BOARD OF DIRECTORS EXTRAORDINARY PUBLIC MEETING

Thursday 26th June 2025, commencing at 16:00

via Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**25/26/88**	**16:00 (2 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/89**	**16:02 (3 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
Year End Closure for 2024/25							
3.	**25/26/90**	**16:05 (20 mins)**	**Draft Annual Report and Accounts for 2024/25:** • **External Audit Year-end Report, 2024/25 – 'ISA260'.** • **Letter of Representations.**	E. Saunders/ R. Lea/ K Byrne E&Y E&Y	To approve the Trust's draft Annual Report and Accounts for 2024/25. To receive the External Audit year-end report for 2024/25 and the letter of representations.	**R/D**	Read report *(to follow)*
4.	**25/26/91**	**16:25 (25 mins)**	**Committee Annual Reports 2024/25:** - **Audit and Risk Committee.** - **Finance, Transformation and Performance Committee.** - **Safety and Quality Assurance Committee.** - **People Committee.** - **Futures Committee.**	K. Byrne J. Kelly F. Beveridge J. Revill S. Arora	To receive the 2024/25 annual reports of the Assurance Committees that report into the Trust Board.	**A**	Read reports

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
5.	**25/26/92**	**16:50 (5 mins)**	**Board Self-Certification of Compliance with the Provider Licence.**	E. Saunders	To approve the proposed confirmation of compliance with condition CoS7: Availability of Resources in the Provider Licence.	**R/D**	Read report
Items for information							
6.	**25/26/93**	**16:55 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
7.	**25/26/94**	**16:59 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 3rd July 2025, Lecture Theatre 4, Institute in the Park.							

BOARD OF DIRECTORS
Thursday, 26th June 2025

Paper Title:	2024/25 Committee Annual Reports
Report of:	Committee Chairs
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☐ To approve ☑
Summary/ supporting information:	The Board is asked to approve the Committee Annual Reports detailing assurances in respect of compliance against individual Terms of Reference for 2024/25.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Impact:	None identified

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

Audit & Risk Committee Annual Report 2024/25

The Audit and Risk Committee

The Audit & Risk Committee (ARC) has primary responsibility for reviewing the effectiveness of the framework for the identification and management of risks and associated controls, corporate governance and assurance frameworks.

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

This report outlines how the Committee has complied with the duties delegated by the Board through its Terms of Reference, developments it has undertaken throughout the year, key assurances that it can provide to the Board and proposed developments for 2025/26.

Constitution

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

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

The ARC Chair presents a Chairs 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 Assurance Committee. Final minutes are also submitted to Board once approved.

Work undertaken in 2024/25 in accordance with Terms of Reference

In discharging its duties, the Committee meets its responsibilities through requesting assurances from internal and external sources and reassurance from management 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 main areas of its responsibility.

Risk Management

The Committee receives the following reports to each of its meetings[1] (all of which have previously been to the Risk Management Forum (RMF) the Executive risk meeting which undertakes the detailed review of risk across the Trust, reporting into ARC):

- **Board Assurance Framework** (BAF) which includes updates on each of the risks provided by the Executive Risk Owners. Whilst the Committee reviews the BAF in respect of compliance with the Risk Management Framework, oversight of the individual risks is undertaken by the Board or one of the other Assurance Committees. ARC refers any areas of query or concern to those Committees for investigation.
- **A report from the RMF** which provides:
  - A report on the Corporate Risk Register (CRR) outlining the current risk themes, actions taken and any barriers to their mitigation. The report also includes analysis of the CRR, highlighting new risks, those with changed risk scores or that are longstanding, and actions taken.
  - A summary of the "deep dives" that the RMF has undertaken in key risk areas. In 2024/25 these included pre-employment HR checks, the Gender Development Service and inpatient admission errors.
  - The approved minutes from the prior RMF meeting.
- **An analysis of the Trust Risk Register** (all Trust risks including those on the BAF and CRR) highlighting the number and percentage of risks by score, static and longstanding risks, those overdue review 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.

Across the year, each of the Divisions presented to ARC on the risk management processes within their Division. The CCAO and ADN&G present on behalf of the Corporate Services. This provides an opportunity for ARC to understand how the Divisions and Services oversee and manage risk on a day-to-day basis.

The RMF presented its Annual Report on Risk Management for 2024/25 to the April 2025 ARC meeting. Chaired by the CCAO, 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 assurances were provided by the RMF:

- Appropriate processes are in place for the oversight and management of risks and that progress against (the RMF) 2024/25 priorities have been made.
- There are robust systems of internal risk management control for oversight of operational risk management in accordance with the RMF Workplan and those systems comply with the key requirements of the Risk Management Strategy.
- The management of risk and the focus on safety continues to be a top priority for the Trust.
- RMF has provided evidence and assurance that in its delegated authority from ARC, RMF is fit for purpose.

[1] Except the June meeting which focuses on the Annual Report and Accounts

Assurance Committee Annual Reports are presented to ARC before onward presentation to Board. Each Annual Report included a section on the oversight of the BAF risks within each Committees' remit describing the deep dives they have undertaken and the reports they have received that support oversight of the risks. All the Assurance Committees provided the following assurance within their report:

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

InPhase (Risk and Incident Management System): ARC retained oversight of the InPhase "Phase 2" Programme in relation to the implementation of the remaining modules (Legal / Claims, NICE Guidance, Central Alert System, Morbidity & Mortality, Nursing Audits, Volunteering Management and FTSU). The project is being overseen jointly by the Trust's Chief Nursing, AHP and Experience Officer and the Chief Transformation and Digital Officer (CTDO). Assurance was provided that the core system remains safe and robust, with progress in several modules. However, significant development for the Phase 2 modules was hindered by the lack of an in-house InPhase Systems Developer. The system has not, therefore, fully realised triangulation of data from all the modules which was a key driver in purchasing the software. A Systems Developer took up post in March 2025 and progress updates will continue through 2025/26.

Risk Appetites and Tolerances Roll-out: Following approval of the Risk Appetite Statements and corresponding Risk Tolerances by the Board[2], ARC was kept appraised of the structured approach being taken to implement the Risk Tolerances starting in the Community & Mental Health Services Division. The roll-out programme will continue into 2025/26, and ARC will maintain oversight.

Fraud Risk Assessment Matrix: The Trust revisited its detailed fraud risks which are recorded in Excel in a format provided by the Government Counter Fraud Profession. Updates were made to risks where appropriate and risks that score 10+ are recorded on the Trust's Risk Register. Assurance was provided that fraud risks are being actively managed and mitigated where possible.

Management reassurances on key risks

During the year the Committee received Annual Assurance Reports for 2024/25 and Forward Plans 2025/26 for key areas of risk. The following pages summarise key information and assurances within these reports.

Clinical and Non-Clinical Claims

(To be completed following presentation of Clinical and Non-Clinical Claims Annual Reports to June meeting).

Project Assurance

The Delivery Management Office provides semi-independent assurance on adherence to programme management standards for strategically important projects to deliver the Trust's Vision 2030 Strategy. Assurance ratings are provided for delivery of the seven strategic programmes in milestone completion % rates – it must be noted however, that this is a two-year forward programme, hence why completion is not 100% at this stage.

At the year end the % of milestones delivered was:

- 80% for 'CYPF Engagement & Experience'.
- 85% for 'Supporting Our People'.
- 70% for 'Collaborate for CYP'.
- 70% for 'Revolutionise Care'.
- 60% for 'Futures'.

[2] Except for Research and Innovation which will be developed during 25/26

Data Quality
Data Quality (DQ) is the cornerstone of good quality reporting and poor data quality can lead to information being both inaccurate and misleading. The Trust's DQ Strategy aims to "strive to achieve the highest quality of data that is parallel to the outstanding care that we provide".

The CTDO provided a detailed report summarising the Trust's DQ 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 2024), the Trust had a DQMI score of 90.6, in comparison to a national average of 73.5. Our DQMI score is in line with our peers (Birmingham Women's and Children's, Great Ormond Street and Manchester University Trusts).

Commissioning Data Set (CDS) Data Quality Dashboard (April 2024 – February 2025):

- Performance of Admitted Patient Care submissions is to a high standard with 15 of 22 areas green therefore performing at the national standard.
- Performance for Outpatient data is to a high standard. 18 of 22 metrics are green.

Clinical Coding Data Security and Data Protection Audit 2024/25 shows the Trust to be exceeding national clinical coding standards.

There are no data security risks on InPhase rated 15+.

Cyber Security
ARC received a report from the CTDO providing assurance of the Trust's cyber security performance against NHSE national priorities as summarised below along with the forward Workplan for 2025/26.

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 Microsoft Advanced Threat Protection is enabled across your device & server estate	
5	Clear policies and processes around secure configuration and management of Active Directory	
6	Maintain supported systems	

NOTE: Priority 1 was rated amber due to work currently underway to assess non critical systems criticality and compliance.

ARC received a detailed report on the cyber security incident that occurred (in late November 2024) to the Trust and its shared digital service partner (at the time), Liverpool Heart and Chest Hospital Assurance was provided that no Trust data was accessed or compromised and emergency business continuity protocols were immediately activated. A number of actions were taken to mitigate the risk of recurrence and a full review of existing cyber risks was undertaken to identify additional mitigations. In July 25 ARC has scheduled a standalone session, which will be provided by the CTDO, to focus on lessons learned from the incident and also from the ceasing of the digital partnership.

Data Protection and the Data Security & Protection Toolkit (DSPT)
The Trust is registered as a Data Controller with the Information Commissioners Office (ICO). Each quarter, ARC received a summary of key data protection activities undertaken to support compliance with data protection principles outlined in the Data Protection Act 2018 (DPA 2018) and NHS specific requirements within the annual DSPT.

The DSPT v7 for 2024/25 has undergone significant change to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance (IG) assurance. The DSPT interim assessment for 2024/25 was submitted in December 2024, with the final submission due in June 2025. It is anticipated regionally and nationally that a significant volume of organisations will not meet all the minimum expected achievement levels. For any objectives not met an Improvement Plan is to be submitted to NHSE

following the final submission. An internal action plan, supported by any recommendations provided by MIAA as part of their annual audit, will form the basis of our actions and Improvement Plan.

Key performance data:

- Subject Access Requests and Disclosure of Personal Data – compliance and performance against statutory timeframes for disclosure of health records under the DPA 2018 remains in a strong position. 1,753 requests were received to end February 2025 with **99.95%** compliance achieved.
- No data security incidents were reported to the ICO during 2024/25.
- The DSPT IG data security training requirement is for 95% of staff to be trained. As at 31 March 2025 **89.19%** of staff were trained. In 25/26 ARC will oversee actions to increase compliance.

Freedom of Information Act 2000 (FOIA) Compliance
An overview of FOIA activity during 2024/25 including a summary of compliance with FOIA legislation was received. Analysis of the types of requests was provided as well as details of exemptions with reasons. A Forward Plan for 25/26 outlined the priorities for the coming year.

Key performance data:

- 698 FOIA requests were received and actioned to the end of February 2025; a 7% increase from the prior year with requests becoming more voluminous, detailed, and complex. Overall, compliance of responses within the prescribed 20 working day timeframe was **90.68%**.
- There are no risks on the risk register relating to FOIA compliance.
- There have been no formal Information Notices or enforcement actions received from the ICO in relation to the Trust's practices or compliance.

Alder Care Lessons Learned
A summary report of NHSE's independent assurance review of the Trust's transition to the new electronic patient record system, Meditech Expanse 2.1, (internally branded as "AlderCare") was received. The review concluded that AlderCare is a safe, effective system and, while the implementation was largely successful, the Trust was encouraged to address technical and support-related gaps and prepare strategically for further upgrades.

ELFS Payroll Service
ARC received a third-party assurance report summarising the findings of Grant Thornton's audit of payroll controls within ELFS Business Services and Advanced Business Software & Solutions Ltd, providers of the Trust's payroll service. Assurance was provided that the payroll controls were suitably designed and operating effectively.

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. In 24/25 there were no advisory engagements.

ARC approved the Internal Audit Plan for 2024/25 which is structured to enable the Head of Internal Audit to provide an annual opinion which is based on the:

- Individual assurances arising from risk-based internal audits taking into account the relative "materiality" of the systems reviewed and management's progress in respect of addressing control weaknesses identified.

- Design and operation of the underpinning assurance framework, risk management systems and supporting processes.
- Organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Throughout the year, MIAA provide a summary of the audit reports issued and management's response to address them. For any reports that are assessed as "Limited" or "No" Assurance a senior representative from the audit area is invited to ARC to present their detailed action plan to address the findings. The Cyber Assessment Framework Part 2 audit received Limited Assurance and the CTDO will be invited to the July 25 ARC meeting to present the action plan.

