NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 25th February 2021, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**20/21/243**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**20/21/244**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/245**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 28th January 2021.**	**D**	Read minutes
4.	**20/21/246**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read action log
Strategic Update							
5.	**20/21/247**	**9:25 (10 mins)**	**Update on the Future of ICSs, Commissioning and Provider Collaboratives.**	D. Jones	To discuss the NHS white paper on the future of the ICSs.	**N**	Presentation
6.	**20/21/248**	**9:35 (10 mins)**	**Alder Hey in the Park Campus Development update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
COVID-19 Assurance Plan – Alder Hey's Response to the Third Wave							
7.	**20/21/249**	**9:45 (55 mins)**	• **Progress on the Trust's Response to the Third Wave.** - **Access and**	J. Grinnell A. Bateman	To provide a progress update on Alder Hey's response to the third wave. To provide an update on access and restoration of	**A** **A**	Presentation Read report

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			Restoration update.		services.		
			• **Staff/Patient Safety:**				
			- **Covid-19 vaccine update.**	M. Swindell	To provide an update on the Covid-19 vaccine for staff.	**A**	Presentation
			- **Staff safety metrics.**	M. Swindell	To provide an update on staff absences and testing.	**A**	Presentation
			- **IPC assurance including nosocomial infections.**	B. Larru	To provide the Board with an update on IPC.	**A**	Read report
			- **Safe Waiting List Management update.**	A. Bateman	To provide an update on patients waiting for an appointment more than 52 weeks and management plan going forward	**A**	Presentation
			• **COVID Risk Register.**	J. Grinnell	To discuss the current key risks.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
8.	**20/21/250**	**10:40 (10 mins)**	**Division of Surgery: Governance and Safety Rates Update.**	A. Bass	To provide a further update on the work that has taken place around safety and governance in the Division of Surgery, following feedback from CQC.	A	Presentation
9.	**20/21/251**	**10:50 (10 mins)**	**Serious Incident Report.**	N. Askew	To provide board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
10.	**20/21/252**	**11:00 (10 mins)**	**Mortality Report, Q2.**	N. Murdock	To present the findings from Q2.	**A**	Read report
11.	**20/21/253**	**11:10 (10 mins)**	**Digital Update.**	K. Warriner	To update the Board on the programme.	**A**	Read report
12.	**20/21/254**	**11:20 (10 mins)**	**Cumulative Corporate Report Metrics - Top Line Indicators:** • **Quality.** • **Safety.**	N. Murdock N. Askew	To receive a report of Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
The Best People Doing Their Best Work							
13.	**20/21/255**	**11:30**	**Cumulative Corporate Report**	M. Swindell	To receive a report of Trust performance for scrutiny and	**A**	*Refer to item 12*

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(5 mins)	**Metrics – Top Line Indicators:** • **People.**		discussion**,** highlighting any critical issues.		
14.	**20/21/256**	**11:35 (15 mins)**	**Alder Hey People Plan Update:** • **Progress against 5 themes within the People Plan.** • **Staff Survey update.** • **EDI Task Force update.**	M. Swindell M. Swindell C. Dove	To provide an update on progress against five of the themes within the People Plan. To provide an update on the Staff Survey – 2020/21. To receive an update from the EDI Task Force Group.	**A** **A** **A**	Read report Verbal Verbal
Lunch (11:50pm-12:10pm)							
Strong Foundations (Board Assurance)							
15.	**20/21/257**	**12:10 (10 mins)**	**Financial Update.**	J. Grinnell	To provide an overview of the position for Month 9 and the latest financial guidance.	**A**	Presentation
16.	**20/21/258**	**12:20 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
17.	**20/21/259**	**12:25 (15 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 22.2.21.** - **Approved minutes from the meeting held of the 14.12.20.** • **Safety & Quality**	I Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Assurance Committee: - **Chair's verbal update from the meeting held on the 17.2.21.** - **Approved minutes from the meeting held on the 16.12.20 and the 20.1.21.** • **People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 19.1.21.** - **Approved minutes from the meeting held on the 17.11.20.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 8.2.21.** - **Approved minutes from the meeting held on the 7.12.20.**	C. Dove S. Arora			
Items for information							
18.	**20/21/260**	**12:40 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
19.	**20/21/261**	**12:44 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 25th March 2021, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in January 2021: - Ref. No: 368 – Reversionary Lease for the construction compound at Alder Lodge – Bevan Brittan

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Letter from Amanda Pritchard re Integrated Care Systems: Next Steps	D. Jones
Integration and Innovation: Working together to improve health and social care for all.	D. Jones
Corporate Report	Executive Leads
CQC Action Plan	E. Saunders
Financial Metrics, M10	J. Grinnell

