and ongoing challenges within the BMA rate card. The risk was subsequently updated to reflect additional mitigations identified to improve access to care.
    - gaps in controls addressed are through the following regular reports: Safe Waiting List management programme, winter plan and monthly updates to address pressures within the Emergency Department
  - *Risk 1.4 Access to Children & Young People's Mental Health:*
    - a deep dive presentation was received at the November 2022 meeting with detailed discussion on both short and long term mitigations and the importance of capturing the strength of partnership working as part of the mitigation for this risk.
    - gaps in controls addressed through application for additional funding to support increased demand, focussing on staff wellbeing to maximise retention, quarterly reports on mental health attendances at the Trust's Emergency Department with actions for reviewing the current pathway to ensure the safety of the children and young people accessing our services 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**.**

- Following agreement of the Board's risk appetite statements, SQAC reviewed the suggested risk tolerances for clinical safety and clinical effectiveness risks with a view to trialling them within the divisions prior to trust-wide roll-out.
- 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.

External inspections undertaken and assurances received

- During the year SQAC has received the following reports from external sources:
    - the Trust commissioned external review by the CCG of the Trust's safeguarding services to identify any areas for improvement. Key findings from the report identified a number of recommendations to take forward which are monitored internally through a newly established Safeguarding & Statutory Services Assurance Group reporting into SQAC on a quarterly basis. SQAC commended the commissioning of this review and passion to influence the safeguarding arrangements across the wider system.
    - The Committee received the Sensory Friendly Environment Northwest Project Report which aims to create sensory friendly environment for children and young people, their families and carers at Alder Hey. The significant work undertaken by the project was commended along with collaboration with key partners to share learning.
    - The 2021/22 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.
    - Audit by MIAA demonstrating robust governance arrangements at both departmental and Trust levels via the HMRG and evidential Board leadership in respect of scrutiny and oversight of mortality.

Responsive

- Quarterly patient and family feedback reports were received noting the Trust's position and further developments including a development project to respond to drive service improvement.
- On a quarterly basis, the Committee received the report of incidents, complaints, PALS, claims and complements. The Committee was encouraged to receive assurance of the continuing developments in responding to the concerns raised by children, young people and their families and achievement of key performance indicators.

Annual Reports

- Annual reports were provided throughout the year to provide assurance to the Committee, these included
  - Safeguarding Children
  - Research
  - Children in Care
  - Clinical Quality Steering Group
  - Clinical Ethics Committee
  - Organ Donation

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:
    - assurances regarding ongoing levels of pressure ulcers in various parts of the Trust. Thorough updates were provided from each division on current state and actions being taken forward to reduce these incidents including a focus group to look at the eradication of non-device related pressure sores and shared learning across the divisions.
    - Further assurances were requested from the Urgent Care Improvement Board relating to performance figures and specifically the data regarding the proportion of patients that are not being seen through the traditional ED route from the previous three months.

- Following an increase in Gram-Negative Bacteraemia cases, the Committee have requested a deep dive in order to understand the reason for this rise in cases.
- In relation to the Never Event Muscle Biopsy, SQAC requested the formation of a working group to pull together all actions relating to ongoing workstreams in train to address consent, procedures, and improvements within Meditech to ensure surgical procedures are clear and well embedded. A reflective report was requested following this review to include compliance with the National Safety Standards for Invasive Procedures (NatSSIPs). The committee requested three and six-monthly updates on the RCA action plan.

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 of Clinical Audit are appropriate for the Trust's operations.
- The mandated Clinical Audit Work Programme has been delivered.

The Chair of SQAC is a member of the People and Wellbeing Committee enabling links 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 2023/24

- Establish the reporting cycle of the patient safety, patient experience and clinical effectiveness groups
- The Committee will continue to monitor the Trust's response to recovery following the pandemic
- The Committee will 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'
- The Committee will maintain an overview of the Quality Assurance Round process to provide an in depth understanding of the issues facing each service and department.
- The Committee will 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; and
- The Committee will continue to seek improvements in relation to nice guidance and clinical audit compliance.

Professor Fiona Beveridge
Committee Chair
April 2023

APPENDIX A

SAFETY & QUALITY ASSURANCE COMMITTEE - RECORD OF ATTENDANCE 2022/23

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 continue to be held virtually via Microsoft Teams.

Member / Date of Meeting	2022									2023			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Fiona Beveridge (Chair) (Non-Executive Director)	x	✓ (Chair)	✓ (Chair)	✓ (Chair)	NO MEETING HELD	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	x	✓ (Chair)	✓ (Chair)	9/11	82%
Kerry Byrne (Non-Executive Director)	✓ (Chair)	✓	✓	✓		✓	✓	✓	✓	✓ (Chair)	✓	✓	11/11	100%
Dame Jo Williams (Non-Executive Director)	✓	X	✓	✓		X	n/a	n/a	n/a	n/a	n/a	n/a	3/5	60%
Jo Revill (Non-Executive Director)	n/a	n/a	n/a	n/a		n/a	✓	X	✓	✓	✓	✓	5/6	83%
Alfie Bass (Chief Medical Officer)	✓	✓	✓	✓		X	✓	✓	✓	✓	✓	✓	10/11	91%
Nathan Askew (Chief Nursing Officer & AHP/HCP Lead)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	X	10/11	91%
Pauline Brown (Director of Nursing)	✓	✓	✓	X		✓	✓	✓	✓	✓	X	✓	9/11	82%
Marianne Hamer (Director of AHPs)	✓	✓	✓	✓		✓	x	x	x	1 item	x	x	6/11	55%
John Grinnell (Deputy Chief Executive/Director of Finance)	✓	✓	X	X		✓	✓	✓	✓	✓	✓	✓	10/11	91%