The Internal Auditors also undertake a quarterly exercise to assess the implementation of agreed actions that have passed their implementation deadline. During the year ARC remained focussed on progress against overdue actions to encourage the timely closure of any gaps in the control environment. ARC approval is required to extend the implementation deadline of actions if the original agreed deadline has not been met.

34 actions were reviewed for implementation and the status confirmed to be 27 (79%) were implemented and 7 (21%) were partly implemented. In addition there were 12 actions that had not reached their implementation deadline at year end.

The key conclusion from MIAA's work for 2024/25 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.

During the year a "light touch" effectiveness review of the internal audit service was undertaken by ARC. This was undertaken via completion of a single question response by ARC Members and appropriate Attendees. Positive feedback was received specifically highlighting Internal Audit's understanding of the Trust and our environment, flexibility, communication, independence and objectivity. No significant weaknesses were identified and no new recommendations were raised (over and above the ongoing recommendations from the prior year, detailed exercise).

Counter Fraud Service (CSF)

The CFS is also 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 and fraud exercises such as the National Fraud Initiative data matching exercise.

The planned work is submitted to ARC for approval in the Counter Fraud Annual Workplan. Throughout the year regular updates are provided along with an Annual Report on the delivery of the Workplan. During the year the CFS undertook two counter fraud reviews (NHSCFA National Procurement Exercises) in relation to Due Diligence and Contract Management. There were no significant gaps identified within processes in relation to Due Diligence. The final report from the Contract Management exercise is expected in 25/26.

As a result of investigations undertaken by the CFS, ARC requested additional work from management in relation to two areas:

- Compliance with the NHS Employment Check Standard Audit. Following a 100% check on the recruitment files of all current staff by HR a number of gaps in key HR documents recorded on the electronic staff record (ESR) were identified. A review of paper HR records was undertaken and documents were added to ESR and, for remaining gaps, documents were obtained from staff where possible. Following this the Committee were assured by the increase in compliance across all areas of the NHS Safer Recruitment Standards and, for areas that hadn't quite reached 100% compliance, the Committee was satisfied with the final outcome given the measures in place and low level of risk remaining.

- Processes to identify if lease cars are held by staff leaving the Trust. Finance provided reassurance to confirm the actions taken to recover the debt owed by an employee who had left the Trust where their lease car obligation had not been identified along with details of additional and tightened controls to prevent recurrence.

The CFS assists the Trust to undertake the annual self-assessment against the "Government Functional Standard 013 for Counter Fraud." The Trust received a 'Green' rating overall and across all 12 components.

During the year the first effectiveness review of the CFS was undertaken by ARC. This was undertaken via completion of a detailed questionnaire by ARC Members and appropriate Attendees. The questionnaire sought ratings of "Agree", "Disagree" or "Unable to Answer" against a series of statements relating to mandate and strategy, stakeholder management, risk assessment and planning, leadership, competence and culture, reporting and funding (resources) as well as providing space for free text feedback. Positive feedback was received specifically highlighting the Counter Fraud Specialist's:

- Significant experience, commercial understanding and judgement gained through her long-standing input to the Trust.
- Understanding of the NHS and the Trust's fraud risks.
- Standing, credibility and impact within the Trust and at ARC.
- Comprehensive and timely response to referrals.
- Support to the Trust's Counter Fraud Champion (CFC).

No significant weaknesses were identified. Recommendations were raised by ARC which included:

- Providing visibility of the fee for the service, the number of days provided and how they are allocated across the various work areas.
- Provision of benchmarking / sector learning / good practice.
- Providing separate reports of the outcome of National and Local Proactive Exercises and Follow Up of Previously Agreed Recommendations.
- Changes to the format and presentation of the Progress Report to more explicitly highlight key messages and improve its impact.
- Creating a network of CFCs and providing guidance as to how to undertake this role effectively.

Clinical Audit

ARC is responsible for the oversight of Clinical Audit but detailed oversight is undertaken by Safety & Quality Assurance Committee (SQAC) as outlined its Terms of Reference. Formal assurance is provided to ARC from the Clinical Audit Team on the delivery of the Clinical Audit Plan and from SQAC as to the effectiveness of the Clinical Audit service. The Committee received the Annual Report for 2024/25 which reflects mandatory national and regional audits, Confidential Enquiries and Trust-wide priority audits, fulfilling the requirements of the NHS Quality Contract and Trust Quality Account.

The Annual Report for 24/25 contained the following assurance statement:

Delivery of the Trust Clinical Audit Plan (including national, regional and trust priority audits) has been delivered in line with accepted practice with the exceptions of:

Submission of data for the nationally mandated UK Renal Registry Chronic Kidney Disease Audit

We did not submit a complete data set for this audit because the UK Renal Registry Annual Report 2021 (published in June 2023) noted several gaps in the data fields from the Trust due to IT issues. A plan of support has been developed for the design and implementation of the data collection forms in AlderCare.

Work is currently underway with the UK Kidney Association for the direct transfer of data from AlderCare to Renal Registry. A test dataset has been sent which should reduce the number of

missing data and reduce the manual data entry required of the current system. Digital, together with clinicians, are currently working to accurately identify all eligible patients, and the registration criteria, from AlderCare. Risk 247 remains on the risk register with a score of 4.

Submission of data for the nationally mandated Respiratory Audit Programme (NRAP) – Paediatric Asthma Secondary Care
We did not submit a complete data set for this audit because there is currently a discrepancy in the data between the number of patients that have been identified by the Trust information systems as eligible for the NRAP audit and those identified by NHSE. Whilst 137 submissions have been made during 24/25, further data submissions ceased in December 2024 until clarity on the eligible cohort or submission has been provided from iDigital. This has been escalated to the Medicine Division triumvirate and iDigital for further support.

External Audit

External Audit continues to be provided by Ernst & Young (EY). The following reports were received from EY relating to 2024/25:

- External Audit Planning Report for the year ended 31 March 25.
- Auditors Annual Report for the year ended 31 March 25.
- 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 (“Letters of Representation”) and provision of specific information in relation to oversight and management of risk relating to the financial statements (Letter titled “Understanding how the Audit Committee gains assurance from management”). The ARC Chair and Interim CFO will sign these documents on behalf of the Trust before the accounts are finalised.

An unqualified opinion on the accounts for 2024/25 was provided to ARC in June 2025.

During the year a “light touch” effectiveness review of the External Audit service was undertaken by ARC. This was undertaken via completion of a single question response by ARC Members and appropriate Attendees. Positive feedback was received specifically highlighting:

- The Partner’s engagement, fair and proportionate responses, willingness to understand the Trust’s position, needs and resource required.
- The Manager being supportive and engaged, taking time to listen to Trust issues and being a credit to EY.
- Consistency of the team in recent years.
- Communication and objectivity.

No significant weaknesses were identified and no new recommendations were raised (over and above the ongoing recommendations from the prior, detailed exercise).

Finance

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

- Annual Accounts 2024/25.
- Statement of Going Concern explaining why it is appropriate to prepare the Trust’s Accounts on a going concern basis.
- Accounting policy updates including to the Corporate Governance Manual and the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation.
- Waiver (of SFIs for procurement) Activity Reports provided by Health Procurement Liverpool (HPL).

- Update on the action plan for property valuations following weaknesses identified in this process in the 23/24 audit (Capital Improvement Plan update).
- Shareholders Register.
- Compliance with the Procurement Act 2023 provided by HPL.

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

Internal Audit Resources

In approving the Internal Audit Plan in recent years, ARC recognised that an increasing proportion of days are required for "mandated" audits leaving fewer days to be directed to areas of Trust priority. Therefore, a benchmarking exercise to compare the size of our Internal Audit Plan to Trusts of similar size and complexity within the Cheshire & Mersey region was undertaken. This exercise identified that our Plan was significantly smaller than the comparator organisations and should increase from 190 days a year to 235. Given the significant increase, a stepped approach with an increase to 225 days in 24/25 followed by a further increase to 235 days in 25/26 was approved.

Approach to the ongoing review of the effectiveness of ARC, Internal Audit, External Audit and the CFS

There are several requirements from external organisations needed to demonstrate the effectiveness of ARC and its assurance providers. The NHS Audit Committee Handbook requires an annual review of Internal Audit and the CFS effectiveness and also suggests that the Committee should review its own effectiveness annually. Whilst The Code of Governance for Provider Trusts requires that an annual review of External Audit be undertaken. Recognising that this could result in significant work for the Committee and its Members and Attendees, ARC agreed a five year forward schedule of full and light touch reviews such that external requirements are met in a pragmatic way as shown below:

Assessment / Year performed	**24/25**	**25/26**	**26/27**	**27/28**	**28/29**	**29/30**
ARC self-assessment	**Full**	Light	ToR Compliance	**Full**	Light	ToR Compliance
External Audit	Light	Light	**Full**	Light	Light	**Full**
Internal Audit	Light	**Full**	Light	Light	**Full**	Light
Counter Fraud Service	**Full**	Light	Light	**Full**	Light	Light

Detailed self-assessment of the effectiveness of ARC

In line with the above table, a detailed self-assessment of ARC was undertaken. No significant actions were identified; the following actions were agreed. To:

- Introduce an additional meeting into the calendar, recognising that all existing meeting agenda are full leaving little room for reflection and horizon scanning.
- Introduce a standalone agenda item to enable horizon scanning of risks.
- Ask external paper providers to adopt the Trust's in-house cover sheets to provide an executive summary to their report
- Consider whether there are any external service providers for which we might wish to request a third-party assurance report (ISAE 3402). (We already regularly request this from ELFs for the payroll service).
- As the ADN&G to review the reporting provided to both SQAC and ARC in relation to Clinical Audit to minimise duplication whilst ensuring both Committees receive the assurance they need.

Other key documents reviewed

- ARC Terms of Reference and Workplan.

- ARC Annual Report 2024/25.
- Update on the progress against ongoing actions from previous ARC self-assessments and effectiveness reviews of internal and external audit.

Trust Governance

- Draft Annual Governance Statement.
- Trust Annual Report 2024/25.
- Annual Reports of the Trust's Assurance Committees.
- Gifts & Hospitality Register.
- Policies and Strategies Approved or Ratified – Fraud, Bribery and Corruption, Conflicts of Interest and Financial Governance.

Developments in 2024/25

The key developments during the year (which are described in detail in the section above) are:

- Completion of the first effectiveness review of the CFS along with agreement of a pragmatic forward plan for the annual assessment of effectiveness of ARC, Internal Audit, External Audit and the CFS.
- Commencing the roll-out of the Risk Tolerances throughout the Trust.
- Completion of a benchmarking exercise to compare the size of the Trust's Internal Audit Plan to those of Trusts of a similar size and complexity within the Cheshire and Merseyside region. Based on the results of this exercises, ARC approved an increase from the current 190 days per year to 235 recognising the increased proportion of days now required for 'mandated' or 'expected' audits and significant changes in the NHS environment. Given the increase was significant, and this impacts on management's time, the Plan for 24/25 was increased to 225 days and a further review will be undertaken to consider the further increase to 235 days.

Assurance Statement

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

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

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

Committee Developments and Priorities for 2025/26

Whilst the Committee has performed its duties as delegated by the Board and mandated through governance requirements, in the forthcoming year specific focus will be given to the following matters (in addition to the Committees core duties):

- Further roll-out of the Risk Tolerances.
- Oversight of InPhase Phase 2 project implementation.

- Introduction of a specific agenda item “Risk Horizon Scanning” to anticipate upcoming risks, particularly those arising from the external environment.
- Agree (with SQAC) the information and assurances provided to both Committees from Clinical Audit.
- Agreement of a schedule of deep dive reviews of the BAF risks such that each risk is reviewed by ARC throughout the year (in addition to a general review of the BAF at each meeting).

Kerry Byrne, Audit and Risk Committee Chair
June 2025

AUDIT AND RISK COMMITTEE – RECORD OF ATTENDANCE 2024/25

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

Member/Date of Meeting	2024				2025	TOTAL	
	Apr	June	July	Oct	Jan		
MEMBERS							
Kerry Byrne (Chair) Non-Executive Director	✓	✓	✓	✓	✓	**5 / 5**	**100%**
Gerald Meehan Non-Executive Director	**x**	✓	**x**	✓	✓	**3 / 5**	**60%**
Jo Revill Non-Executive Director	✓	✓	✓	✓	✓	**5 / 5**	**100%**
Quoracy achieved	**YES**	**YES**	**YES**	**YES**	**YES**	**5 / 5**	**100%**
ATTENDEES							
John Grinnell Chief Executive	✓	✓	✓	**x**	**N/A**	**3 / 4**	**75%**
Emily Kirkpatrick Deputy Director of Finance	✓	✓	**x**	✓	✓	**4 / 5**	**80%**
Rachel Lea Interim Chief Financial Officer	✓	✓	✓	✓	✓	**5 / 5**	**100%**
Erica Saunders Chief Corporate Affairs Officer	✓	✓	✓	✓	✓	**5 / 5**	**100%**
***Adam Bateman** Deputy Chief Executive / Chief Operating Officer	✓	N/A	✓	✓	✓	**4 / 4**	**100%**
Jackie Rooney Ass. Dir. of Nursing & Governance	✓	✓	**Deputy**	✓	✓	**5 / 5**	**100%**
Ernst & Young (External Audit)	HR	HR/DS	N/A	**x**	DS	**4 / 5**	**80%**
MIAA (Internal Audit)	GB/KS	KS	KS	KS	GB/KS	**5 / 5**	**100%**
Counter Fraud Service	VM	N/A	N/A	VM	VM	**3 / 3**	**100%**

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

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

Counter Fraud Service (MIAA) Representative:
Ms V Martin (VM)

Finance, Transformation and Performance Committee Annual Report 2024/25

The Finance, Transformation and Performance Committee

This report provides a summary of Finance, Transformation and Performance Committee (FTPC) activities and assurance that the Committee has carried out its obligations in accordance with its Terms of Reference and work programme for 2024/25 and identifies key actions to address developments in the Committee's role.