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 28th January 2021 at 9:00am,** via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	Ms. L. Cooper	Director of Community and Mental Health	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. C. Liddy	Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Staff Story	Ms. C. Barker	Chief Pharmacist	(CB)
Apologies:	Prof. M. Beresford	Associate Director of the Board	(PMB)

Staff Story

The Chair welcomed the Trust's Chief Pharmacist, Catrin Barker, who agreed to attend January's Trust Board to talk about the role of the Pharmacy Department during the roll out of the Pfizer Covid-19 vaccine. Catrin informed the Board of the Pharmacy Department's response to the first wave of the pandemic in March 2020; ensuring the Trust had the right stocks of medicine, configuring the team in order to care for the cohort of adult patients admitted to Alder Hey, upscaled the amount of Pharmacy staff on ICU and extended the service to provide cover during the weekend period. Attention was drawn to the distress that some team members experienced as a result of seeing patients die from Covid-19, but it was pointed out that the support they received from the psychologist on ICU was amazing.

The Board was advised that the team is more prepared to deal with the 3rd wave of the pandemic, partly due to the learning that has taken place around the treatment of adults with Covid-19. It was also pointed out that the Trust took the opportunity to enrol its first adult patient who recovered from Covid-19 onto the research recovery study.

Catrin referred to the licencing of the vaccine which took place on the 2.12.20 and the uncertainty about how it was going to be rolled out. The Trust had been designated as a spoke that would be supplied by a bigger hub. Catrin advised of the issues that were experienced in respect to the delivery of a freezer to store the vaccines and the quick turnaround from delivery of the vaccine at 10:30am on the 6.1.21 to the commencement of staff vaccination on the same day. The Board was advised that the Trust has a process in place for new medicines therefore the vaccine was approved for use in the Trust by the Clinical Development Evaluation Group (CDEG) who led the application. Training for the provision of the vaccine was led by Cath Benson who trained all respective staff on its handling.

Catrin explained about the reconstitution of the vaccine and how it had to be dealt with in a two-hour period. It was reported that each vial has the capacity to hold six doses but only five were permitted to be used. Following a change in guidelines on the 5.1.21 it was confirmed that the sixth dose could be used legitimately which meant that all relevant staff had to be trained on PGD2 by the 6.1.20. The Board was advised that the Trust arranged for 975 doses of vaccine to be provided to staff via the three allocations that were received.

It was reported that Carol Platt and colleagues set up a vaccination room which incorporated an anaphylactic area to accommodate staff members who experience side effects following vaccination. Catrin advised the Board of how proud she was of the team after having reviewed how the vaccination room had been set up in order to sign it off and seeing the work and effort that had gone into preparing this area to ensure it was fully fit for purpose.

It was felt that the overall vaccine campaign was really successful with 3000 members of staff receiving the first dose of the vaccine within a two-week period. Catrin Barker paid tribute to the Vaccination Team and advised that it has been a privilege to work with them.

On behalf of the Board, the Chair thanked Catrin and her team for the work that has taken place to support ICU and the roll out of the vaccine across the Trust.

Louise Shepherd thanked Catrin for her amazing contribution to the Trust and for building a wonderful team that the organisation is very proud of.

20/21/220 Welcome and Apologies

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

The Board was advised that the focus of January's meeting is mainly on operational issues. The Board Assurance Committees have scrutinised the majority of the items on the Board agenda to provide real rigour around the governance element of these issues. The Chair pointed out that the level of planning that has taken place to accommodate changes and ensure the restoration of services is really humbling.

20/21/221 Declarations of Interest

The Board noted the declaration received from Fiona Marston in relation to her association with the Liverpool Tropical School of Medicine.

20/21/222 Minutes of the previous meetings held on Thursday 17th December 2020
Resolved:
The minutes from the meeting held on the 17.12.20 were agreed, pending the following amendments to agenda item 20/21/2:

Paragraph 8 should read as follows - The Trust Board felt that the case for submitting responses to NHSE/I via the three collaboratives was appropriate, and

following discussion agreed to approve the Alder Hey response to the consultation that is being conducted by NHSE/I.

Paragraph 9 should read as follows - A discussion took place around the Cheshire and Merseyside Health Care Partnership Draft MoU. The Board supported the overall direction of the Draft MOU though recommended some return comments on a number of areas of clarification, as detailed in Alder Hey's response. Attention was drawn to the importance of ensuring that the voice of children and young people is not lost.

Paragraph 11 should read as follows – **Resolved:** The Board approved the Alder Hey response to the consultation process that is being led by NHSE/I to determine the future of ICSs.

20/21/223 Matters Arising and Action Log

There were no matters arising and the actions relating to January 2021 were either closed or to be addressed during the meeting.