Member / Date of Meeting	2022									2023			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Adam Bateman (Chief Operating Officer)	✓	✓	✓	X	NO MEETING HELD	✓	✓	✓	✓	✓	✓	✓	10/11	91%
Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	X		✓	✓	✓	X	✓	✓	✓	9/11	82%
Melissa Swindell (Chief People Officer)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11	100%
Dani Jones (Director of Strategy & Partnerships)	X	✓	Deputy	Deputy		Deputy	Deputy	Deputy	Deputy	Deputy	✓	X	9/11	82%
Kate Warriner (Chief Digital Information Officer)	Deputy	Deputy	Deputy	Deputy		Deputy	Deputy	Deputy	Deputy	Deputy	Deputy	Deputy	11/11	100%
Benedetta Pettorini (Divisional Director, Surgery)	X	Deputy	X	Deputy		Deputy	Deputy	Deputy	Deputy	Deputy	Deputy	Deputy	9/11	82%
Urmi Das (Divisional Director, Medicine)	✓	Deputy	✓	✓		✓	✓	Deputy	✓	✓	✓	Deputy	11/11	100%
Lisa Cooper (Divisional Director, Community & Mental Health)	✓	✓	X	✓		✓	✓	✓	✓	✓	✓	Deputy	9/11	82%
(Divisional Director, Research)	HC 1 item	x	HC Part meeting	x		x	x	✓	x	x	x	x	3/11	27%

Divisional Clinical Leads for Safety: **• Chris Talbot, Surgery** **• Medicine** **• Jacqui Pointon, Community**	✓ ✓ X	**Deputy** ✓ X	**Deputy** ✓ ✓	**X** ✓ ✓		**X** ✓ ✓	**Deputy** ✓ ✓	**Deputy** **Deputy** X	**X** ✓ ✓	✓ X X	✓ ✓ ✓	**Deputy** ✓ ✓	**8/11** **10/11** **7/11**	**73%** **90%** **64%**
QUORUM ACHIEVED	**YES**	**YES**	**YES**	**YES**		**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**11/11**	**100%**

Member/Date of Meeting	**2022**									**2023**			**TOTAL**	
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
ATTENDEES														
Adrian Hughes (Deputy Chief Medical Officer)	**X**	✓	✓	**X**		**X**	✓	**X**	**X**	**X**	**X**	**X**	**3/11**	**28%**
Phil OConnor (Deputy Director of Nursing & AHPs)	✓	✓	**X**	**X**		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**2/11**	**19%**
Cathy Umbers (Associate Director for Nursing and Governance)	✓	**n/a**	**n/a**	**n/a**		**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**1/1**	**100%**
Jackie Rooney (Associate Director for Nursing and Governance)	**n/a**	**n/a**	✓	✓		**X**	✓	**X**	✓	✓	✓	✓	**7/9**	**78%**

Beatrice Larru (Director of Infection Prevention Control)	✓	✓	✓	**X**		✓	**X**	**X**	✓	✓	✓	✓	**8/11**	**73%**

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee Annual Report 2022/23

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 2022/23 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 '**The best people doing their best work'** as set out in the Trust's People Plan are met:

- Looking after our People
- Belonging to the NHS
- Growing the Future
- 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
- Director, Alder Hey Academy
- 1 x Senior representative from each Division

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

Principal Review Areas / Achievements in 2022/23

Trust People Plan 2019-2024

- The Committee received progress reports against the targets and measures set out in the People Plan 2019-2024. These were delivered monthly from each division through their wider knowledge of the Trust via the Integrated Performance Report (formerly the Corporate Report) and individual detailed metric reports. A Corporate Services Collaborative meeting was established during the summer acting as a mechanism to bring the 12 non-clinical service departments together to focus on particular issues and areas for improvement identified via aggregated performance data across the same metrics used by the clinical Divisions.
- The committee was kept abreast of internal communications with a particular focus on the new website and intranet development throughout the year. The new staff intranet was launched in March 2023. PAWC supported the establishment of a 'Celebration & Recognition' working group.
- The Staff Survey 2022 initial results were received noting a 54% response rate compared to 45% nationally; staff reporting Alder Hey overall as a recommended place to work was 67%, which is a small dip but still a good result compared to the sector. During the year the committee continued to oversee implementation of the action plan and the Trust's response to feedback from staff including a full review of the quality of appraisals and the development of a health and wellbeing framework launched through the refreshed Health and Wellbeing Steering Group. In March 2023 a piece of work was commissioned for Divisions to report back to PAWC on the outcomes of their 'Big Conversations' with staff.
- PAWC received a presentation on the proposals in relation to the development of the People Plan 2022-2030. It was noted that this had been developed in line with the National People Plan, system developments (ICS), increased workforce vulnerabilities and changing societal landscape. Challenges to delivery were acknowledged including recruitment, strengthening of partnerships and ensuring an interface with between staff and patient safety and wellbeing.
- A Programme Assurance Report was received detailing progress made against the workstreams 'workforce planning' and 'great place to work'. Assurance was received that the two programmes had been completed utilising the Brilliant Basics methodology.

- During the year, an induction review was undertaken to tackle the ongoing challenge that often new starters can feel isolated, unsupported and undervalued. Root causes were presented to the committee along with thirteen actions agreed to ensure new starters feel fully supported and welcomed to the Trust and stay at the Trust for longer.
- Assurances in relation to industrial action were provided to PAWC on the positive and productive working with the RCN, derogations and impacts to service provisions and risks identified being proactively managed.
- Following feedback that the Trust's Personal Development Review paperwork was too complicated and felt like a form filling exercise, a thorough review was undertaken resulting in wholesale changes to the process including: tweaks to the PDR window moving away from the existing 4-month timeframe and a real focus going forward on performance in role and a career conversation around ambition and aspiration in line with the Messenger Review recommendations.
- A refreshed approach to listening to staff was presented to the committee following a series of listening events undertaken across Alder Hey. A number of different strategies are in progression to respond to staff feedback and help improve engagement.