The Finance, Transformation and Performance 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
- 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]
- Managing Director/CFO
- Director of Finance and Development
- Chief Operating Officer
- Chief People Officer
- Chief Transformation and Digital Officer
- Managing Director of Innovation
- Director of Corporate Affairs
- Director of Marketing and Communications
- Development Director
- Chief Strategy and Partnerships Officer

Expected to attend each meeting is: Associate Director of Finance, Deputy Director of Finance, and Director of Transformation.

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 2024/25

Assurance on five FTP Key Risks

- Regular assurance reports were received on the following:
    1) Immediate financial performance including system position.
    2) Capital Programme.
    3) Efficiency Programme.
    4) Benefits realisation governance and prioritisation of Change Programme to 2030
    5) The Campus & Park developments

Details of assurances received are listed below.

Quarterly meetings with deep dives on divisional performance

The Committee continued to meet with all divisions on a quarterly (face-to-face) basis to review activity, spend, CIP position, productivity and performance along with actions taken to improve the financial position. Mitigation plans and forecast position for each division were received to provide assurance around future financial sustainability. These included greater awareness and understanding of costings and coding, income generating opportunities, transformation proposals linking to Vision 2030 and how we will work 'smarter' in the future, focus on WTE numbers, and re-introduction of the mutually agreed resignation scheme.

Financial and Operational Performance

- At its April 2024 meeting, the committee received the 2023/24 year-end financial position report for 2023/24 noting a reported £10.3m adjusted financial performance surplus against a target of £12.3m. The cash balance position at M12 was reported at £78.2m. Our capital expenditure was report as £25.3m, this later reduced to £23.1m following audit adjustments, and the Trust delivered its cost improvement plan target of £17.7m.
- The draft 2025/26 Annual Plan was received ahead of Trust Board approval in March 2025. FTPC noted the significant challenge ahead for Cheshire & Merseyside and risks to achieve break even plan as drug cost pressures, the pay award gap, ERF cap, delivery of CIP and changes to PFI accounting.
- The Committee regularly monitored the agreed financial metrics in the Integrated Performance Report and received substantive updates with regard to specific issues identified. Particular attention was given to performance against national treatment time targets and efforts being taken to reduce waiting times including new models of care and better use of technology and the optimisation programme.
- FTPC received the outputs from the piece of work undertaken to look at bank spend against sickness across the Trust. It was reported that despite a reduction in sickness there had been an increase in bank expenditure to cover sickness. Work remains ongoing in relation to financial controls and close monitoring.
- Monthly financial position reports were received in-year detailing surplus position, CIP posted to date, updates in respect of the wider Cheshire and Merseyside plans and overall control total. In addition, regular updates on the 2024/25 financial efficiency programme were presented clearly detailing immediate actions taken to address the level of risk to delivery of full efficiency target. The position reported at 25th March 2025 was a surplus of £1.8m YTD, which was off plan due to the impact of the pay award not being fully funded.
- The outputs from the external finance review mandated by NHSE was received. PWC were appointed to undertake the review which was overall positive with a recognition of the strong

controls and processes in place and demonstration of strong management of finances to deliver our plans. Nine recommendations came out of the piece of work, none of which were deemed significant and a number of these were already included in the financial improvement programme. Notwithstanding, some risks to delivery of plans were recognised and plans to mitigate were fully developed.

- The Committee received a concluding follow up report on the actions implemented as a result of the last internal review of the HFMA Finance Sustainability Audit undertaken in November 2023. Assurance was received that all areas were reported as green and that several new initiatives had been rolled out to help tighten controls. Remaining actions were rolled into a master list encompassing the NHSE and ICB Controls checklist.
- The Committee was informed of the impact in relation to industrial strike action which continued into the early months of 2024/25 with Junior Doctor strikes.
- Updates on the 5 Year Capital Plan were presented to the Committee noting the impact of 2024/25 being the final year of allocation. A Capital Management Group has been reinstated to manage the challenges around this.
- The National Cost Collection 2023/24 Post Submission Report was received which had been prepared in line with the Approved Costing Guidance. The report identified a number of areas in which the Trust is struggling to comply with and an action plan produced to address these ahead of the next submission.
- The Committee was kept well informed of the progress towards delivering a Children's Health Campus including key risks to delivery. Significant milestones on the following projects were provided during the year: commencement of the Gender Development service, Beech House (Police Station) fully occupied, completion of Springfield Park (phase 2), works completed for fracture/dermatology outpatients and final fit out of social prescribing base camp.
- Progress against the Trust's Green Plan was regularly reported to the Committee including updates on carbon emissions showing a reduction of 18% from 2021/22 to 2023/24. A number of projects were initiated during the year to contribute to CIP including national procurement on energy, replacement programme for existing bulbs to LED and assessing the use of non-sterile gloves (environmental impact).
- Procurement updates were received on a quarterly basis highlighting the major milestones achieved since implementation of the shared service. At October 2024, 68 schemes had been delivered against a plan of 75 with a full year effect savings of £484k against a planned £442k. At the December 2024 meeting the Committee were advised of the forward look to include Novembers CIP savings which was forecast to deliver an additional £429k.
- The Committee received the feedback from a procurement sprint undertaken by HPL as part of the Finance Improvement Programme. The sprint highlighted areas of good practice as well as a number of actions that are now monitored on a regular basis through SDG and FTPC. As at March 2025, 12 actions complete, 16 actions on track and 5 actions over due, to be chased and complete in Q1 25/26.
- The Committee was kept abreast of the progress against the Digital and Data Futures Strategy noting the associated challenges and mitigation plans. Updates on key areas of transformation, operational performance and progress with digital developments were provided in-year including submission of the National Digital Maturity Assessment, collaboration working with the ICB around joined up digital opportunities across Liverpool, relaunch of the Alderc@re Programme Board to support Phase2. The Committee was kept informed of the cyber security incident that occurred in-year and plans put in place to address and mitigate future occurrences.
- Work remains ongoing with Meditech to support further development and address immediate challenges through Alderc@re strategic sessions.

- FTPC approved two debt write off reports of £10,585.51 and £33,230.23 following assurance that all efforts to recover monies had been exhausted and internal controls updated minimise such costs reoccurring.
- Bi-monthly assurance reports were received by the Committee in relation to the facilities management service provided by Mitie. The report detailed planned preventative maintenance performance and progress against key issues such as energy consumption, green roof works, the corroded pipework and included remedial actions where service failure points have occurred.
- The Committee received monthly Chair's reports from the 2030 Programme Board established as the 'control room' for strategic deployment of our Vision 2030 programme. The reports detailed the work being taken forward to drive forward our strategic goals including key strategic and financial updates, programme governance and operational challenges.
- Regular monitoring of the Workforce Optimisation/Efficiencies Programme was undertaken during the year which provided assurance on the actions being taken internally to ensure grip and control on workforce numbers and agency spend following announcements from the ICB regarding workforce controls.
- The Committee received the outcome of the competitive process undertaken for provision of Occupational Health Services at Alder Hey Children's NHS FT noting a cost saving of c£40k per year with the new contract.
- The outputs from the Clinical Coding Review were received by the Committee. The report provided assurance that the Trust compares well with other organisations but that there are areas for improvement which will be taken forward through a Service Improvement Plan for 2025/26. The coding service has recently been audited independently and received a high level of assurance.
- The Committee recommended the renewal of the Meditech EPR contract to the Board of Directors for a five-year period.

<u>Strategic Partnerships</u>

- Regular updates on the development of the Surgical NICU being delivered in partnership with Liverpool Women's NHS FT were received. The reports provided assurance that key risks were being managed effectively including progress of the build, budget, operational preparedness, workforce recruitment, capacity & demand and clinical governance pathways.

<u>Committee Governance</u>

- The draft Terms of Reference and Work Plan for 2024/25 were received and approved.
- The 2023/24 Committee Annual Report was received.

<u>Board Assurance Framework</u>

- FTPC received assurance reports for Board Assurance Framework risks under its area of responsibility (risk 1.2, risk 1.3, risk 1.4, risk 3.1, risk 3.2, risk 3.4 and risk 4.2). This process proved an effective mechanism for gaining assurance to controls and any required actions.
- FTPC 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*	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	**3x5**	3x3

3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	4x2	3x2
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	**4x4**	4x2
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	**4x4**	4x3
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	**4x4**	2x4

** Joint responsibility with SQAC*

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

- *Risk 1.2 Children and young people waiting beyond the national standard to access planned care and urgent care*.
  - gaps in controls were regularly addressed through updates within the Integrated Performance Report. At M11 the position against national standards were:
    - All RTT patients who would breach 65 weeks have been provided with a treatment plan before 31st March 2025.
    - Overall DMO1 compliance for the trust remains positive at 94%.
    - During February 2025, the ED achieved 79.1% against the 4-hour KPI, higher than the national standard of 78%.
    - Average ambulance handover time is 21 minutes (within the 30-minute target).
- *Risk 1.3 Building and infrastructure defects that could affect quality and provision of services*
  - Progress against the actions to address gaps in controls were monitored on a monthly basis by FTPC through the facilities management assurance reports from the Building Services Team (referenced within report).
- *Risk 1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies*
  - gaps in controls were regularly addressed through updates within the Integrated Performance Report including key actions being taken forward to mitigate the increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. At February 2025 there were zero patients waiting over 52 weeks in CAMHS & Community Paediatrics.
- *Risk 3.1 Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus*
  - Substantive reports were received each month on Alder Hey's vision to create a 'health campus' on Springfield Park (referenced within report).
- *Risk 3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan*
  - Progress against the actions to address gaps in controls were monitored by FTPC through Chair's reports from the 2030 Programme Board (references within the report).
- *Risk 3.4 Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.*
  - Monthly 'top risks' RAG report received covering financial performance including system position, efficiency programme, capital programme, benefits realisation and campus; these reports are usually first on the agenda for discussion/assurance. In addition, substantive reports on each of the key risks are received.

- *Risk 4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families*
    - gaps in controls were regularly addressed through the Digital and Information Technology progress report with a particular focus on delivery of Vision 2030, national and regional updates, operational performance and risk.

- The application of risk appetite continued throughout 2024/25. The outputs of a working group looking at financial risk thresholds was presented to the committee for consideration as follows:
    - Alder Hey has is a MINIMAL risk appetite for risk which may compromise the Trust's compliance with its statutory duties.
    - Alder Hey has a MINIMAL risk appetite to financial risk in respect of meeting its statutory duties.
    - Alder Hey has a MINIMAL appetite for risk to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level.
    - Alder Hey has an OPEN appetite for investments which may grow the size of the organisation.
    - Alder Hey has a CAUTIOUS risk appetite for actions and decisions that whilst taken in the interest of ensuring quality and sustainability of the patient in our care, may affect the reputation of the organisation.
    - Alder Hey has a CAUTIOUS risk appetite for system working and partnerships which will benefit our local population.
    - Alder Hey is committed to providing patient care in a safe environment and has an OPEN risk appetite for risks related to the Trust's estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.
    - Alder Hey has a MINIMAL appetite for risk relating to exposure or loss resulting from a Cyberattack.
    - Alder Hey has a CAUTIOUS risk appetite in relation to delivering transformational change aligned to the Trust's Strategy.

  These recommendations were subsequently approved by the Board of Directors and work is ongoing in the form of a pilot review of all risks within the Community and Mental Health Division regarding practical application of risk tolerances and understanding the potential change to our risk profile.

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

<u>Business Cases approved</u>

- Second CT Scanner
- Development of Alder Park
- Increased ASD capacity
- Increased ADHD capacity

<u>Further assurances</u>

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

Extraordinary Meetings Held
During the year, one extra-ordinary meeting was convened to receive an updated position on the development of the Neonatal Building.