20/21/224 Covid-19 Assurance Plan – Alder Hey's Response to the Third Wave

Covid-19 Wave 3 Response - Overarching Plan

The Board received the overarching plan for the Trust's Covid-19 Wave 3 response which provided an update on the organisation's clinical and operational response to the 3rd wave, outlined Alder Hey's role in the system and the continued efforts to maintain access to services for children and young people.

Building on the system requirements and Alder Hey's knowledge of the 1st and 2nd wave, the Trust set out the priorities of its response to guide the organisation through the 3rd wave and provide a foundation for decision making. The following priorities were agreed:

- Ensure paediatric critical care could open to full capacity if required (high priority, but low likelihood).
- Deliver good access to planned care for children and young people; including urgent and key elective cases:
  - Theatre schedule to run to 67% of pre Covid levels (100 sessions per week).
  - Outpatients to sustain a full schedule overall.
- Establish adult ICU for Covid-19; up to a maximum of 10 patients.
- Provide paediatric capacity for Cheshire and Merseyside; up to a maximum of 20 patients in total.
- A number of staff volunteers to work at the Nightingale Hospital.
- Vaccinate all of the Trust's staff and support the wider system in the vaccination programme.

It was pointed out that there could be a reduction in available critical care capacity during the next two/three weeks in Cheshire and Merseyside therefore it has been agreed that Liverpool Heart and Chest Hospital (LHCH), supported by Alder Hey, will offer the system an additional 10 critical care adult beds and 20 general acute CPAP beds. The Board was advised that this is largely a LHCH offer but Alder Hey will support where necessary with staffing levels.

The Board was advised that the Clinical and Operational Teams have re-shaped the capacity of the hospital to maintain access for children and young people whilst

offering an adult intensive care unit for 9 to 10 patients, delivering a vaccination programme and where possible offering support to services under pressure in the system, from a staff support perspective.

As with Wave 1 and in accordance with a reiteration of support from NHSE/I on the 11th January for organisations to minimise activity unrelated to the COVID effort, the Trust has re-enacted a 'Governance Lite' model that includes maintaining its Board and sub-committee assurance with slimmer agendas focussing on key issues and risks. Similarly, any non-urgent internal meetings have been cancelled. To further support this, a rapid review of Q4 priorities has been conducted to ensure the organisation creates the focus to support its response and where necessary continue to drive forward activities that will support Alder Hey's recovery and strategic objectives.

It was confirmed that the Trust will continue to assess the situation regularly, but it was felt that Alder Hey is stable at the present time, has good visibility of its data and emerging pressures.

Adult ITU Governance Arrangements

The Board was provided with an overview of the governance arrangements in place following a request to open a nine-bed adult Intensive Care Unit (ICU) within the Trust's critical care floor to provide additional support to the system in response to the current Covid-19 pressures.

It was reported that the Trust has considered all aspects of governance arrangements relating to the care of this patient group and attention was drawn to the external support that Alder Hey has received from adult providers; Liverpool University Foundation Trust (LUFT) and LHCH in terms of specialist adult colleagues and intensivists helping clinical teams provide best care in line with the guidance that has been developed by LUFT and LHCH based on their learning and national guidance.

The Board was advised that the risks posed by having adult patients in a paediatric facility have been assessed and ranked as low as patients will be non-ambulant upon admission due to either being intubated or ventilated and sedated. As patients become clinically stable and extubated, they will be repatriated to their local hospital.

In terms of safeguarding adults, the Alder Hey Safeguarding Team will ensure that relevant aspects of adult safeguarding are considered, such as identifying patients who are sole carers for other vulnerable adults or have dependents who have been left on their own. The team will also work with external agencies to co-ordinate responses as required. The Family Liaison team will work with the Safeguarding team to ensure that the Trust meets its statutory requirements in relation to this.

It was reported that capacity will be maintained in Paediatric Intensive Care Unit (PICU) for children and young people. Risks or incidents appertaining to adult patients placed with the Trust will be managed via the Trust policy process with additional oversight from the Executive Lead for Adult Critical Care, the Clinical Director of ICU and the Ward Manager of ICU.

In terms of redeploying staff, it was pointed out that a lot of learning has taken place since the 1st wave of the pandemic and the Trust has tried to improve the experience of redeployment for staff whilst balancing the need to transfer staff into different areas to work. There has been a focus on staff support, with psychology support available around the clock for all members of staff who have been

redeployed. Staff will also have access to a range of support services which will either be via self-referral or via discussion and signposting with the SALS service.

The Chief Nurse, Nathan Askew, paid testament to the many staff who have offered their services following the Trust's request for volunteers to support the adult ICU pod. The organisation asked for 100 volunteers and received a response from 170 members of staff. As a result of this the Trust has been able to redeploy the required amount of staff and also have volunteers on standby in the event Alder Hey needs to increase its PICU capacity. It was reported that as of next week more volunteers will be attending the PICU department for training.