Trust People Plan 2030

- Following launch of the Trust's Vision 2030, PAWC received a presentation on the People Plan embedded within this. Work was undertaken with Strasys Consulting to help understand the current workforce dynamics and how we will address the four areas of need for staff and children: looking after each other; create a sense of belonging; embrace new ways of working and learn and grow for the future. Challenges to delivery including operating environment and the market were acknowledged and how these will be addressed thinking differently about the different groups of staff, how we support, retain and help staff develop in their roles and attract future workforce. New metrics for 2023/24 are now in development which will be reported to the committee in due course.

Looking After our People

- PAWC received performance deep dive reports on the following staffing metrics:
    - Sickness Absence – noting the highest reasons for absence, current benchmarking data showing Alder Hey in the upper-mid range. Assurance was provided by the ongoing support and staff initiatives to help absent staff back to work. PAWC welcomed the establishment of a Menopause Support Group. The February 2023 position was reported at 5.89% against a target of 5%.
    - Staff Turnover – noting an increase year on year finishing at 14.17% against a 10% target for 2020/21. The Committee supported the establishment of a Task and finish group to take forward this work and improve the position. The February 2023 position was reported at 14.62% against a target of 10%.
- Quarterly updates on the People Pulse Staff Survey/Temperature Check were received detailing the themes and actions and process being developed for training staff to become active bystanders when bullying or harassment takes place, barriers to reporting bullying and strengthening links to the Behavioral Framework.
- PAWC received a presentation detailing a number of actions implemented to help staff address the current pressures in relation to the cost-of-living crisis and welcomed the review of the 'wage stream' app being utilised by other Trusts which allows employees the control over their finances and allows them access to their salary as and when needed which could help reduce the number of people applying for loans.
- A summary of cases brought through Freedom to Speak Up for 2021/22 was presented to the committee noting positive performance against the national staff survey results relating to speaking up. The committee approved adoption of the new national FTSU Policy and reflection tool.

- As a result of the 'Flowers' legal case that has been ongoing for a number of years relating to the treatment of overtime payments and in particular payments for voluntary overtime in the calculation of holiday pay, PAWC received a report confirming that NHS Employers had agreed a settlement for overtime payments and pay during annual leave. Assurance was received in relation to the requirements under the Bear/Flower legal challenges and outcomes, which ensures staff are paid in accordance with Agenda for Change Terms and Condition in relation to their annual leave and holiday pay.
- PAWC received the Nurse Workforce Report 2021/22 noting the overall impact of the success of the international recruitment campaign, reduction in vacancies, response to the pandemic and other developments to support safe nurse staffing. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2021/22 demonstrated that the average overall staffing level was 92% for the year. However, between November 2021 to February 2022 staffing levels were reported to be between 81% to 88%, with decreased staffing levels across day and night shifts and across registered nurses and HCAs. Assurance was provided that this was negated through invoking staffing levels around the amber & red categories which presented a clear escalation policy in line with the National Guidelines Establishment reviews were undertaken to address any gaps in line with RCN standards and workforce group chaired by Chief Nurse meeting monthly.
- An update on the Wellbeing Guardian role and progress against the implementation of the 9 core Health & Wellbeing Guardian principles was received demonstrating completion of phases 1 and 2. Progression to phase 3 of the plan was agreed.
- PAWC received and approved pay progression proposals for those staff not employed under the Agenda for Change terms and conditions.
- An overview of the Trust's volunteering activities was presented to the committee noting their crucial contribution in transforming the way the NHS works. An increase of 15% of BAME volunteers being recruited was noted along with the positive outcome of the palliative care project, volunteer to career programme and young volunteer programme.
- PAWC received the outputs from the Health and Wellbeing Steering Group and noted the plethora of actions underway to improve the personal health and wellbeing of our staff.

<u>Belonging to the NHS</u>

- Equality, Diversity and Inclusion (EDI) Steering Group:
    - The Committee welcomed the formation of the Equality, Diversity and Inclusion Steering Group chaired by a Non-Executive Director and received an initial update from its inaugural meeting noting that all Network Chairs had been appointed.
    - Received and noted the EDI Steering Group Terms of Reference.
- PAWC received the contents of the Gender Pay Gap Report 2022 summarising a mean gender pay gap of 27% and median gender pay gap of 19% mainly within our Medical and Dental staff groups and is reflective of an ageing male workforce within this staff group. Medical & Dental female workforce profile is evolving with an increased number of female consultants being appointed. The reasons for a gender pay gap were noted as multi-factorial; terms and conditions, length of service, gender mix, pension and flexible working arrangements – all impacting on the overall gender pay gap results. Assurance was received that actions have been identified to ensure an equitable workforce and reduce this gender pay gap which have been incorporated into the People Plan, progress against these actions will be reported to PAWC during 2023/24.
- The Equality, Diversity and Inclusion Annual Report 2022/23 was received highlighting the progress made in building the foundations to embed equality, diversity, and inclusion into our core business. Whilst noting the performance delivery to date the committee acknowledged the continued commitment towards achieving the objectives identified in line

with the specific duties of the Public Sector Equality Duty set out in the priorities and plans 2023/24 and look forward to receiving updates in due course.