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

Assurance Statements

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

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

The Committee holds key relationships with Futures Committee enabling:

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

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

Committee Priorities for 2025/26

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2025/26:

- The Committee will continue to focus and seek assurances regarding the top five risks/key priority areas in 2025/26 which would enable the Trust to deliver its clinical, operational and financial targets;

    1) Trust Financial performance
    2) System financial performance
    3) Campus and Capital Programme
    4) Transforming Alder Hey (ways of working, futures, AI & Digital)
    5) Operational performance (productivity, access, targets, benchmarking)
- Receive reports and monitor actions with regard to the Finance Improvement Programme (FIP), Clinical Collaboratives, Fit for the Future, and any other transformation programmes that will facilitate the trust to reach financial sustainability.
- Monitoring and reporting of follow-up actions (including outputs from relevant checklists) taken in respect of its areas of responsibility.
- The Committee will continue to hold the Divisions, Digital, Data Delivery and the Campus to account for their performance and will seek to drive measurable improvements in efficiency and productivity.

- The Committee will scrutinise and review post implementation evaluations of prior year investments to gain assurance that benefits outlined have been secured, and feed lessons learnt into new cases.

John Kelly
Committee Chair
April 2025

FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE - RECORD OF ATTENDANCE 2024/25

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

Member/Date of Meeting	2024									2025			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MEMBERS														
John Kelly (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	12/12	100%
Jo Williams (Non-Executive Director)	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Shalni Arora (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	11/12	92%
John Grinnell (Managing Director/CFO)	✓	x	✓	✓	x	✓	✓	✓	x	✓	✓	✓	9/12	75%
Rachel Lea (Director of Finance and Development)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12	100%
Adam Bateman (Chief Operating Officer)	✓	✓	✓	x	x	✓	x	✓	✓	✓	✓	✓	9/12	75%
Melissa Swindell (Chief People Officer)	✓	✓	x	x	✓	✓	x	✓	✓	✓	✓	✓	9/12	75%
Kate Warriner (Chief Transformation and Digital Officer)	✓	✓	✓	✓	✓	Deputy	✓	✓	✓	Deputy	Deputy	✓	12/12	100%
Erica Saunders (Director of Corporate Affairs)	✓	x	✓	✓	x	✓	x	✓	x	✓	✓	✓	9/12	75%
Jayne Halloran (Development Director)	✓	✓	✓	x	✓	✓	✓	✓	x	✓	✓	x	9/12	75%
Dani Jones (Chief Strategy and Partnerships Officer)	✓	✓	✓	Deputy	✓	✓	Deputy	✓	x	✓	✓	✓	12/12	100%

Member/Date of Meeting	2024									2025			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Quorum achieved	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**12/12**	**100%**

ATTENDEES														
Emily Kirkpatrick (Deputy Director of Finance)	✓	✓	✓	✓	x	✓	**x**	✓	✓	✓	✓	✓	**10/12**	**83%**
Andy McColl (Deputy Director of Finance)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**12/12**	**86%**
Natalie Palin (Director of Transformation)	✓	**x**	✓	✓	**x**	✓	✓	✓	✓	✓	✓	✓	**10/12**	**83%**

Safety & Quality Assurance Committee Annual Report 2024/25

The Safety & Quality Assurance Committee

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

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

Constitution

The Membership comprises:

Non-Executive Director x 3 one of whom shall be the Chair
Chief Medical Officer
Chief Nursing Officer, AHP and Experience Officer
Managing Director/Director of Finance
Chief Operating Officer
Director of Corporate Affairs
Chief People Officer
Chief Digital Information Officer
Associate Chief Nurses x3
Head of Nursing for Research

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

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

Principal Review Areas / Achievements in 2024/25

Quality Improvement

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

- All milestones within the 'Learning from Negligence and Litigations' workstream were achieved in-year and moved to business as usual, training sessions from the GMC

including 'decision making and consent' and 'patient record keeping' have been made available to all within the Trust to support continuous improvement. In addition, Hill Dickinson now provide data sharing of learning from claims (once liabilities agreed for individual claims).

- Through the Antimicrobial Resistance Workstream, the trust secured funding for ICNet, a surveillance software package that provides an advanced data set that can be analysed to inform areas of improvement and future antibiotic prescribing.
- Implementation of the national patient safety training framework throughout the organisation through the 'Education and Training' workstream. 99.02% of our staff have completed level 1 training (March 2025).
- PSIRF training was implemented in line with national service specification to support the transition to the new framework.
- The Committee continued to receive updates in relation to the management of diagnostic notifications which, despite ongoing efforts to communicate the importance of using the system to clinicians, continued to accumulate during the year. An updated SOP was developed during the year to reflect an update in Meditech to require non-permanent clinical colleagues to assign their orders to a permanent member of staff and further reduce the risk of unacknowledged notifications. SQAC will continue to monitor this risk into 2025/26.
- A programme of work established to oversee Parity of Esteem.
- Work from the Total Parenteral Nutrition Workstream resulted in an 8% decrease in administration errors in 2023/24 compared to 2022/23 and a 45% decrease in incidents causing harm compared to previous year.
- A video 'advert' was produced by members of The Forum for the recruitment of young Patient Safety Partners. In total 55 candidates were offered the role.
- Successful implementation of Newborn Health Screening Pathways.

<u>Safe</u>

- Quarterly reports from the Director of Infection Prevention and Control were received outlining the actions being taken to ensure compliance with the expected Health and Social Care Act 2008: IPC code of practice.
  During the year the Committee noted the increased reporting of *Clostridiodes difficile* infections both internally and nationally. Following a number of investigations, a detailed report was later received providing assurance that there had been no lapses in care in relation to these cases. Plans have been developed by the IPC Team to test and isolate patients in a timelier manner and capacity for cleaning has been increased including the use of fogging machines. The Committee welcome the introduction of IPC Champions who meet monthly with divisions.
- Monthly updates in relation to continued pressures within the Emergency Department (ED) were provided to the Committee along with ED mental health attendances highlighting actions taken to ensure Children and Young People were being triaged and treated in line with national targets. These included continued Brilliant Basics support to review the triage model, ensure improvements embedded within the emergency department and Trust to maintain improvements in 4-hour performance through the Winter Planning Meetings, work to maximise efficiency with the new Primary Care provider within the UTC and the work ongoing for the Ground Floor Emergency Expansion. Year to date (February 2025) performance against national 4-hour target was 79.1%, higher than the national standard of 78%. Median time to triage for February was 15 minutes; in line with the national standard of 15 minutes.
  SQAC are assured that the Division is well sighted on the issues surrounding ED attendances and therefore agreed that these would be monitored locally with exceptional items reported on within the Medicine Division Monthly Report.

- The Committee continued to receive quarterly detailed oversight reports from the Sepsis Steering Group providing assurance against proportion of sepsis inpatients receiving antibiotics within both 90 and 60 minutes of diagnosis. Whilst the 90-minute administration target has been at or above 90% for 11 of the last 12 months, the 60-minute target for inpatients remains a challenge albeit only slightly over time in some cases. The team is continuing to focus on the appropriateness of administering antibiotics within 60 minutes and are now looking at a 45-minute window to improve the ability to establish the correct diagnosis and give appropriate treatment. The Committee continued to focus on sepsis training compliance which reported at 87% for the month of March.
  During the year, the Sepsis Steering Group continued to work closely with the BI team to develop a dashboard; this work remains ongoing along with the harmonisation of ED / inpatients data collection.
- The Committee received quarterly reports from the Drugs and Therapeutics Committee and welcomed the attention given to drug shortages during the year, including the management of associated risks. SQAC was assured that colleagues remain fully sighted on the issue continue to work with the national group in this regard.
- Safeguarding Quarterly Assurance Reports were received during the year outlining the governance arrangements in place to ensure the Trust meets its statutory safeguarding responsibilities including:
    - The successful appointment of the Named Doctor for Safeguarding commencing in post during Q1.
    - Level 3 safeguarding training compliance continued to be closely monitored in-year which remained below the 90% target at 83.61% (Mar 2025). SQAC welcomed a number of changes implemented to strengthen the approach to cancellations.
    - During Q3, MIAA undertook an audit of the systems and processes in relation to safeguarding; the outputs of this would be received in the Q4/Annual Report.
    - A Sexual Safety Working Group was established during the year following a commitment to sign up to the Sexual Safety Charter signalling a commitment to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace.
- The Committee continued to monitor outputs of the Safe Waiting List Management Programme and welcomed the progress made, with patients who are delayed two years or more reducing by 49%.
- Following the Independent Inquiry into the issues raised by the David Fuller case whereby inappropriate and unlawful actions in the mortuaries of NHS hospitals in Kent occurred, SQAC received progress reports on the self-assessment work undertaken in response to the recommendations from the Fuller Public Inquiry, Phase 1. The Committee welcomed establishment of a working group to self-assess against the 17 recommendations from Phase 1 which concluded that overall, there are good arrangements in place within the Trust to ensure the security and dignity of the deceased children and young people in our care. However, there are areas where current arrangements need to be strengthened to ensure they are fully robust. Phase 2 of the Inquiry will look at the broader national picture and a further report will be presented to SQAC in due course.
- SQAC was presented with the key findings, learning and areas for potential improvement from the Patient safety learning review undertaken into a reported safeguarding incident on trust premises in line with PSIRF requirements. Despite the incident occurring outside the building and outside of the Trust's control, a full investigation was undertaken to understand any learning and improvement opportunities from the sequence of events. SQAC was assured by the recommendations coming out of the review to ensure that Alder Hey is as safe as it can be.
- The Committee remained sighted on the status of the Trust's diagnostic notifications in Meditech following introduction of a new system during 2023/24 noting that despite

improved engagement unacknowledged notifications continue to accumulate. Following a detailed analysis the majority are linked to training doctors (residents). A solution to reconfigure the Meditech system was approved during the latter part of the year to ensure that resident doctors assign their orders to a permanent member of staff. SQAC will receive a further report in due course.

- The report from the internal review into systems and processes within cardiac surgery following concerns raised about some practices within the department was received. The review highlighted several good areas of practice along with areas for improvement. A number of actions remain ongoing, but SQAC welcomed the open and honest fashion in the way this review had been undertaken.
- SQAC approved the Merseyside Joint Agency Protocol Acute Life-Threatening Event (ALTE) and Merseyside Joint Agency Protocol Sudden Unexpected Death Childhood (SUDiC) for Children aged 0 to under 18 years.

Caring

- SQAC received quarterly Patient Experience and Engagement / Family Feedback Reports from the Patient Experience and Engagement Group (PEEG) which demonstrated the Trust's ongoing commitment to improving patient experience and engagement through various initiatives and feedback mechanisms. SQAC welcomed the alignment of the Equality Delivery System 2022 Framework with the PEEG to further support an inclusive and fair healthcare system. The recruitment of Patient Safety Partners was celebrated by the Committee along with the introduction of a Family Wellbeing Hub.
- Quarterly Compliments, Complaints and PALS Reports were presented to the Committee. During the latter part of the year, SQAC welcomed the report in A3 format showing good compliance against complaints being responded to within 25 days (Q3 = 85%). Challenges with meeting this target within the Community and Mental Health Division was acknowledged due to the large volume of PALS relating to ASD/ADHD pathways.
- Quarterly reports detailing the work undertaken by the Alder Hey Youth Forum, the Chameleons and the youth engagement team were received during the year. A wide range of developmental opportunities and pathways to education, training and employment are offered to the children and young people along with support mechanisms which empowers them to have their voices heard and contribute towards service redesign, research and quality improvement across the Trust.

Effective

- SQAC received a report summarising the work undertaken in relation to EDS22, the quality improvement tool developed by NHSE to help organisations enhance the services they provide to local communities and create better working environments for staff, aligning with the Equality Act 2010 and the Public Sector Equality Duty.
  Despite the report providing assurance that overall scoring across the three domains was 24, meaning we are a Trust rated as 'Achieving', a meeting would be held with the EDI Lead to better understand the assessments, what they mean for our children and young people, stronger links with the health inequalities team and to agree future reporting into the committee.

- Monthly reports from the Clinical Effectiveness and Outcomes Group (CEOG) were received providing assurance against the oversight of clinical audit, NICE Guidance, national mandated audits and compliance with policies/documents.
- Divisional Assurance Reports were received monthly providing assurance against several key topics including 3 successes, 3 key challenges, regulatory requirements, incidents,

complaints, Friends and Family Test, management of risks, sepsis compliance, clinical audit compliance, people metrics and areas for escalation.