Fiona Marston asked as to whether the Trust is following local or national policy in respect to colleagues who have volunteered to support the Trust look after adult patients on ICU. It was reported that there is a national assessment for all volunteers, of which, the Trust has confirmed that all staff volunteers especially those classed as high risk will be re-assessed in the 3rd wave.

The Chair thanked Nathan Askew for providing assurance to the Board on this matter and drew attention to the pastoral care that has been made available for staff following learning from the first wave. The Board noted the significance of the support that Alder Hey is wrapping around its staff and felt that it is crucial to do so in such unprecedented times.

Access and Restoration Update

The Board received a summary of the progress that has been made in restoring services between August 2020 and December 2020. The following highlights were shared with the Board:

- It was reported that the Trust has maintained a high level of restoration at 95% for outpatients and elective care.
- In elective care Alder Hey has succeeded the restoration target driven by additional weekend working and maintained the increased levels of Day Case activity.
- The clinical divisions are continuing to take additional actions to improve outpatient restoration including;
  - Maximising the opportunities that digital and phone clinics create.
  - Continuing with extra weekend and evening sessions.
  - Working with specialties to increase patient numbers per clinic with agreed increases in ENT, Cardiology, Paediatric Surgery and Dental.
  - Review of speciality use of attend anywhere for scope to expand virtual clinics.
  - Increased Nurse Led and Registrar clinics.
  - Continuing to review clinical pathways.
  - Extended sessions into evenings.
- *Diagnostics:* – The percentage of diagnostic tests performed within 6 weeks in December was 92.3%. This drop in performance relates to waiting times for MRI scans under general anaesthetic. Staff have been very committed and have worked additional sessions to ensure there is not a significant increase in the length of wait for this service.
- *Emergency Department (ED) performance* – The ED four-hour access standard performance for December 2020 was 98.63%. It was reported that Alder Hey was ranked as the number one ED in the country for timeliness of care, during December 2020.
- *Cancer Performance:* The Trust achieved 100% for access times in respect to timeliness of cancer care in December 2020.

- The total number of patients waiting over 52 weeks in December for planned care is 184. Specialties with the most significant backlog challenge have been identified and there will be a concentration on providing additional support to these teams via the recovery framework. There has also been a focus in respect to the validation of referral to treatment (RTT) pathways to ensure all patients are on the right reportable pathway. It was reported that the Trust is seeking to take additional action to improve capacity including an incentive model to support and sustain additional sessions, and secure capacity in the independent sector.
- There has been significant progress made with restoring services to date, but it was pointed out that during January the impact of Wave 3 will have an adverse effect on waiting times and levels of restoration as the Trust delivers mutual aid to the region and establishes an adult ICU on the site of Alder Hey. The Board was advised that the Trust is looking to implement alternative solutions to offset this.

Staff/Patient Safety

Covid-19 Vaccine Update

It was reported that 79% of the Trust's workforce have received the first dose of the Pfizer Covid-19 vaccination. The Board was advised that Alder Hey is working in partnership with Liverpool Heart and Chest Hospital (LHCH) to roll out the vaccine to staff. An offer has also been received from Clatterbridge with regard to providing the Oxford/Astra Zeneca vaccine to Alder Hey staff who are contra-indicated for Pfizer. The Alder Hey vaccine hub will reopen in March 2021 in order to provide staff with their second dose of the vaccine.

A table relating to the breakdown of staff groups who have received the vaccine was shared with the Board. There has been feedback from a number of staff members indicating their reasons for declining the vaccine. Information has been shared across the Trust to offer assurance on the safety of the vaccine.

Staff Safety Metrics

An update was provided to the Board on figures relating to staff absence. The following data was provided:

- Overall absence - Total absence was just under 9%, which is a slight reduction on last month.
- Non Covid-19 related sickness - 5.2%
- Covid-19 related sickness - 3.7%.
- There are 21 members of staff who are symptomatic or have been confirmed as Covid+.
- There are 20 members of staff who are self-isolating.
- There are 16 members of staff who are shielding.

IPC Assurance
Resolved:
The Board received and noted the content of the IPC dashboard.

Safe Waiting List Management Update

The Board received an update on progress with the management of the waiting list since December 2020. The following points were highlighted:

- Significant validation has been undertaken to improve and assure data quality.
- Governance and assurance structures are in place with CCG and NHSE, with external assurance from MBI Healthcare.
- The inpatient RTT assurance review has been completed.
- New standards for clinical review to keep children safe on the waiting list.
- No harm identified from clinical reviews of long-wait patients.
- Internal plan to grow capacity.

It was reported that the results of the safe waiting list management review were shared with the regional office on the 22.1.21 and were well received. The Trust has been working closely on this issue with Liverpool CCG and their Head of Quality/ Chief Nurse, Jane Lunt, who have both been very supportive.