- The Committee received the Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) reports noting good progress in terms of the race equality metrics but, disappointingly slower progress in terms of our disability metrics. Going forward, trend identification for to a minimum of 3 years data were requested for greater assurance. Received and approved the action plans 2022/24 for publication – these will now be progressed into 2023/24.

New Ways of Working

- Apprenticeship Plan noting the range of apprenticeship opportunities the trust has to offer, ongoing conversations with external stakeholders to potentially help grow our apprentice opportunities to support our existing staff. PAWC recognised the challenge in terms of funding for apprenticeships which are 95% funded by the government leaving the Trust to cover the remaining 5%.
- The Committee received an update on the continued implementation of the mandated e-roster system noting the benefits to maintain safe staffing levels across the organisation. PAWC welcomed the benefits realisation update and savings achieved within the departments that have gone live. Once full implementation is complete the Committee will receive a further update.

Governance

- Approved Annual Committee Report 2021/22.
- Approved the Committee Terms of Reference for the year 2022/23.
- Approved the Committee Workplan for 2022/23 noting the refined focus to take into account the four major strategic areas around the People Plan.
- PAWC continued to ratify all relevant workforce policies.
- The Committee welcomed the approved Trade Union Partnership Agreement and noted the significant progress in partnership working and positive relationship with the Trust's Staff Side Group.
- Received the CCG Annual Workforce Development Update 2021/22 noting the contents of the report and actions taken to address any areas with lower-than-expected targets. Updates were received via substantive divisional metrics reports and deep dives into turnover rates, staff retention and health and the continual monitoring of staff health and wellbeing throughout the year.

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

- During the year, PAWC received deep dive presentations for each of the BAF risks which gave the Committee the opportunity to gain further understanding of the risks and the controls in place to mitigate them, along with the current gaps in controls and ongoing actions. As the risk areas fall within PAWC remit, various reports on aspects of the risks, controls and actions were received throughout the year 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 October 2022 meeting with particular attention to the gaps in controls. Additional mitigations were highlighted to the committee including a new sickness absence training programme plan; the establishment of the recruitment, attraction and retention project and the establishment of a Task & Finish Group to review turnover rates and analyse the data.
  - The deep dive of this risk prompted a review of the level of risk of the future workforce and better alignment to the national plan.
- *Risk 2.2 Employee Wellbeing*
  - A deep dive presentation was received at the September 2022 meeting detailing several further actions that had been identified to further mitigate this risk including roll out of mental health awareness training for managers; ensure current staff support provision is adequate and sustainable and widen the network of support via SALS and PALS.
- *Risk 2.3 Workforce Equality, Diversity & Inclusion*
  - A deep dive presentation was received at the December 2022 meeting noting the development of an Annual EDI Plan and EDI Lead to commence in post January 2023 as part of the further mitigations to this risk.

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**.**

- Following agreement of the Board's risk appetite statements, PAWC reviewed the suggested risk tolerances for workforce risks with a view to trialling them within the divisions prior to trust-wide roll-out. The committee held a long discussion on the appropriateness of the suggested tolerances and agreed to discuss this further through a working group before formal agreement.

Sub-Committee / Working Groups

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 and six-monthly Health & Safety updates noting: Trust wide Non-Clinical Incidents by Cause Group; Non-Clinical Incidents by Category and Division; Top 3 Incident Types – by Category and Division; RIDDORs; Claims and the H&S Dashboard.

Staff Story

The Trust welcomes and encourages feedback and recognises the importance of being a learning organisation. During the year, a member of staff attended a meeting to share their experience of working with SALS following a diagnosis of severe anxiety and OCD. The Committee learned of the support that had been provided by the SALS team and their sheer dedication and commitment to helping staff to who access the service. The committee thanked the staff member for sharing this story to provide insight that could help many other people across the NHS and provide an opportunity to triangulate, build relationships and support the Board's ongoing journey for organisational learning.

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.

The committee was chaired by Non-Executive Director, Fiona Marston to September 2022. In October 2022, Fiona stepped away from the Board for a period of six months to undertake a piece of consultancy work in relation to the Trust's Research and Innovation Strategy. During this time, Dr Marston was also a member of the Innovation Committee enabling links with specific workforce issues in a multi-factorial way, specifically in relation to specific workforce projects and initiatives.

From October 2022 the committee was chaired by Jo Williams, Trust Chair.

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 2023/24

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2023/24:

- Focus on monitoring the implementation of a 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:
  - Looking after our People
  - Belonging in the NHS
  - Growing for the Future
  - New Ways of Working
- 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 Task Force to ensure a strategic coherence in all matters related to Equality, Diversity and Inclusion and its determination to embed the work across the Trust.

Dr Fiona Marston
Committee Chair (to September 2022)

Dame Jo Williams
Committee Chair (October 2022-March 2023)

PEOPLE & WELLBEING COMMITTEE – RECORD OF ATTENDANCE 2022/23

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.