- The Committee received the Trust Quality Account for 2023/24.
- Quarterly performance reports were received from the Clinical Research Division – these were in addition to the monthly divisional reports – and provided assurance against deployment of the Research Strategy 2024-2030 and the dedicated programmes of work that deliver against a number of underlying strategic initiatives, updates on external grant funding and the status of the research portfolio.
- The Terms of Reference and Work Plan were comprehensively reviewed to ensure a focussed oversight role of key issues relating to the safety of our patients and their families.
- The Committee received and approved its 2023/24 Annual Report ahead of onward reporting to the Audit and Risk Committee and Board.
- The results of the Friends and Family Test were monitored by SQAC during the year. At Q3, 93.93% of responses received were rated good or very good.
- The CEOG Terms of Reference and Work Plan were ratified.
- Biannual Aggregated Analysis Report detailing the themes and trends for incidents, complaints PALS, claims and inquests were received providing assurance that the Trust is compliant with NHS Quality Contract reporting requirements.
- Quarterly Mortality Assessment Reports were received broken down to show activity from the Hospital Mortality Review Group (HMRG) and a statistical analysis of mortality. The reports concluded that HMRG is providing effective and comprehensive reviews in a timely manner, meeting the four-month standard. There were two potentially avoidable deaths in the 2024 cases reviewed but assurance received that these were due to external factors and there were no issues relating to care received at Alder Hey. The new Medical Examiner process, designed to provide independent scrutiny of care provided, improve accuracy of information during the death certification process and give bereaved people the opportunity to raise concerns was fully implemented in-year and has not raised any concerns to date.
  The Committee welcomed the ongoing benchmarking with Birmingham Children's Hospital enabling us to compare figures and trends and to work together to improve processes.
- The Committee regularly monitored compliance against National Institute for Health and Care Excellence (NICE) Guidance and actions taken to meet expected standards and ensure patient safety. SQAC noted the continued trend in compliance for the majority of assessments and received assurance from divisions in relation to three open guidelines outside of the three-month standard review in terms of timely completion.
- SQAC received progress updates against the Trust Wide Clinical Audit Annual Work Programme 2024/25. During the year there had been 19 nationally mandated audits and 23 local Trust priority audits with good progress against the majority. A small number of audits had fallen overdue during the year and escalated to the appropriate senior staff within the Divisions to rectify. SQAC welcomed the process in relation to monitoring of audit findings at the Clinical Effectiveness and Outcomes Group.
- Quarterly assurance reports in relation to the Trust's participation in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) programme, Perinatal Mortality and Morbidity Confidential Enquiries (MBRRACE) were received during the year. SQAC was assured that the Trust remains compliant with submissions. Participation with the programme is mandatory and part of the Quality Accounts submission.
- The 2023/24 Annual Organ Donation report was presented to the Committee indicating a positive picture in terms of organ donation with no missed referrals to NHS blood and transplant during the year.
- SQAC received the Commissioning for Quality & Innovation (CQUIN) year-end report noting good progress against 7 of the 9 CQUINs agreed for 2023/24. The CQUIN relating to supporting patients to drink, eat and mobilise after surgery was not achievable due to

differing data codes in the paediatric population. Moving forwards, the Committee were supportive of no optional CQUINs being undertaken next year following an announcement by NHSE that these would no longer be required.

- Following commencement of the Children and Young People's Gender Service (North West), on 1st April 2024, SQAC received quarterly updates on the status of the new service including assurance against how we are managing risks, caseload, waiting times to initial assessment and treatment, was not brought rates, incident reporting, recruitment of staff, FFT data and FoI requests.
- SQAC received a presentation on antimicrobial resistance and the work being undertaken by the dedicated workstreams to support the global effort to combat resistance.
- Monthly Integrated Governance Reports were received in respect of the Liverpool Neonatal Partnership. The reports detailed assurances on how Alder Hey and Liverpool Women's NHS FT are working together to improve neonatal services across the North West including
    - Successes
    - Challenges
    - Performance metrics
    - Mortality data
    - Risks
    - Incidents and learning

  During the year, the improving strength of the partnership was evidenced in the evolving reports and integrated approach across both sites.
  SQAC welcomed Kerry Byrne's appointment as a Non-Executive Director on the LNP Board.

<u>Well-Led</u>

- Bi-annual reports detailing the themes and trends from the Quality Assurance Rounds (QAR) were formally received highlighting the main successes and challenges and actions to address them. During 2024/25 a hybrid model to QARs was adopted and a new standardised information pack developed to align with Vision 2030 and the new CQC single assessment framework. A total of 32 QARs were undertaken during the period Feb 24 – Feb 25 and any risks associated with challenges are addressed at the point of presentation with a solution focused approach. The team are exploring a process for the triangulation of QAR findings with those findings from the fortnightly quality rounds (QRs)
- SQAC received Ward Accreditation Reports demonstrating assurance of standards of practice by measuring the quality of care delivered by wards and department teams. A short pause in assessments being undertaken during 2024/25 was noted due to a change in the leadership of the programme. A total of 10 assessments were undertaken during the year (of 24 required) with the remaining 14 to be completed by the beginning of June 2025. The vast majority of practice is good, and feedback from patients and families is generally very positive which is reflected in the number of wards who have been awarded Outstanding for Caring. A number of themes were identified and shared with teams in order to share the learning and improve the experience and safety of our children, young people and families.
- 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*	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	3x5	3x3

** Joint responsibility with FT&P*

SQAC continued to receive Executive updates against each of the BAF risks and assurance was provided that scores, gaps in assurance and mitigations continued to be managed in-year.

- Specific items to highlight in relation to oversight of these risks include:
  - *Risk 1.1 Inability to deliver safe and high-quality services*:
    - gaps in controls addressed through updates on projects being overseen by the PSSB. These reports are usually first on the agenda for discussion/assurance.
    - Regular reports on:
      - Actions taken by the Sepsis Steering Group and performance against the sepsis KPIs
      - NICE Guidance implementation
      - Patient experience
      - EPRR compliance
      - Infection Prevention and Control
      - Liverpool Neonatal Partnership
      - CQC assurance reports on IR(ME)R standards
  - *Risk 1.2 Children and young people waiting beyond the national standard to access planned care and urgent care:*
    - gaps in controls are addressed through the following regular reports: Safe Waiting List Management Programme. Monthly updates to address pressures within the Emergency Department and performance against national waiting times.
  - *Risk 1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies*
    - gaps in controls addressed through regular reports on mental health attendances at the Trust's Emergency Department.
    - A deep dive on this risk was undertaken in January 2025. SQAC learned that there is no national standard for waiting times for access to CAMHS services and were assured by the introduction of an internal waiting list standard. As a result, there are no children waiting over 52 weeks to commence treatment. The service has seen increased referrals since 2019/20, but improvement plans are in place to address this. There has been no change to the risk score during the year and it was agreed that the risk would be rearticulated for 2025/26 to reflect the emerging position and gaps.

  Based on the processes for overseeing these risks as summarised above, SQAC can confirm that management are effectively managing these risks and are taking timely steps to reduce their risk score**.**
- The application of risk appetite continued into 2024/25. The outputs of a working group looking at clinical risk thresholds was presented to the committee for consideration as follows:
  - The Trust has NO appetite for risks that compromise patient safety
  - The Trust has a MINIMAL appetite for risks that may compromise the delivery of outcomes for our patients

- The Trust will apply an exception to 'quality-safety' risks that cannot be reduced to a score of less than the threshold despite all mitigations and for those risks to remain active and reviewed on a three-monthly cycle, with a view to undertaking a robust review every 12 months.

These recommendations were subsequently approved by the Board of Directors and work is ongoing in the form of a pilot review of all risks within the Community and Mental Health Division regarding practical application of risk tolerances and understanding the potential change to our risk profile.

- 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.

Responsive

- Quarterly Healthcare Transition Reports were received detailing the processes and oversight in place for monitoring quality and safety for young people preparing for adulthood from children's healthcare providers to adult healthcare providers, as per NICE Guidance. Whilst a number of key successes and achievements were noted, access to and the collection of data remained a challenge for the transition team during the year following the roll out of Alderc@re. The team continue to work with BI to develop meaningful data reports and provide assurance to SQAC in terms of progress. A key success noted in year was the new process of monitoring the transition of inpatients over the age of 18 to ensure they are on track. This process is still in its early stages but has seen positive results to date.
- SQAC maintained oversight of the Trust's position in relation to compliance with the NHS Emergency Preparedness Resilience & Response (EPRR) Core Standards. Despite growth and improvement, compliance against the standards remains within the 60% margin. The committee challenged the lack of divisional engagement in the process and received assurance that responsible officer/s would be identified with clear lines of reporting via divisional governance reports (from March 2025).
- The Committee received an update from Health Inequalities & Prevention (HIP) Steering Group noting the huge amount of work undertaken during the year to support health inequalities work across the organisation, Improve My Life Chances and the wider Vision 2030. The HIP focussed on three metrics during the year with additional public health input through Liverpool and Sefton Local Authorities. The establishment of a 'Wellbeing Hub' was welcomed as a Trust-wide wellbeing offer, services for the hub will be delivered in partnership with the Citizens Advice Bureau and Health Junction.
  SQAC welcomed the commencement of the new Consultant in Paediatric Public Health Medicine during the year to provide clinical leadership to the HIP agenda.

External inspections undertaken and assurances received

- During the year SQAC has received the following reports from external sources:
  - The key findings of CQCs inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) on 11th September 2024 were presented to SQAC. The report identified areas of good practice with no safety concerns, however breaches under the regulations were outlined and therefore an Improvement Notice was issued to the Trust.
    Assurance reports were presented to the Committee from the working group established to oversee the action plan developed to address the breaches. All actions were completed within the timeframe specified by CQC and a Closure Notice subsequently received confirming closure of the enforcement. The Radiology Team

have undertaken to review lessons learned and develop best practice for future inspections.

- The 2023/24 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.

Annual Reports

- Annual reports relating to 2023/24 were provided throughout the year to provide assurance to the Committee. These included those from / relating to:
  - Safeguarding Children
  - Clinical Research Division
  - Patient Safety Programme Board Annual Report
  - Clinical Effectiveness and Outcomes Group Annual Report
  - Clinical Audit
  - Annual IPC Committee Report
  - Organ Donation
  - Clinical Ethics Committee
  - Drugs & Therapeutics Committee

Further Assurances

- The Committee has continually challenged assurance processes when appropriate and has requested and received assurance reports from Trust management and various other sources, both internally and externally throughout the year, including:
  - Divisional focussed deep dives including analysis of, and actions required for improvement:
    - Nurse Staffing (fill rates/safe staffing)
    - Deep dive – into the correlation of waiting times for Friends & Family tests
    - Patients deteriorating to critical care
    - Trust approach to implementation of Marthas Rule
    - Policy compliance
  - The Committee received the findings of the Patient Safety Incident Investigation Report in relation to a never event which left a patient with a surgical instrument (retractor) left inside her tummy. Several areas for consideration were identified from the review and a full action plan developed to address these. A further update against the recommendations is expected at the April 2025 meeting.

Items to bring to the Board's attention

There are no matters to highlight.

Assurance Statements

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

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

- The remit and resources dedicated to clinical audit activities are appropriate for the Trust to meet its obligations for the Quality Account.
- The mandated Clinical Audit Work Programme has been delivered with the exception of:
    - UK Renal Registry Chronic Kidney Disease Audit.
      The UK Renal Registry Annual Report 2021 published in June 2023 noted several gaps in the data fields from the Trust due to IT issues. A plan of support has been developed for the design and implementation of the data collection forms in Meditech. Progress with this plan will be provided by Medicine division and monitored at CEOG. The initial dataset has been produced and data is currently being submitted manually to the UK Renal registry until a digital solution is built in Meditech. Consultant confirmed 'partial' submissions have been completed historically and currently with approximately 50% of the dataset submitted. Risk 247 remains on the risk register with a score of 4 and review date of 14/04/2025.

      Work currently underway with UK kidney Association for direct transfer of data from Meditech to Renal Registry (UKKA). Test dataset has been sent. This should reduce number of missing data and reduce manual data entry required with current system. Currently working to accurately identify all eligible patients, and the registration criteria, from Meditech.

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

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

Committee Priorities for 2025/26

- Further develop the reporting of Clinical Effectiveness and the Patient Experience group to mirror the utilisation of the Brilliant Basics approach, currently demonstrated through the Patient Safety Board.
- Approve the Quality Strategy 2025 – 2030 and monitor performance against the annual implementation plan
- Continue to hold the Divisions to account for quality performance and will seek to drive measurable improvements in key quality indicators form 'ward to board'
- Maintain an overview of the Quality Assurance Round process to provide an in depth understanding of the issues facing each service and department; and
- Oversee the delivery and governance of the Patient Safety Strategy and associated aims in the context of the Trust's overall strategic direction and re-stated ambition to achieve an overall 'Outstanding' rating from CQC.
- Continue to seek improvements in relation to NICE guidance and clinical audit compliance, particularly implementation of learning.
- Further embed the Patient Safety Incident Response Framework processes and develop learning from patient safety events.
- Start to ensure that patient safety and quality data reviewed in Divisions and through other processes in operation across the Trust enables enquiry into health inequalities in support of the strategic priority in this area.