The Chair thanked Adam Bateman for the update and reassuring results.

Covid-19 Risk Register

The Board received the Covid-19 Risk Register which was submitted to provide assurance of the effective management of Covid-19 operational risks, in line with national guidance.

It was pointed out that the majority of the themes highlighted in the risk register have been discussed during the Covid-19 Assurance Plan progress update and are still consistent with the current environment.

On behalf of the Board, the Chair thanked staff members who are having to adapt their work lives to look after the cohort of adult patients in ICU, as well as those who are working very hard to maintain access to services for children and young people

Resolved:
The Board noted the updates provided under the Covid-19 Assurance Plan Progress Update.

20/21/225 CQC Section 31 Response and Action Plan

The Board received an update on the actions taken in response to the Section 31 notice issued by CQC on 18th December imposing conditions upon the Trust's registration and discussed the implications of caring for this complex patient cohort for the wider system.

Louise Shepherd provided an overview of the circumstances that preceded CQC issuing the Trust with a Section 31 notice, along with the information requests that were made by CQC to provide assurance that Alder Hey was a safe place for children and young people who self-harm.

A discussion took place with the Deputy Chief Inspector for Hospitals for CQC, Ann Ford, and it was agreed that the Trust would submit an action plan to CQC prior to the Christmas holiday. Following submission of the plan a meeting took place on the 8.1.21 with CQC and the feedback was positive. The Trust demonstrated that it had taken the notice seriously and had taken immediate action to ensure the safety of

children and young people, but it was pointed out that some of the actions in the plan would take longer to fully implement them.

Further clarity was provided around the pathway for children and young people accessing Alder Hey and it was confirmed that the main focus of the immediate safety actions that took place were in ED and Ward 4C. A meeting took place on the 26.1.21 following the submission of additional information and it was confirmed by CQC that they would be lifting the Section 31 notice, based on the evidence provided and the mitigations that have been implemented by the Trust.

The Board was advised of the formal process that the Trust and regulator are required to undertake in respect to lifting the conditions imposed by the Notice; CQC have confirmed that they will publish this information on their website.

A discussion took place around the national issue that is being experienced in respect to the complexity of patients with mental health issues accessing trusts and it was reported that CQC has acknowledged that this matter has wider connotations across the system. The region has also been advised that a paper has been compiled and submitted to regional management this week that sets out a proposal for a more systematic approach to address this problem.

It was reported that the Trust is looking to produce a long-term sustainable plan for this area of work which will be monitored by the Safety and Quality Assurance Committee (SQAC) and submitted to the Trust Board for assurance purposes. Fiona Beveridge pointed out that SQAC has received a report on the outcome of the investigation that resulted in the Trust being served a Section 31 notice. The Board was informed that there is an action plan in place following the investigation and SQAC will monitor the plan until each action has been addressed. It was suggested that the report on the outcome of the investigation and the action plan, once completed, should be shared with CQC. Nathan Askew and Louise Shepherd agreed to discuss this matter outside of the meeting.

20/21/225.1 Action: NA/LS

Resolved:
The Board noted the update on the actions taken in response to the Section 31 notice issued by CQC on the 18.12.20.

20/21/226 Use of Restrictive Physical Intervention and Clinical Holding Report for 2019/20

An update was provided to the Board of the activity in relation to the use of restrictive physical intervention and clinical holding across the Trust for the reporting period of the 1.4.2019 to the 31.3.2020.

The Trust reported 150 incidents regarding the use of restrictive physical intervention and clinical holding of children and young people accessing services at Alder Hey, of which, 129 were related to the Tier 4 Unit.

A discussion took place around the low reporting of restrictive physical intervention and clinical holding across all areas of the organisation, which is potentially due to a number of factors:

- Staff lack of awareness regarding requirement to report the use of restrictive physical intervention and clinical holding, even with full agreement of the child, young person and/or parent or carer.

- Lack of clarity within the Trust's incident reporting system (Ulysses) and number of categories available for staff to use.
- Lack of staff training on the use of restrictive physical intervention and clinical holding which may have led to staff feeling unsafe to report for fear of criticism or repercussions.

The Board was advised that improvement actions have been identified, especially around education and training for staff. The Trust has appointed an appropriate training provider to deliver accredited training across the Trust. The provision of this training as part of a pilot on Ward 4C, ED and Outpatients was approved by SQAC in October 2020.

Further improvements have been made to the reporting of restrictive physical intervention and clinical holding via Ulysses, and a review of policies and procedures that relate to this area of work is underway.

All provider organisations require an Executive Director or equivalent who takes lead responsibility for the Trust's restrictive physical intervention and clinical holding. It was confirmed that Nathan Askew has agreed to be the Trust's Executive Lead for restrictive physical intervention and clinical holding.