	April 2022	May 2022	June 2022	Aug 2022	Sept 2022	Oct 2022	Dec 2022	Jan 2023	March 2023	TOTAL	
MEMBERS											
Fiona Marston (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	N/A	N/A	N/A	N/A	5/5	100%
Jo Williams (Non-Executive Director)	N/A	N/A	N/A	N/A	✓	✓ (Chair)	✓ (Chair)	x	✓ (Chair)	4/5	80%
Fiona Beveridge (Non-Executive Director)	x	✓	x	✓	✓	✓	✓	x	✓	6/9	67%
Ian Quinlan (Non-Executive Director)	x	x	✓	x	x	✓	✓	x	x	2/9	22%
Garth Dallas (Non-Executive Director)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓ (Chair)	N/A	1/1	100%
Melissa Swindell (Chief People Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9	100%
Adam Bateman (Chief Operating Officer)	✓	✓	✓	✓	✓	x	✓	✓	x	7/9	78%
Nathan Askew (Chief Nursing Officer)	✓	x	✓	✓	x	✓	x	✓	x	5/9	56%
Alfie Bass (Chief Medical Officer)	x	✓	x	x	x	x	x	x	✓	2/9	22%
Mark Flannagan (Director of Marketing & Communications)	x	✓	✓	x	✓	✓	✓	✓	✓	7/9	78%
Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9	100%
1 x Senior representative from Surgical Division	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9	100%

1 x Senior representative from Medical Division	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9	100%
1 x Senior representative from Community Division	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9	100%
1 x Senior representative from Research Division	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9	100%
Quorum achieved?	**NO**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**NO**	**YES**	**7/9**	**78%**

	April 2022	May 2022	June 2022	Aug 2022	Sept 2022	Oct 2022	Dec 2022	Jan 2023	Mar 2023	TOTAL	
ATTENDEES											
Sharon Owen (Deputy Chief People Officer)	✓	x	x	x	✓	✓	✓	✓	✓	6/9	67%
Jo Potier (Associate Director of OD)	✓	✓	✓	x	✓	✓	✓	✓	✓	8/9	89%
Ayo Barley (Equality & Diversity Lead)	x	✓	x	x	Post vacant	Post vacant	Post vacant	N/A	N/A	1/4	25%
Angie Ditchfield (Equality & Diversity Lead)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	1/1	100%
Tony Johnson (Staff Side Chair)	x	x	x	x	x	x	x	x	x	0/9	0%

Alder Hey Children's NHS Foundation Trust

Innovation Committee Annual Report 2022/23

The Innovation Committee

The 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 innovation.

The Committee operates under the broad aims of developing the Trust's Innovation Strategy and related activities, to provide assurance to the Board that delivery in this area supports the Trust's Strategic Plan.

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

- Steer the development of a cohesive approach to innovation, ensuring that the Trust maximises the opportunities presented by its facilities, clinical expertise, partnerships and networks;
- Make recommendations to the Board to pursue specific projects and initiatives that fall within the duties of the committee;
- Seek and commission external advice as deemed appropriate to the successful delivery of this agenda.

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:

- 3 Non-Executive Directors (one of whom is the Chair)
- Chief Executive
- Chief Medical Officer
- Clinical Director of Innovation
- Director of Finance
- Managing Director of Innovation
- Director of Corporate Affairs
- Chief Digital and Information Officer

Expected to attend each meeting are the Deputy Managing Director of Innovation, Finance Lead for Innovation and Director of Research.

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 2022/23

Strategy and Operations

- The Committee received and approved the 2022/23 Innovation Operational Plan drawn in accordance with the NHS Operational Planning Guidance for 2022/23 and continued to monitor progress on a quarterly basis throughout the year via the performance reports.
- Quarterly Innovation Performance Reports were received in-year and whilst noting the progress against KPIs, strategy development and divisional performance the Committee requested greater detail to be included in the updates including financial outturn and grant funding. The risk in relation to financial sustainability of the Innovation Centre and achieved/unachieved targets was also requested for inclusion for greater assurance. At year end, it was agreed to refresh the pipeline and commercial opportunities in order to provide a forward look and set a clear context and to improve visibility grant opportunities should be included in the report going forward.
- Innovation Management Accounts were received at each meeting. The financial overview for month 9 was reported at a balanced position year to date, with a £0.3m deficit forecast for the year. The main areas of challenge relating to timing of grants and commercial revenue streams delay to due external factors. Assurance was provided that largely income shortfalls are mitigated through cost reduction and that the detail of the deficit position for the year was taken through RABD.
- The 2030 Innovation Strategy: 'Todays Child, Tomorrow's Healthier Adult' was received noting the ambition set out in the Strategy and commitment to innovate.
- The Committee approved the 2022/23 Operational Delivery Plan to enable deployment of the deliverables and benefits realisation.
- Strategic overview and progress reports on the 'Alder Hey @nywhere Digital Platform' were received (the integrated health platform and intelligence tool that enables a new hybrid of hospital and virtual models of care for both patients and clinicians). Key achievements were noted by the Committee during the year including the rise to new opportunities and significant interest from industry partners in the project. Further assurance was requested on the business development proposal to include clinical safety, clinical and operational asks, a specific brand and communications plan (including a market assessment of competitors and the national landscape), and product positioning.
- Regular Marketing and Communications Plan updates were provided to the Committee and whilst acknowledging the Plans aims to support both brand positioning and drive business to Alder Hey, further detail was requested by the Committee to identify next steps to identify the organisation's lead products, advise on the process for selling lead products, the positioning of innovation, potential customers, with a tactical plan to underpin this area of work. This will be aligned with the commercial opportunities pipeline work and activities

Growing Through External Partnerships

- The Committee received a presentation on the Lab to Life Child Health Data Centre concept, a dedicated unit to attract external investment. The presentation detailed the vision and expected outputs from the project.
- The Committee was kept abreast of the commercial and partnership agreements during the year and agreed the need for a Standard Operating Procedure for partnership agreements to be implemented. This was approved during the year and is now in place. In order to achieve revenue forecasting, an independent consultant has been appointed with sales and business development track record and expertise. This consultant will work with the team to develop a commercial prospects pipeline tracker and identify opportunities and align with Trust strategy 2030 Futures initiatives This new report will be presented at Innovation Committee and RABD from 2023/24 financial year onwards.
- The Committee was advised of the Trust's successful pre-development bid following submission to the Metro Mayor's Liverpool City Region strategic investment fund. Alder Hey

received confirmation that the bid had been approved in August 2022 and that the Trust is one of the Liverpool City Region's innovation pipeline projects.