Professor Fiona Beveridge

Committee Chair
April 2025

APPENDIX A

SAFETY & QUALITY ASSURANCE COMMITTEE - RECORD OF ATTENDANCE 2024/25

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

Member / Date of Meeting	2024									2025			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Fiona Beveridge (Chair) (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	NO MEETING HELD	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	11/11	100%
Kerry Byrne (Non-Executive Director)	✓	✓	x	✓		✓	✓	✓	✓	✓	✓	✓	10/11	91%
Gerald Meehan (Non-Executive Director)	✓	✓	✓	x		✓	✓	x	✓	✓	✓	✓	9/11	82%
Alfie Bass (Chief Medical Officer)	x	✓	x	✓		✓	✓	✓	✓	x	x	✓	7/11	64%
Nathan Askew (Chief Nursing AHP & Experience Officer)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	x	10/11	91%
Adam Bateman (Chief Operating Officer)	x	✓	x	✓		✓	✓	x	✓	✓	x	✓	7/11	64%
Erica Saunders (Chief Corporate Affairs Officer)	✓	✓	x	✓		✓	✓	✓	x	✓	✓	✓	9/11	82%
Melissa Swindell (Chief People Officer)	✓	✓	x	x		✓	x	x	✓	x	x	x	4/11	36%
Kate Warriner (Chief Digital Information Officer)	IG	IG	IG	✓		IG	PW	IG	IG	LB	PW	PW	11/11	100%

Member / Date of Meeting	2024									2025			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Rachael Pennington (ACN - Surgery)	✓	✓	✓	KB		✓	KB	KB	✓	✓	KB	✓	11/11	100%
Jacqui Pointon (ACN – Community & MH)	✓	✓	✓	✓		x	x	✓	x	x	✓	x	6/11	55%
Cathy Wardell (ACN - Medicine)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11	100%
Laura Rad (Head of Nursing for Research)	✓	✓	x	✓		x	✓	✓	✓	✓	✓	✓	9/11	82%
QUORUM ACHIEVED	YES	YES	YES	YES		YES	YES	YES	YES	YES	YES	YES	11/11	100%

Member/Date of Meeting	2024									2025			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
ATTENDEES														
Jackie Rooney (Associate Director for Nursing and Governance)	✓	x	✓	✓		LW	✓	✓	✓	LW	✓	✓	10/11	91%
Bea Larru (Director of Infection Prevention Control)	x	x	✓	x		1 item	✓	x	x	x	1 item	1 item	5/11	45%

People Committee Annual Report 2024/25

The People Committee

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

The Committee has delegated authority from the Trust Board to oversee all workforce matters within the Trust in support of the delivery of high-quality patient and family centred care. It does this principally via the Divisions through monitoring of workforce standards and targets.

Constitution

The Membership comprises:

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

Expected to attend each meeting: Director of People Services/Deputy Chief People Officer, Director of Culture and OD, Alder Hey Academy Director, Head of Equality, Diversity and Inclusion and the Chair of Staff Side.

To ensure that the People Committee remains strategic and assurance led, it is also supported by the Health & Safety Committee, Education Governance Steering Group, Equality, Diversity and Inclusion Steering Group, JCNC and LNC which monitor quality assurance at an operational level and report into PC. A schedule of attendance at the meetings is provided in Appendix A which demonstrates each meeting was quorate.

Principal Review Areas / Achievements in 2024/25

People Plan 2030

The Committee continued to receive monthly progress reports against delivery of the People Plan embedded within Vision 2030. Year 2 targets and measures were closely monitored throughout the year including risks to delivery against the five workstreams established to ensure that the fundamental changes required to support our people are delivered.

Some of the highlights during the year include:

- Brilliant Basics (management) training rewritten and relaunched.
- Strengthening of EDI recruitment processes.
- Launch of the Anti-Racism Framework.
- A real focus on understanding organisational culture.
- Development of the staff thriving index.
- Introduction of a workforce stability metric.

- Further analysis of the Strasys data in relation to the five workforce groups to inform operational plans.
- Agreement to rearticulate the Trust Values.

Focus areas for the next 18 months were received in the People Plan 2024 to 2030 clearly setting out how we intend to achieve our People Vision of One Alder Hey '*a healthier, happier, fairer place to work, where every colleague can achieve their potential'.*

- Divisional workforce metrics were presented monthly by senior representatives from each division (surgery, medicine, research, community and corporate) through their wider knowledge of the Trust via the Integrated Performance Report. In addition to receiving updates against the workforce KPIs and actions to address areas of concern, divisions reported on outputs from local 'BIG conversations' held following the results of the staff survey and health and wellbeing initiatives implemented in response to some of the matters raised by staff.

<u>Thriving</u>

- Quarterly Freedom to Speak Up (FTSU) / Raising Concerns reports were received during the year providing rich data on the number of contacts by professional groups, themes, status of cases and assurance around escalation processes for concerns that relate to patient safety and quality. The FTSU Visibility programme continued during the year and has been very well received by staff, the number of cases increased during the year providing assurance that staff feel safe to raise their concerns. An audit of FTSU was undertaken during 2024/25 by MIAA which was awarded substantial assurance with FTSU training at 98% across the organisation.
- Updates against the Trust's Internal Communications Plan were received during the year noting the work undertaken in relation to the People Plan:
  - Ongoing commitment to Ask the Execs.
  - media interviews and engagement.
  - Staff Awards.
  - Showcase on Black History Month.
  - Awareness raising with the FTSU Champions.
  - Recognition campaign for retirements.
  - audience reached via our social media channels.
- In response to the challenges set out by the ICB to deliver increased workforce productivity and create workforce efficiencies to achieve significant financial savings, a Workforce Efficiencies Programme was established reporting into the People Committee. Regular updates were provided to provide assurance on key metrics provided to the ICB including WTE numbers (current and forecast), temporary staffing spend and potential workforce efficiencies for 2024/25 and beyond.
- Regular reports on the leadership development work sitting within the Thriving Leaders workstream of the 2030 People Programme were provided to the committee in order to meet the changing needs of the organisation in the delivery of Vision 2030. Assurance was provided in relation to the number of staff attending all offers of leadership training which is key to success of the organisation.
- People Committee approved recommendations in relation to remunerations of individuals on non-AFC contracts for 2024/25 and for on-call allowances. For non-AFC contracts, it was agreed that these would remain on the terms and conditions already in place and for on-call payments it was agreed to increase allowance by 5.5% in accordance with the 2024/25 pay award.
- The 2024 Staff Survey results were received noting a 62% response rate (*60% for the previous year*) compared to 50% nationally. A number of key positives were presented to the Committee including scoring higher than average across all of the people promise elements, staff recommending Alder Hey as a place to work increased to 73.96% and staff recommending Alder Hey as a place for treatment increased to 89.59%.

That said, the Committee noted that there are 38% of colleagues who did not complete the survey; communications and engagement will continue across the organisation to encourage staff to further increase completion rates and enable a greater volume of rich data to be analysed and acted on.
BIG conversation packs will be distributed to departments and a staff survey working group has been established to deliver improvement actions.

- The Committee received a paper outlining the framework to support health and wellbeing at Alder Hey. The framework is based on the insights and evidence gathered from the NHS England Organisational Health and Wellbeing framework and includes initiatives such as SALS, arts for health, the Alder Centre provision, professional wellbeing support, Schwartz Rounds, financial health and wellbeing support and the menopause group. People Committee will continue to monitor progress against the framework into 2025/26.
- The Committee welcomed the formation of a Sexual Safety working Group following adoption of the Sexual Safety Charter in November 2023 to oversee the action plan developed to ensure all ten charter commitments and also analyse data from the new staff survey question in relation to unwanted behaviour of a sexual nature in the workplace.
  In addition, Alder Hey has identified a Domestic Abuse and Sexual Violence Executive Lead and Operational Lead to help share and promote good practice.
  A review of existing Trust Policies is underway to incorporate sexual safety where appropriate.

<u>Belonging in the NHS</u>

- The 2024 Gender Pay Gap Report was received summarising that on average, female employees earn 25% less than male employees. Assurance was provided that this was reflective of the NHS which has a higher proportion of females in lower banded roles and a greater ratio of male employees with long length of service in the in the higher paid medical and dental professions. In 2023, female employees earned 27% less than male employees which shows that there has been some improvement in closing the gap.
- The Committee received the Workforce Equality, Diversity and Inclusion Annual Report 2024 demonstrating significant progress in relation to meeting our obligations defined in the Equality Act 2010. The report highlighted a number of initiatives to embed equality, diversity and inclusion making it a central element of our core business. Key achievements include:
  - Establishment of four staff networks
  - ‘Ally’ training delivered
  - Navajo Charter Mark award
  - Participation in Liverpool Pride event
  - Reasonable adjustments Policy launched
  - Recognition of campaigns such as disability history month, LGBTQIA+ history month, religious celebrations.
- Throughout the year, regular updates were provided to the Committee on the key strategic and operational issues emerging that could impact the organisation in relation to equality, diversity and inclusion.
- The Committee received and approved the 2023/24 Workforce Race Equality Scheme (WRES) report noting improvements in six out of the nine indicators; a vast improvement on the previous year. Areas for improvement were highlighted in the report to address those indicators that has remained static or worsened, these are being taken forward in the WRES Improvement Plan.
- The 2023/24 Workforce Disability Equality Scheme (WDES) Report was received and approved noting that the Trust had made improvements in 7 out of the 10 indicators of disability equality; again, a huge improvement on previous years. With the support and involvement of the ACE staff network, the WDES action plan was updated in response to the 2023/24 WDES

data to make sure that improvements against the themes identified are addressed and strategies are developed to improve these areas.

- The Committee was kept abreast of the work undertaken in relation to compliance with Improving the Working Lives of Doctors in Training standards framework, noting that 'poor trainee experience' had been added to the risk register. A task and finish group has been established to look at short, medium and long term solutions and a number of actions are being implemented to improve the lives of doctors in training.
- Proposals to enhance PDR quality, increase engagement and ensure the process is a valuable tool for employee development and organisational success were approved for the 2025/26 appraisal round. These include a refreshed PDR framework, divisional training events and additional resources for managers.
- The Committee received the outputs from the EDS22 assessment noting an overall scoring across all three domains of 24 meaning that the Trust is rated as 'Achieving'. A number of good practices across each of these domains was highlighted in the report and next steps to build on our progress and ensure meaningful, sustainable improvements.

Workforce Planning

- The Committee received and noted the update from NHS England setting out the scope of the independent review of physician associates and anaesthesia associates.
- A deep dive into Trust wide sickness absence was undertaken during the year to understand key patterns, common causes of sickness across the Trust and divisionally and the impact on spend. Despite a reduction in sickness absence since 2022/23, the overall position was above Trust target of 5% sitting at 6.1% for January 2025. A number of supportive measured have been implemented to support management through sickness absence processes and focus on return-to-work processes.
- The Committee received a report detailing corrective pay required under 'Bear/Flowers' regulations to ensure that staff are appropriately paid during periods of leave in line with Working Time Directive and AfC terms.
- A report detailing the incredible work of the Alder Hey Volunteering Team during 2023/24 was received commending the dedication and positive impact volunteers continue to have on our staff, patients, families and visitors.
- An update on the emerging 'Fit for the Future' collaborative was received which has been established to fundamentally focus on transformation, workforce planning and continuous learning. Fit for the Future is designed to support the three new clinical collaboratives formed to enable the transformational clinical changes needed.
- The Committee received the Nursing Workforce Report 2023/24 providing assurance that the Trust has safe staffing levels across all in-patient and day case wards, and appropriate systems and processes are in place to manage the demand for front line nurse staffing.
  The Trust's international recruitment programme continued during the year with successful recruitment of 97 nurses and 38 internationally educated nurses.

Governance

- The Committee received an annual report of employee relations activity/cases that were actively managed throughout 2023/24 receiving assurance that practices are in line with Trust Policy and process and that the Trust is working to best practice guidance and NHS recommendations for all cases.
- An update on the Trust's three-year DBS renewals programme was received. The position reported in April 2024 showed that there are 94.68% of colleagues who have had a DBS check within the last 3 years. Despite the 3-yearly renewal check being Trust mandated and not an NHS standard and a cost pressure, the Committee agreed that DBS checks support safer recruitment and supported the continuation of the programme.