Resolved:
The Trust received and noted the content of the Use of Restrictive Physical Intervention and Clinical Holding report and approved the Trust's identified Board lead for restrictive physical interventions and subsequent reduction programme.

20/21/227 Serious Incident Report

The Serious Incident report was presented to the Board to provide an overview of the current position for incidents reported externally to the Strategic Executive Information System (StEIS), including new incidents reported between the 1.12.20 and the 31.12.20. The following points were highlighted:

- There were no new Never Events reported during December 2020.
- There were two incidents formally reported during December:
  - *StEIS Reference 2020/23828:* Waiting list data quality issues - An investigation has commenced and is expected to be completed within the agreed timeframe of the 5.3.21.
  - *StEIS Reference 2020/23808:* Grade 3 pressure ulcer under halo spinal jacket - Following a review of the manufacturer's instructions, it was agreed that potentially there were a number of things that could have been done to provide pressure relief therefore staff have since received training on this device. An investigation has commenced and is expected to be completed within the agreed timeframe of the 5.3.21. The outcome of the RCA and lessons learned will be shared at a later date.
- There are six ongoing incidents currently under investigation which were reported to the Trust Board on a previous occasion, of which, three will be completed by end of January 2021.

Resolved:
The Board received and noted the contents of the Serious Incident report for December 2020.

20/21/228 Cumulative Corporate Report – Top Line Indicators

Quality/Safety:

Sepsis Compliance – It was reported that compliance has been fluctuating month on month, therefore, a meeting has taken place with the Sepsis Team to discuss this matter. Following investigation, it was found that there were a number of factors that have contributed to the fluctuation in compliance, ranging from staff absence which affected training/education performance, the acuity of some patients along with a small proportion of patients receiving antibiotics just outside of the sixty minute compliance period. It was reported that for each case reviewed there was a legitimate reason as to why a delay had occurred in administering antibiotics. The team are aware that compliance needs to improve and there is a plan in place, particularly around the education of staff.

Play and Learning – The Board was advised that satisfaction with play has decreased slightly in December but the satisfaction with education has increased. It was pointed out that the Play Team are doing everything that they can to support children and young people, taking into account the current pressures and restrictions. The Trust is now measuring patients who are entitled to respond to the education question therefore it was felt that feedback on this area will increase.

The Board was advised that all nosocomial Covid-19 infections are investigated. A report on this matter will be submitted to the Board following February's Safety Quality Assurance Committee (SQAC).

Kerry Byrne pointed out that the Trust is achieving the ED four-hour access standard consistently, but the friends and family test (FFT) for ED remains amber and queried the reason for this. It was reported that the FFT question relates to perception rather than the four-hour target. There are still families waiting a long time in ED for the care that they receive, and it was felt that it would be beneficial to look into expectation setting for when patients arrive at the front door. Nathan Askew agreed to discuss this matter with the team.

20/21/228.1 Action: NA

Resolved:
The Board received and noted the quality/safety update that is highlighted in the weekly cumulative Corporate Report top line metrics.

20/21/229 Cumulative Corporate Report – Top Line Indicators

People

It was reported that mandatory training levels reduced in December and are presently at 85.03%. It was pointed out that some areas of mandatory training are required to be done on a face to face basis, of which, the Trust hasn't been able to do since March 2020 due to restrictions.

The Chair queried as to whether this issue has been raised nationally. It was reported that there hasn't been any scrutiny system wide/nationally, but it was agreed to broach this subject in order to gain feedback on this matter.

20/21/229.1 Action: MS

Resolved:
The Board received and noted the quality/safety update that is highlighted in the weekly cumulative Corporate Report top line metrics.

20/21/230 Alder Hey in the Park Campus Development update

The Board received an update on the progress, risks and actions on key capital projects. The following points were highlighted:

- The Clinical Hub and Dewi Jones construction are progressing well and will be completed by the end of 2021.
- The Neonatal development design is currently at stage three and will be ready to tender at conclusion of this stage. Work is ongoing to finalise the plans for the ground floor of the construction.
- *Relocations* – A number of options are being examined for corporate office accommodation and new working practices.
- *Park Reinstatement Phase 1* – It was reported that Phase 1 of the park will be completed in March/April 2021. The Trust is presently out to tender for Phase 2 and 3 and it is the intention to hand over the majority of the park by the end of 2021 with everyone off site by 2023. The Trust will continue to liaise with Liverpool City Council to ensure the park is sustainable going forward, following handover by the Trust.
- *North East Plot Development* – An update was provided on the live planning application by Step Places for the North East plot of land. As previously discussed, this includes key worker accommodation and other potential aligned opportunities regarding family accommodation and science/office space. Equally the quality of the proposed development aligns with our campus vision and per our requirements of any potential developer on the site.