- The Innovation Committee noted the Bluetree Group licence update (BrillianSee transparent mask product and license) and agreed to support the continuation of the license deal to March 2024. Towards the end of 2022/23, a task and finish group was established to progress a business development options plan following a number of manufacturing challenges and delays with Bluetree. This will be submitted to the Research and Innovation Committee during 2023/24.

Culture

The Committee received the draft Engagement and New Pipeline Plan and was advised of the work that is being created to increase the quality of the Pipeline in terms of internal engagement, which will be reported on in due course to the Research and Innovation Committee and Trust Board.

Business Development

- Cheshire & Mersey ICS / NHS England Innovation partnership activities:
    - Establishing the Automation Solutions Centre of Excellence.
      The Committee received an overview of the growth and business development of the Robotic Process Automation (RPA) Programme to a Centre of Excellence Service that offers fee for service innovation and automation solutions to other Trusts. The Committee commended the work in this area and noted the grant funding secured to establish Alder Hey as the Centre of Excellence for the C&M region.
    - CYP As One Platform and ICS C&M Beyond CYP Programme.
      The Innovation Committee received a report that provided information about the partnering activities with the C&M system and the business development of the CYP As One Mental Health Platform. The initial evaluation report detailing the associated research and evaluation work in collaboration to measure the impacts of healthcare inequalities will be received in due course by the Research and Innovation Committee.
- The Committee received an update on the Children's Health Alliance Innovation Programme that has been developed over the last twelve months. Feedback and challenge was provided relating to; the importance of having a clear set of goals and priorities to enable constructive comments and decisions to be made, whilst ensuring that future priorities align with the Trust's overall Vision 2030 Strategy.

Growth

- The Committee received regular summaries of the income generated via grants noting the work that has been taking place on infrastructure grants that has led to Trust being sponsored to write a strategic outline case to expand Alder Hey Innovation. The Trust is also in the process of creating an effective bid proposal that is linked in with an ask that has been submitted to the department of Levelling Up.

Risk

- The 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

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 Committee noted that a deep dive into the operational risks relating to innovation was presented at the Risk Management Forum in October 2022 noting a total of 11 risks. Nine risks had recently been added with 2 long standing risks which were legacy risks. One risk which scored highly at a 16 was 'Delayed growth plan (strategy KPIs)' which would be mitigated through the new innovation strategy underpinned by an operational delivery plan approved by Innovation Committee in August 2022.
- The Innovation Committee received regular status updates 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.

Committee Governance

- Approved the Innovation Committee Annual Report for 2021/22.
- Approved the Innovation Committee Terms of Reference for 2022/23.
- Approved the Innovation Commercial Partnerships Standing Operating Procedure.
- Approved the Intellectual Property Policy with onward submission to RABD for ratification.
- Received the Research and Innovation Committee Governance Structure, planning update and close down report – see section below.

Awards and Achievements

Innovation have received 7 awards in total for 2022/23.

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 innovation function is 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 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 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.

Innovation Committee Close Down Process

- The Committee held its final meeting under its current terms of reference on the 6th February 2023 before being formally closed down. The committee will transfer all open actions and activities to the appropriate new and existing governance arrangements.
- The Innovation committee will be replaced by the newly formed Research and Innovation Committee (R&IC), with the first formal meeting to commence in April 2023, and subsequent quarterly meetings. The terms and reference were approved by the Trust Board of Directors on the 27th of October 2022
- A letter was sent to Innovation Committee members and advisors on the 27th January 2023 to advise the changes and thank colleagues for their contribution and support.
- In summary it is envisaged that essential governance activities of Committee, such as responsibility for oversight and assurance for the Board will be merged with those of the corresponding governance committee for Research to form a new R&I Committee (R&IC). This new Committee is a key element of the strategic, on-going closer integration of Research and Innovation, which we expect to be enshrined in the Trust's developing Vision 2030 strategy refresh, along with closer interactions with the Trust's Digital and Education activities. Its responsibilities will include areas of overlap between R and I, such as commercial income generation and evaluation of new treatments, devices and processes.

Shalni Arora
Committee Chair
April 2023

Alder Hey Children's NHS Foundation Trust

INNOVATION COMMITTEE - RECORD OF ATTENDANCE 2022/23

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

All meetings were held virtually via Microsoft Teams.

Member/Date of Meeting	2022				2023	TOTAL	
	April	Aug	Oct	Dec	Feb		
MEMBERS							
Shalni Arora (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	**5/5**	**100%**
Fiona Marston (Non-Executive Director)	**x**	**x**	**N/A**	**N/A**	**N/A**	**0/2**	**0%**
Ian Quinlan (Non-Executive Director)	✓	✓	✓	**x**	**x**	**3/5**	**60%**
John Kelly (Non-Executive Director)	**N/A**	**N/A**	**N/A**	✓	✓	**2/2**	**100%**
Louise Shepherd (Chief Executive)	✓	**x**	✓	✓	✓	**4/5**	**80%**
Alfie Bass (Acting Chief Medical Director)	**x**	**x**	**x**	**x**	**x**	**0/5**	**0%**
Rafael Guerrero (Clinical Director of Innovation)	**x**	**x**	**x**	**x**	**x**	**0/5**	**0%**
Iain Hennessey (Clinical Director of Innovation)	✓	✓	✓	✓	**x**	**4/5**	**60%**
Claire Liddy (Managing Director of Innovation)	✓	✓	✓	✓	✓	**5/5**	**100%**
John Grinnell (Director of Finance/Deputy CEO)	**x**	✓	**x**	**x**	✓	**2/5**	**40%**
Erica Saunders (Director of Corporate Affairs)	**x**	✓	✓	**x**	✓	**3/5**	**60%**
Kate Warriner (Chief Digital and Information Officer)	✓	✓	✓	✓	✓	**5/5**	**100%**
Quorum achieved	**YES**	**YES**	**YES**	**YES**	**YES**	**5/5**	**100%**