- Approved the Committee Annual Report 2023/24.
- People Committee continued to ratify all relevant workforce policies.
- Approved the Committee Terms of Reference for the year 2024/25.
- People Committee is responsible for oversight of the following Board Assurance Framework (BAF) risks on behalf of the Trust Board:

Ref	Risk	Score	Target
		IxL	
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	3x4	3x2
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	3x3	2x2
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	4x3	4x1

At each of its meetings, the Committee received Executive updates against each of the BAF risks receiving assurance that scores, gaps in assurance and mitigations continued to be managed in-year.
During the year, the Committee monitored progress against mitigating actions identified to reduce the risk to its target rating through the various reports identified above as part of normal committee business. Specific items to highlight in relation to oversight of these risks include:

- *Risk 2.1 Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people*
  - A deep dive presentation was received at the January 2025 meeting with particular attention to the gaps in controls. Additional mitigations were highlighted to the committee including actions being taken through the workstreams sitting within the People Plan, Trust wide roll out of new managing absence training for line managers and continued designated HR, SALS and Occupational Health support and the establishment control project.
- *Risk 2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families*
  - Gaps in controls addressed through People Plan reports (cultural journey presentation, thriving leadership programme/staff thriving index, FTSU/raising concerns, stability index).
- *Risk 2.3 Failure to successfully embed workforce equality, diversity and inclusion across the organisation*
  - A deep dive presentation was received in November 2024 and following a thorough refresh of the risk, the Committee confirmed that they were assured that the actions outlined within the risk would address the gaps highlighted. This was also supported by the progress reports and updated from the EDI Lead during the year.

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

- The application of risk appetite continued into 2024/25. The outputs of a working group looking at workforce risk thresholds was presented to the committee for consideration as follows:
  - Alder Hey has a CAUTIOUS risk appetite for risk that may threaten the sustainability of its workforce, in terms of numbers, skill, health and wellbeing.
  - Alder Hey has a CAUTIOUS risk appetite for risk which may compromise its plans to develop a more diverse and inclusive workforce.
  - Alder Hey has a CAUTIOUS risk appetite for risk which may compromise the ongoing development and sustainability of an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families.

These recommendations were subsequently approved by the Board of Directors and work is ongoing in the form of a pilot review of all risks within the Community and Mental Health Division regarding practical application of risk tolerances and understanding the potential change to our risk profile.

Health & Safety

- The Annual Health & Safety Performance Report 2023/24 was received providing assurance that the Trust is compliant with the Health and Safety Policy Statement and that the Trust had no cause to involve the Health and Safety Executive with any enforcement activity.
- The Committee received the 2023/24 Non-Clinical Claims Report noting a significant increase from the previous year. Actions to mitigate future risk and recurrence of claims were detailed in the report and the oversight and management of non-clinical claims has transferred to the Clinical Legal Services function.
- Health & Safety updates were received for quarters 1 & 2 (2024/25) noting the activities delivered by the team including first aid training for staff, ongoing site inspections, practical manual handling training and risk assessment training.

Sub-Committee / Working Groups

The Committee received the minutes from the following working groups:

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

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 People Plan 2030 was on track and all key workforce risks were being managed.

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

Committee Priorities for 2025/26

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

- Focus on monitoring the implementation of the refreshed People Plan, as part of the Trust Vision 2030 Strategy
- Focus on the key areas which would enable the Trust to deliver this vision:
- Thriving @ Alder Hey
- Professional Development Hub

- Workforce Planning
- To monitor the implementation of the ‘Organisational Design Collaborative’ (was Fit for the Future)
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- The Committee will oversee the delivery of the work of the EDI Steering Group to ensure a strategic coherence in all matters related to Equality, Diversity and Inclusion and its determination to embed the work across the Trust.

Jo Revill, Committee Chair
May 2025

PEOPLE COMMITTEE – RECORD OF ATTENDANCE 2024/25

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

	May 2024	July 2024	Sept 2024	Nov 2024	Jan 2025	March 2024	TOTAL	
MEMBERS								
Jo Revill (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	6/6	100%
Fiona Beveridge (Non-Executive Director)	**x**	✓	✓	**x**	✓	✓	4/6	67%
Garth Dallas (Non-Executive Director)	✓	**x**	✓	✓	✓	x	4/6	67%
Melissa Swindell (Chief People Officer)	✓	✓	✓	✓	✓	✓	6/6	100%
Adam Bateman (Chief Operating Officer)	✓	**x**	**x**	✓	✓	✓	4/6	67%
Nathan Askew (Chief Nursing Officer)	✓	✓	✓	**x**	**x**	**x**	3/6	50%
Alfie Bass (Chief Medical Officer)	**x**	**x**	**x**	**x**	✓	**x**	1/6	16%
Joe Fitzpatrick (Internal Communications Manager)	✓	✓	✓	✓	✓	✓	6/6	100%
Erica Saunders (Chief Corporate Affairs Officer)	✓	✓	✓	**x**	✓	✓	5/6	83%
1 x Senior representative from Surgical Division	✓	✓	✓	✓	✓	✓	6/6	100%
1 x Senior representative from Medical Division	✓	✓	✓	✓	✓	✓	6/6	100%
1 x Senior representative from Community & Mental Health Division	✓	✓	✓	✓	✓	✓	6/6	100%
1 x Senior representative from Clinical Research Division	✓	✓	✓	✓	✓	✓	6/6	100%
Quorum achieved?	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**6/6**	**100%**

	May 2024	July 2024	Sept 2024	Nov 2024	Jan 2025	Mar 2025	TOTAL	
ATTENDEES								
Sharon Owen (Deputy Chief People Officer)	x	✓	✓	x	✓	✓	4/6	67%
Jo Potier (Associate Director of OD)	✓	✓	✓	✓	x	x	4/6	67%
Katherine Birch (Academy Director)	✓	✓	✓	✓	✓	✓	6/6	100%
Angie Ditchfield (Head of Equality, Diversity and Inclusion)	✓	✓	✓	✓	✓	✓	6/6	100%
Julie Worthington (Staff Side Chair)	x	✓	x	✓	x	✓	3/6	50%

Futures Committee Annual Report 2024/25

Futures Committee

The Futures Committee was established by the Board of Directors to assist in overseeing and monitoring execution of the Trust's 'Futures' strategic initiative, the strategies of its various components and their key themes *(replacing and subsuming the responsibilities of the Research and Innovation Committee*).

The Committee operates under the broad aims of a) overseeing delivery and periodic reviews of the various activities undertaken within the Trust's 'Futures' strategic initiative and b) providing assurance to the Board that delivery in these areas supports the Trust's strategic priorities.

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

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

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

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

Constitution

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

- Non-Executive Directors x 3 [one of whom shall be the Chair]
- Chief Executive
- Chief Scientific Officer
- Managing Director of Futures
- Clinical Director of Innovation
- Director of Research
- Director of Alder Hey Academy
- Chief Digital and Transformation Officer
- Managing Director of Trust
- Director of Finance and Development
- Chief Medical Officer
- Chief Nursing Officer
- Chief Corporate Affairs Officer
- Director of Strategy and Partnerships

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

The Committee may request the attendance of any Non-Executive Directors, Executive Directors, Divisional Directors, Lead Research Nurse and Senior Innovation Consultants 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 2024/25

Transition to the new committee

At its inaugural meeting in April 2024, the Committee:

- Discussed and agreed ways of working to drive implementation and deliver the Futures Strategy.
- Received an update against each of the disciplines sitting under Futures including:
  - Research – noting soft launch of the Research Strategy 2024-2030, achievement of financial performance, commencement of the second round of treatment for the first patient to be treated with gene therapy via the Clinical Research Facility, and facilitation of a visit from NIHR GOSH Biomedical Research Centre, as part of our building external partnerships work.
  - Innovation - agreeing a shift in focus for this area defined as 'benefits to Alder Hey' and not income generating as previously. Notwithstanding this, benefits realisation would be undertaken for cash saving projects/products in order to make sound investment decisions.
  - Academy – receiving a summary of the how the Academy is wrapped around the Futures Strategy in terms of recruitment, development, enabling learning and fast exchange of knowledge. Development of a global offer was noted as the Commercial Strategy is defined.
- The year-end financial position with both innovation and research ending the year on budget.
- Welcomed an update on the Wavelength and Alder Hey Charity collaboration providing a bespoke opportunity for external private and public sector leaders to learn about excellence in innovation, meet front-line clinicians at Alder Hey Innovation and tour the facilities. This model for knowledge transfer and income generation via an educational offer was very much welcomed by the Committee in keeping with the Futures model.
- Received a progress update on the Futures Strategy and Implementation Plan, agreeing areas for further refinement and development of a decision matrix. The Committee discussed the core principles, pillars and objectives to deliver the Strategy including
  - Pillar 1: Discover - accelerate discovery and translation through a culture of collaboration.
  - Pillar 2: People – develop and support our people to research, innovate, learn and train.
  - Pillar 3: Grow – secure new investment to grow our discovery programmes and ensure financial sustainability.

    - Pillar 4: Transform – reinvent paediatric health care by building world-class data and digital capabilities.

  Updates against each of these pillars were delivered at each meeting thereafter.
- Was provided with an update on the work underway to integrate relevant aspects of Academy and iDigital activities with Research and Innovation.
- Received an update on the partnership with Strasys and agreed to extend an invitation to them to future meetings.
- Reviewed the risk register for research and innovation.
- Reviewed the Board Assurance Framework specifically focusing on risk 4.1 'Failure to deliver Pioneering Breakthroughs via Game-Changing Innovation that has positive impact for Children and Young People'.
- Received the following supporting documents for information
    - Research Management Board Minutes
    - Innovation Management Board Minutes
    - R&I Performance Reports, Q4 2023/24
    - R&I Management Accounts, Q4 2023/24

<u>Delivering the Futures Strategy</u>

- The Committee approved the Futures Strategy and supported proposals in relation to its delivery. The Committee took assurance that there was scope to repurpose existing budgets to enable commencement of Strategy delivery.
- A business case was subsequently approved which detailed resource and activities needed to initiate Alder Hey Futures and the optimal approach to implementation i.e. no new budget allocation in 2024/25, with 100% of the costs required covered by re-purposed budget. In August 2024, it was agreed to initiate the 'Discover', 'Develop' and 'Grow' pillars of activity and form a leadership team for Futures delivery and oversight. The milestone plan for this work was monitored by the Committee at each meeting noting progress against each pillar as detailed in the report.

<u>Pillar 1: Discover</u>

- At each meeting, the Futures Committee received updates against Futures pillar 1: Discover, including pipeline projects and submissions. A focus on tangible benefits for each project remained a focus at each meeting including
    - Creation of an EDI workstream
    - Protected time for 6 staff members to either complete a PhD publication or submit an external grant application to enable them to move on to university senior lecturer or other senior research positions
    - Three protocols developed under the Rapid & Robust Evaluation workstream,
    - Alignment to Discover themes and funding allocations
    - Overview of internal capacity and capability funding allocation for 2025/26
    - The work ongoing to engage children and young people, in particular visiting schools with the mobile research unit.
- The Committee received a presentation on the Cystic Fibrosis Innovation Hub to accelerate the development of new tests and treatment approaches for lung infections and improve the way that lung health for people with cystic fibrosis is managed. Following an in-depth

discussion on these scientific discoveries and lifechanging stories, the Committee welcomed updates against this study under the 'Discover' pillar.

- In response to feedback that the Innovation pipeline was too disparate, the Committee welcomed a reduction in projects from 65 to 31 all aligned with Futures / Vision 2030 work and opportunities clearly identified.
- The Committee was kept appraised of the opening of the Northern Institute for Child Health and Wellbeing, a groundbreaking partnership between Alder Hey and the University of Liverpool and supported by Alder Hey Children's Charity which is set to transform the lives of children and young people, not just in Liverpool, but across the UK and beyond. The Institute was formally announced in October 2024 by the Right Hon. Wes Streeting MP, Secretary of State for Health and Social Care and will focus on research and innovation and provide cutting-edge solutions to some of the most pressing issues facing children today.
- The Committee received a presentation on the Clinical Research Development Programme for non-medical staff. The programme is funded by Matalan via the Alder Hey Charity and supports staff through research internships funded Masters by Research (MRes), and pre-doctoral fellowships, in collaboration with partner universities and organisations like the NIHR Applied Research Collaboration North West Coast (ARC NWC). Key achievements during 2024 were presented to the Committee including:
    - Supported staff: 52 non-medical health care professionals, including nurses, physiotherapists and occupational therapists.
    - Mentorship programme
    - Testimonials from interns and MRes participants highlighted personal and professional growth, improved research skills, and the ability to balance clinical and academic careers.
    - Staff contributed to securing £6.6M in research funding.
- The Committee received a presentation on the deployment in intensive care of Etiometry, a physiological monitoring platform designed to:
    - improve patient safety through enhanced visualisation
    - Implement predictive monitoring tools
    - Optimize healthcare resources, particularly ventilator weaning protocols.
    - Create high-quality research datasets for collaboration with external partners.

  Projected benefits of the platform were noted estimating a reduction of ICU bed days by 100 days annually and a reduction in cancelled elective surgeries.