A question was raised as to the status of the key worker accommodation. Step Places have confirmed that they are looking to develop a key worker offer and staff employed by Alder Hey will be given first choice to rent accommodation with a possible option to buy. Surveys carried out to date have indicated a preference from our staff for this type of accommodation.

Fiona Marston queried the Trust's process for reflecting upon lessons learned following completion of the overall construction work/facilities. It was confirmed that the Trust is conducting a post project evaluation which will date back to 2010 when the project to build the new hospital commenced and will incorporate the campus to date. Once the evaluation is complete it will be submitted to the Trust Board and shared with the Government.

A discussion took place about the financial issues that have been experienced at specific times during the development of the campus, which will be included in the evaluation. It was pointed out that the development programme feels a lot more stable in comparison to earlier years and having a more structured team in place provides oversight on what is a very complex programme. The Trust has redesigned some of its processes, especially in respect to seeking more independent cost consultancy advice at the beginning of programmes.

Attention was drawn to the complexity and the impact that the programmes will have on each other, for example, rehousing of corporate teams, the flow through the hospital and utilising the opportunities of the ground floor in the new Neonatal Unit. The Board was advised that the Executive Team is going to set time aside to look at the next phase of the Trust's strategy to ensure that the organisation future proofs opportunities for clinical growth and business development growth whilst making full use of the potential of the programmes that are currently being progressed as part of the campus development. The outcome of discussions will be submitted to RABD.

The Chair drew attention to the public and media interest that has been shown regarding the development of the campus and highlighted the importance of providing clear internal and external communications over the next few weeks.

Resolved:
The Board received and noted the Campus Development update.

20/21/231 Financial Update

In Month 9 the Trust reported a £0.3m deficit which is £0.7m ahead of the original plan, in line with FCT. The actual YTD is a £2.4m deficit which is £0.6m ahead of the original plan, in line with FCT.

The Trust's latest forecast submitted in January 2021 is now a £4m deficit, an improvement of £1.2m. This is due to two issues being resolved; Wales marginal rate risk of £0.9m has been removed and the crisis care funding of £0.3m has been confirmed.

The end of year position is expected to be a deficit of £1.2m. It was reported that cash funding is to be paid to providers for the shortfall in non-clinical income levels, of which, Alder Hey will receive c£2m. There will be no cash funding in respect to annual leave accrual but there will be an allowable overspend in year-end positions which will be £0.7m to £1.2m. With these two issues removed it leaves the Trust with an underlying position of £1.2m deficit at the end of the financial year.

Alder Hey's capital forecast is £43m to March with only £17m spent to date (M9) which requires c£27m to be spent in Q4. An acceleration spend is required along with a year-end strategy to manage the risk of underspends.

It was reported that operational planning for 2021/22 has been suspended nationally and won't be signed off until Q1. Operational guidance for Q2 to Q4 will be issued in April, with operational plans to be submitted and commissioner plans agreed by the end of June. There will be a costing block model in place from Q1 of the new financial year with Q4 reverting to a block arrangement, on commissioner allocation.

The Board was advised that the capital spend limit for 2021/22 will be similar to the previous year. The early FCT Cheshire and Merseyside gap is £60m, but it was felt that this would be solved during the course of the financial year.

It was reported the Trust will commence planning for the new financial year during the next couple of weeks. It will look at the key principles for 2021/22 and as part of the planning process the Trust will look to eradicate historic issues as much as possible, focus on business development activities and benefits realisation whilst looking to maximise income via commissioner discussions. It was reported that there will be funding to aid recovery in the new financial year. The Board was advised that it is clear that mental health will be a priority in 2021/22 and it was felt that there will be an opportunity to access additional funding to address this area of work.

The Chair highlighted the importance of considering the impact of a shadow Integrated Care System and the distribution of funding. It was pointed out that this will be a national discussion more so that an Alder Hey response.

Resolved:
The Board received and noted the financial update for Month 9.

20/21/232 Board Assurance Framework

The Trust Board received a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the Trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The following points were highlighted:

- It was pointed out that the BAF is receiving detailed oversight from the Assurance Committees which is enabling the Trust to understand the organisation's risks and address them.
- It was reported that SQAC has conducted a deep dive into risk 1.2 and two more of the Assurance Committees have identified their top risks.
- During November's Audit and Risk Committee meeting there was a focus on workforce planning which has resulted a request to the People and Wellbeing Committee to track mitigations, which was agreed within its priorities.
- The Board was advised that discussions have been taking place around the Trust's risk appetite and what it will look like going forward.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report as at the end of December 2020.

20/21/233 Board Assurance Committees

Audit and Risk Committee – The Board noted the Chair's highlight report from the meeting that took place on the 21.1.21. The minutes from the meeting held on the 19.11.20 were submitted for information and assurance purposes.