Member/Date of Meeting	2022				2023	TOTAL	
	April	Aug	Oct	Dec	Feb		
ATTENDEES							
John Chester (Director of Research and Innovation)	✓	✓	✓	✓	✓	**5/5**	**100%**
Emma Hughes (Deputy Managing Director of Innovation)	✓	✓	✓	✓	✓	**5/5**	**100%**
Rachel Lea (Deputy Director of Finance)	**x**	**x**	✓	**x**	**x**	**1/5**	**20%**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 27th June 2023

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 ■
Background Papers and/or supporting information:	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements.
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations**
Resource Impact:	None identified

Alder Hey Children's NHS Foundation Trust

NHS Improvement Provider Licence Self-Assessment - Update as at June 2023

Licence Condition	Current position	Assurance	Gap	Action
Section 1 – General Conditions				
G1 - Provision of information	All monitoring submissions to NHSI provided by deadline via the portal. Additional documents provided on request.	• Deputy DoF checks financial returns before submission and reports to RABD. • Annual Report and Accounts audited and scrutinised by Audit Committee then BoD.	None identified at present	None – the Trust remains compliant with this condition.
G2 – Publication of information	Trust reports placed in the public domain in accordance with NHSI requirements, e.g. Annual Report and Accounts.	• Hard copies of Annual Report and Accounts available on request. • Trust website • Trust Publication Scheme	None identified at present	None – the Trust remains compliant with this condition.
G3 – Payment of fees to NHS Improvement	This condition reflects the power given to NHSI under the Act to require licensees to pay fees in relation to its regulatory functions. Fees are not currently in place, not has any decision yet been taken as to whether NHSI will begin to charge fees.	N/A	N/A	None required at present. Provision has never been implemented

Licence Condition	Current position	Assurance	Gap	Action
G4 - Fit and proper persons as Governors and Directors	Trust arrangements reflect CQC regulation 5 (applies to directors only). This includes a separate declaration, amendments to Directors' contracts/letters of appointment, additional checks around insolvency and disqualification and revised Recruitment Policy	• 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	None at present	None outstanding – CQC satisfied with current arrangements following last inspection
G5 – NHS Improvement 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 May 2023.	None identified at present	Continue to track new guidance through appropriate committee on publication
G6 – Systems for compliance with	Systems and processes are currently set up to ensure compliance with	• Annual review – Licence Compliance undertaken	None identified at present	Compliance with Licence conditions formally

Licence Condition	Current position	Assurance	Gap	Action
licence conditions and related obligations (i.e. NHS Acts and Constitution)	provisions of the Licence and other mandatory requirements; risk set out in BAF. Constitution reflects current legislation.	• Integrated Performance Report links to NHS Oversight Framework • Certification produced in accordance with paras 10 and 11 of this Condition annually covering financial year. • Monthly Board and assurance committee oversight of BAF.		reviewed by the Board as part of its annual work plan.
G7 – Registration with the Care Quality Commission	Currently registered without conditions for all relevant services.	Overall rating 'good' (April 2021).	None identified at present	Continue with regular engagement meetings with CQC; ensure NHSI informed of all key issues.
G8 – 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	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 equality of service access within Annual Report for 2022/23.

Licence Condition	Current position	Assurance	Gap	Action
		where any ambiguity exists for example with regard to age limits (16 – 18) and where adult transition services are not established		
G9 – Application of S.5 (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 2 – Pricing				
P1 – Recording of Information	Under this condition NHSI may require licensees to record information on their costs in line with guidance. They may also require licensees to record other information, e.g. quality and outcome data to support NHSI in carrying out its pricing functions. PLICS has been developed and is actively used by Divisions routinely and as part of GIRFT and specialty reviews; and the finance team have developed a suite of reports in support of service line reporting.	• Reports to RBD and Audit Committee • Trust submits National Cost Collection data to NHS England & Improvement in line with timetable and guidance • NHS Improvement costing information, methodologies and governance is rated as above average of all trusts in England. • Suite of quarterly reports to Divisions regarding service line, consultant, procedure and patient level cost and income performance.	None identified at present	Continue to develop and refine reporting / costing at service line level / patient level costing.

Licence Condition	Current position	Assurance	Gap	Action
P2 – Provision of information	As G1 above. NHSI places particular emphasis on the availability of consistently recorded and accurate information on costs to enable them to set prices for NHS services at an appropriate level.	Reports to RBD and Audit Committee. The Trust assess its costing processes against NHSE&I's assessment framework. The costing processes scored 88% for 2022/23 against the assessment framework, which is higher than the average of our peer group (85%) and all trusts nationally (also 85%).	None identified at present	As above P1
P3 – Assurance report on submissions to NHSI	Links to P2 above – NHSI will require assurance on the accuracy of the costing information provided.	Reports to RBD and Audit Committee as required.	N/A	N/A
P4 – Compliance with the National Tariff	This condition imposes an obligation on providers as well as commissioners to charge for NHS services in line with National Tariff.	Reports to RBD and Audit Committee as required. Contracts signed with commissioners based on national standard contracts. Impact of national tariffs reflected in financial plans agreed by the Board.	None currently identified	None from a compliance perspective
P5 – Constructive engagement concerning local tariff modifications	The Act gives NHSI responsibility for setting the process and rules around local pricing modifications. This condition requires licensees to engage constructively with commissioners to try	Reports to RBD	None currently identified	Trust will follow guidance as and when applicable and where local pricing modifications are agreed with Commissioners