<u>Pillar 2: People</u>

At each meeting, the Futures Committee received updates against Futures pillar 2: People, including:

- progress on embedding the Futures work into Strong Foundations
- progress on embedding the Futures work into the new induction programme
- ongoing discussions with external parties regarding the Futures Fellowship programme.
- resource secured to support the development of the pillar
- scoping and design of professional development focusing on career pathways
- Starting Well funding secured for early career researchers.

Pillar 3: Grow

At each meeting, the Futures Committee received updates against Futures pillar 3: Grow, including:

- a pillar overview and update detailing the three-pronged approach being taken: fueling investment, growing workstreams and creating capacity.
- key posts recruited during the year.
- efforts to secure external investment, partnerships, and revenue streams

- The Committee welcomed sight of the Futures Financial Framework established to underpin financial governance and management around Futures activities.
- The Committee supported continuation of the Strasys partnership for 1 year subject to Board approval and welcomed the new direction of travel looking at larger scale strategic opportunities from an initial review of projects and ideas. At the end of this contract, it was agreed to work on an advice and opportunities basis with Strasys moving into 2025/26. Particular areas to support strategic growth would be considered.
- An update was received on the support requested from the Alder Hey Chairity in pursuit of delivering the Futures Strategy. Plans to merge funding streams for Research & Innovation were approved starting April 2025 pending approval from the Charity's funding committee.
- An update on the 'Paediatric Open Innovation Zone' (POIZ) proposal to Liverpool City Region Combined Authority was reviewed. A £4.1m investment was later secured as part of this initiative. This is the largest single investment into the Trust's Innovation activities, to date, and will support a strategic shift in emphasis to 'home grown' development of innovative physical and digital devices towards 'co-creation' with commercial partners. As such it will strengthen the Trust's position as a global leader in paediatric healthcare innovation.
- At each meeting, horizon scanning on securing new investment was provided including:
  - £3.2m awarded from the NIHR capital investment fund to purchase the new MRI scanner, which is now in place and a -80 freezer now installed and running.
  - NIHR capital award – further NIHR funding of £1.1m secured for two technical upgrades to the scanner and to equip a state-of-the-art ophthalmology research area with some match funding from a charity in San Francisco
  - Clinical Research Facility funding extension until 2029 (additional £0.6m)
  - £3m in direct awards for the Little Hearts At Home project.
  - Mobile research bus available for unlimited use across the Trust – part of the ARC North West application by LUHFT

  The Committee welcomed the proactive horizon scanning and updates against these and efforts to streamline grant application processes and support clinicians in identifying funding opportunities.
- The Committee discussed the development of Futures within the global arena and received updates on progress in relation to international partnerships including international hospitals and universities in Brazil, China and Vietnam to provide education & training, Innovation, upskilling & development of services, charitable work and infrastructure & design to enhance paediatric health education and training globally.

Pillar 4: Transform

At each meeting, the Futures Committee received updates against Futures pillar 4: Transform, including:

  - A pillar overview and update on the three workstreams focussing on secure data environment insight portal (supporting research studies allowing collaboration nationally, regionally and internationally), generative AI architecture and Alder Hey Anywhere – a patient and clinical portal for improving experience.

- The Committee received a comprehensive demonstration of the Lyrebird AI transcription tool for Medical Practitioners which securely listens in the background throughout consultations and then intelligently generates a note ready to transfer into a patient's medical record. The tool was initially piloted within clinics and expanded across outpatients. Initial reports from this project show high clinician satisfaction and 50-100% clinician time savings per patient.
- Updates on the Data Strategy project to ensure development of key projects in line with the aims were received.
- The Committee was informed of the AI coding case study; a project looking at AI to augment future ability to improve accuracy of clinical data and relieve the burden on coding staff. An implementation timescale of 6-12 months was noted agreeing the preferred option of a commercial partnership with the providers, Phare Health.
- An update on the Alder Hey Anywhere project and next steps was received. The groundbreaking digital platform developed by Alder Hey Innovation in collaboration with Microsoft is set to revolutionise the way in which patient care is delivered to children and young people, creating a "hospital without walls" making patient care more accessible and personalised.
- An update on the development of the Digital, Data and AI Strategy was received. The Committee is expecting the final strategy at its June 2025 meeting along with a detailed investment plan.
- Developments of the new patient portal were noted with in-house development initially investigated but not viable. The risks and challenges to procuring an off-the-shelf product were discussed and it was agreed the preferred supplier would be Patients Know Best (PKB). This decision was taken as this portal already integrates with the NHS app for streamlined patient interaction, allows proxy access structured to accommodate children and parents (aligning with GOSH). The benefits to implementing this portal will reduce admin burden for appointment scheduling and improve patient experience.

<u>Risk and Assurance</u>

- The Futures 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 strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	3x3	3x2

- The Committee received an update at each meeting on BAF risk 4.1 and assurance was provided that the score, gaps in assurance and mitigations continued to be appropriately managed in-year.
    - Specific items to highlight in relation to oversight of this risk include:
        - Research Management Board Minutes
        - Performance measurement reports from both Research and Innovation.
        - Finance reports from both Research and Innovation
        - Updates against the four pillars within the Futures Strategy
        - Impact reports from pilot projects

  The application of risk appetite continued into 2024/25. In 2024, the Board approved a HIGH risk appetite level for the Futures risk type category, however discussions were subsequently taken forward to look at the appropriateness of splitting out this category to better capture the wide range of risks that sit within clinical innovation i.e. clinical risk, statutory duties, regulatory requirements, investment activities etc. A small Futures working group met during April 2025 to discuss and propose appropriate risk thresholds for clinical innovation risks. This work will be presented to the June 2025 Futures Committee for consideration, ahead of Board approval.

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

- Regular Research and Innovation Finance Reports were received noting the position at M12 2025:
    - Innovation: adverse position of £74k at M12.
    - Research: favourable position of £226k at M12.
    - CIP Target: Removed for CRD in 24/25; expected to contribute to a £2m trust-wide investment target.
    - An action was agreed to strengthen MRI scanner pipeline to meet next-year budget targets.
- Quarterly performance reports for Research and Innovation were received detailing RAG rating progress against KPIs under each of the pillars, risks, new and working pipeline submissions, priority, active & deployed project updates and commercial updates.
- Clinical Research Division quarterly reports were received providing assurance in relation to performance, programmes and partnerships, financial sustainability (funding and awards) and strategy deployment. This report is received by the Safety and Quality Assurance Committee who take assurance from the report from a patient safety perspective.
- The Committee received a document providing a comprehensive review of the 'CYP As One' platform commissioned by Beyond: Cheshire and Merseyside Children and Young People's Transformation Programme as a unified digital referral system for CAMHS (Children's and Young Adults' Mental Health Services). Benefits to the platform were welcomed by the Committee noting reduced admin burden, faster access to services and standardised referral data for regional decision-making. Future potential for the platform is now being explored to support broader healthcare pathways.

- An update on the Was Not Brought (WNB) AI tool developed to address missed outpatient appointments was provided to Committee. The impact of the predictor tool was noted as
    - Alder Hey: a drop in WNB rates from 12% to 10% improving clinic efficiency.
    - Sheffield Children's: WNB rates reduced from 11% to 9%, especially benefiting deprived and non-English-speaking families.
    - Children's Hospital Alliance: Achieved a 25% reduction in DNAs (Did Not Attend), saving 27,500 appointments and £3 million over two years.
    - Resource savings: over 4,000 appointments saved in just two months across participating trusts.
    - Health Equity: helped address non-economic barriers like language, family responsibilities, and mental health.

  The WNB AI tool is now being prepared for broader adoption across NHS Trusts.

Committee Governance

- Approved the Research and Innovation Committee Annual Report for 2023/24.

Items to bring to the Board's attention

There are no matters to highlight.

Assurance Statements

Through the various mechanisms set out above, the Committee has gained assurance that the Trust's Research and Innovation functions are operating effectively and in line with relevant standards and legislation.

Based on the information provided, the Committee members can confirm that the assurance framework is fit for purpose and that the control environment is operating at a satisfactory level.

The Chair of the Futures Committee is a member of the Finance, Transformation and Performance Development Committee enabling links and additional oversight of financial & commercial aspects of R&I activity to be dealt with in a multi-factorial way.

A Summary Report is presented to the Board following each Futures 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 2025/26

- Liverpool Institute for Child Health and Well-being – drafting an Institute strategy, establishing oversight arrangements and initiating collaborative projects
- Paediatric Open Innovation Zone - completion of formalities for funding, assessment of appropriate structure and implementation

- Education, training and career development: building capacity and capability across the elements of Futures
- Receiving, approval and implantation of data and AI strategy
- Continued monitoring of delivery of strategy for pioneering breakthroughs
- Diversification of income streams – exploration of options for: a separate legal entity to support Futures activities; international income-generating educational and innovation partnerships; benefit sharing from generative AI solutions
- Integration within the new Growth and Opportunities (GO) collective – including potential new ‘umbrella’ governance structure

Shalni Arora
Committee Chair
May 2025

FUTURES COMMITTEE - RECORD OF ATTENDANCE 2024/25

The quorum necessary for the transaction of business:
Chair or nominated deputy, one other NED, Chief Scientific Officer and/or Managing Director of Futures and one other Executive Director.

Member/Date of Meeting	2024				2025	TOTAL	
	April	June	Sept	Nov	Mar		
MEMBERS							
Shalni Arora (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	5/5	100%
Garth Dallas (Non-Executive Director)	✓	✓	✓	✓	✓	5/5	100%
John Kelly (Non-Executive Director)	✓	x	✓	x	✓	3/5	60%
Louise Shepherd (Chief Executive)	✓	✓	x	n/a	n/a	2/3	67%
John Chester (Chief Scientific Officer/Director of Research)	✓	✓	✓	✓	✓	5/5	100%
Adam Bateman (Managing Director of Futures)	✓	✓	✓	✓	✓	5/5	100%
Iain Hennessey (Clinical Director of Innovation)	✓	✓	✓	✓	x	4/5	80%
Dan Hawcutt (Clinical Director of Research)	x	✓	✓	✓	✓	4/5	80%
John Grinnell (Managing Director/CFO)	✓	✓	✓	✓ As CEO	✓ As CEO	5/5	75%
Katherine Birch (Academy Director)	✓	x	✓	✓	x	3/5	60%
Kate Warriner (Chief Digital and Information Officer)	✓	Rep	Rep	Rep	✓	5/5	100%
Rachel Lea (Director of Finance and Dev't)	✓	✓	✓	✓ As CFO	✓ As CFO	5/5	100%
Alfie Bass (Chief Medical Officer)	x	x	x	x	x	0/5	0%
Nathan Askew (Chief Nursing Officer)	x	x	x	x	x	0/5	0%
Dani Jones (Chief Strategy & Partnerships Officer)	x	✓	✓	x	x	2/5	40%
Erica Saunders (Chief Corporate Affairs Officer)	✓	x	x	✓	✓	3/5	60%
Quorum achieved	YES	YES	YES	YES	YES	5/5	100%

Member/Date of Meeting	2024				2025	TOTAL	
	April	June	Sep	Nov	Mar		
ATTENDEES							
Emily Kirkpatrick (Deputy Director of Finance)	✓	✓	✓	✓	x	4/5	80%
Sarah Leo (Head of Research Operations)	✓	✓	✓	✓	✓	5/5	100%

BOARD OF DIRECTORS
Thursday, 26th June 2025

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☐ To approve ☑
Summary/ supporting information:	As part of the regulation and oversight of NHS provider organisations, Foundation Trusts are required to make an annual self-certificated declaration relating to compliance with NHS Provider Licence conditions. The Trust is required to submit an annual declaration of its compliance with Condition *CoS7: Availability of Resources in the Provider Licence*. This report outlines the Trust's compliance with the regulation.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Impact:	None identified

Does this relate to a risk? Yes ☑ No ☐					
Risk Number/s	Risk Description				Score
1.1	Inability to deliver safe and high-quality services				3x3
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's
NHS Foundation Trust

1. Introduction

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

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

2. Compliance 2024/25

Licence Condition	Supporting Evidence	Confirmed/ Not Confirmed
CoS7 – Availability of resources	• Monthly Financial Reports to Finance, Transformation and Performance Committee and Board. • Monthly Integrated Performance Report. • 2024/25 Annual Accounts prepared on a going concern basis. • 2025/26 Annual Plan. • Income and expenditure budgets have been set on robust and agreed principles, Divisions should be able to provide high-quality healthcare within the resources available, provided cost improvement plans are achieved.	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.

3. Recommendation

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

Erica Saunders
Chief Corporate Affairs Officer
June 2025

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 CoS7

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:

Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (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 "CoS7"

Financial Year to which self-certification relates **2024/25** Please complete the explanatory information in cell E36

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

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

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

EITHER:

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. **Confirmed** Please fill details in cell E22

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. Please Respond

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Please Respond

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

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

The Trust Board 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**	John Grinnell
Capacity	Chair	**Capacity**	Chief Executive
Date	26 June 2025	**Date**	26 June 2025

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