Licence Condition	Current position	Assurance	Gap	Action
	to reach local agreement before applying to NHSI for a local modification. Deputy Director of Finance works closely with local commissioners (ICBs) to address specific service issues.			(ICBs) which meet NHSI's criteria for notification.
Section 3 – Choice and Competition				
C1 – The right of patients to make choices	This condition requires licensees to notify their patients when they have a choice of provider either under the NHS 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.	Reports to RBD re contract performance. 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	None currently identified	Patient information leaflets updated as required to include aspects on choice where appropriate
C2 – Competition oversight	This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	This will be considered on a case-by-case basis when the Trust bids for or establishes contractual arrangements for the provision of services. Trust follows relevant guidance where applicable.	None currently identified	None currently identified

Licence Condition	Current position	Assurance	Gap	Action
		Major contract changes reviewed and approved by the Board and or R&BD.		
Section 4 – 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 and new models of delivery. Significant partnership work has continued in-year, detailed in the Trust's Annual Report.	Reports to BoD Annual Report.	None currently identified	None from a compliance perspective
Section 5 – 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 G9 above	See G9 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 and financial management	Trust has robust corporate and financial governance arrangements that are compliant with all relevant guidance including that issued by NHSI	Internal and external audit reports provided to Audit Committee, Board and Governors. Annual Governance Statement, HoIAO, CQC well-led inspection and monthly	None currently identified	Track any updates and changes to guidance

Licence Condition	Current position	Assurance	Gap	Action
		monitoring of financial and performance risks.		
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	N/A	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	N/A	N/A
CoS6 – Co-operation in the event of financial distress	This condition applies when a licensee fails to meet the test of sound financial management (as per CoS3) under the RAF, in which case the licensee is required to provide information to 3rd parties as directed by NHSI and allow access to premises. We are currently rated as 2 under the SOF.	Integrated Performance Report scrutinised by RBD and BoD and Exec Performance Reviews oversee operational delivery.	None identified	Trust financial position and risks to delivery continues to be subject to regular review and update

Licence Condition	Current position	Assurance	Gap	Action
CoS7 – Availability of resources	This condition sets out the Board certification requirement which aims to provide NHSI 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.	All previous updates to certification requirements have been fulfilled either by the entire Board or by RBD as part of its delegated authority.	None identified	Certificate to be drafted for consideration by the Board to the required timescale and to be available for NHSI audit purposes. The Trust has forward plans in place that meet this condition.
Section 6 – NHS Foundation Trust Conditions				
FT1 – Information to update the register of NHS foundation trusts	Trust constitution, annual report, annual accounts and auditor's report have been consistently provided to NHSI within the specified timescales.	Reports to the Board. Publication of Trust information on NHSI's website	None identified	Ensure any changes to guidance are tracked e.g. amended requirements in the ARM
FT2 – Payment to Monitor in respect of registration and related costs	This condition creates the provision for Monitor to charge fees specifically to FTs for the cost of regulation e.g. maintaining registers etc. No decision has yet been taken by NHSI/Monitor as to whether this will be put into practice however a separate consultation is planned. NB Monitor has had the power to levy fees from FTs since 2004 but has chosen not to do so.	N/A	N/A	N/A
FT3 – Provision of information to advisory panel	The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	Governors are provided with all Board papers and full information about the Trust via briefings and at regular meetings. Key issues presented to Governors at every meeting	None currently identified	Ensure any new Governors are aware of the process for submitting a query to the Panel as part of induction

Licence Condition	Current position	Assurance	Gap	Action
	NB. The Act requires a majority of governors to support the submission of a query following consideration at a full meeting of the Council of Governors.	Governors are regularly reminded that they are able to observe Board and Committee meetings.		
FT4 – NHS foundation trust governance arrangements	This condition builds upon the existing requirements set out in the Code of Governance and other guidance documents including the ARM. The Trust has consistently complied with the requirements to demonstrate the effectiveness of its governance arrangements.	External and internal audit reports to Audit Committee. There is a well-developed committee structure supported by approved terms of reference (reviewed annually). Board assurance committees are subject to an annual effectiveness review to ensure that they are discharging their duties as defined in their terms of reference. The Trust has a robust governance framework in place as outlined in the Annual Governance Statement.	None identified at present	Continue to ensure requirements are adhered to.

Erica Saunders
June 2023

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Alder Hey Children's NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2022/23

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	[including where the Board is able to respond 'Confirmed']
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed']
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']

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

Signature  **Signature** 

Name Dame Jo Williams **Name** Louise Shepherd

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Financial Year to which self-certification relates **2022/23**

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

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

Signature		**Signature**	
Name	Dame Jo Williams	**Name**	Louise Shepherd
Capacity	Chair	**Capacity**	Chief Executive
Date	27 June 2023	**Date**	27 June 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A	

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Alder Hey Children's NHS Foundation Trust *Insert name of organisation*

NHS Improvement

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2022/23** Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

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

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

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

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed Please fill details in cell E22

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

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

The Trust Board have reviewed the cash balances and resources available and conclude there is adequate resources within the Trust. The Board have also considered the financial governance framework that operates within the Trust and a set of scenarios in assessing the ability of the organisation to respond to any unforeseen financial challenges. For these reasons, the Board see itself as a going concern basis in preparing the accounts

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

Signature		**Signature**	
Name	Dame Jo Williams	**Name**	Louise Shepherd
Capacity	Chair	**Capacity**	Chief Executive
Date	27 June 2023	**Date**	27 June 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.