RABD – During the meeting on the 25.1.21 the Committee discussed all of the items on the agenda and received a presentation from Claire Liddy on the Trust's Innovation Strategy. The approved minutes from the meeting held on the 23.11.20 were submitted to the Board for information and assurance purposes.

SQAC – During the meeting on the 20.1.21 the Committee addressed the majority of the items submitted to the Board during January's meeting. An in-depth discussion also took place around the safe wating list and no child unaccounted for. The approved minutes from the meeting held on the 18.11.20 were submitted to the Board for information and assurance purposes.

People and Wellbeing Committee – It was reported that the work plan for the BAME Task Force Group is being refreshed.

Resolved:
The Board noted the approved minutes of the respective Assurance Committees.

20/21/234 Any Other Business

Alder Hey Charity Board Meeting – 27.1.21

The Chair advised that the Board of Alder Hey's Charity had a very positive meeting on the 27.1.21. The Charity was very supportive of the Neonatal proposal which was presented by Jo Minford and Hannah Rogers. It was reported that Rick Turnock is the Chair for the Charity's Spending Committee and his understanding of the Trust will be of great benefit.

Attention was drawn to the money that has been raised by the Charity to help with construction costs of the Trust's mental health building on the site of Alder Hey and it was pointed out that the Charity has agreed to raise £2.5m to help towards the building of the new Neonatal Unit. The Charity Board highlighted the difficulties of raising funds at the present time but confirmed that it will endeavour to do its best.

The Charity Board discussed its aspirations and it was confirmed that the Charity is keen to look at alternative ways for wider engagement with Alder Hey's workforce and address funding issues, once the pandemic is over. Fiona Ashcroft and Mark Flannagan presented their organisation's Communications Strategy and David Powell provided an update on the issues relating to the Campus.

The Chair advised the Board of the importance of ensuring that the Charity is aware of the risks that the Trust carries, which could impact on Alder Hey's reputation.

Governor Only Meeting – 27.1.21

It was reported that Rachel Lea and Ian Quinlan were invited to attend January's Governor Only meeting to provide an update on the Trust's finances and the financial pressures being experienced across the system. Ian Quinlan advised that the governors appreciated receiving this information.

20/21/235 Review of the Meeting

The Chair acknowledged the pressures being experienced system wide and commended staff for the work that is taking place at Alder Hey to balance the needs of children and young people, as well as the cohort of adult patients in ICU. Attention was also drawn to the pastoral care that has been established to support staff through unprecedented times as a result of the pandemic.

Date and Time of Next Meeting: Thursday the 25th February 2021 at 9:00am via Teams.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2020-March 2021)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 25th of February 2021							
24.9.20	20/21/123.1	DoS – Governance and Safety Rates	Provide an update a further update on the work that is taking place to address governance in the DoS.	Alfie Bass	25.2..21	Closed	**23.1.21** - This item has been deferred to February due to the governance light committee approach that has been taken as a result of the 3rd wave of the pandemic. **19.2.21** - This item has been included on February's agenda. **ACTION CLOSED**
26.11.20	20/21/177.3	Covid-19 Assurance Plan – Progress Update	*Financial Framework Update* - During the next regional call, query the detail of the incentives if the Trust exceeds its targets.	Rachel Lea	25.2.21	Closed	**17.12.20** - It was confirmed that the incentive model is on hold at the moment. This query has been lodged with the regional office and an update will be provided in due course. **19.2.21** - It has been confirmed that the incentive scheme for 20/21 has been withdrawn due to wave 3. **ACTION CLOSED**
26.11.20	20/21/177.4	Covid-19 Assurance Plan – Progress Update	Arrange for a Board strategy session to place in February.	Karen McKeown	25.2.31	Closed	**27.1.21** - A Board strategy session has been scheduled for the 29.4.21. **ACTION CLOSED**
28.1.21	20/21/225.1	CQC Section 31 Response and Action Plan	Discussion to take place about sharing the report on the outcome of the investigation relating to StEIS reference number 2020/13420, with CQC as well as the action plan, once complete.	Nathan Askew/ Louise Shepherd	25.2.31	Closed	**19.2.21** - It was confirmed that a discussion has taken place regarding this matter. **ACTION CLOSED**
28.1.21	20/21/228.1	Cumulative Corporate Report – Top Line Indicators	*Quality: Friends and Family Test for ED* - Discussion to take place with the ED Team about the possible benefits of exception setting for when patients arrive at the front door.	Nathan Askew	25.2.31	Closed	**19.2.21** - It was confirmed that a discussion has taken place with the ED Team regarding this matter. **ACTION CLOSED**
28.1.21	20/21/229.1	Cumulative Corporate Report – Top Line Indicators	*People: Mandatory Training* - Enquire as to whether mandatory training is on the radar from a national/system wide perspective.	Melissa Swindell	25.2.31	Closed	**19.2.21** - There have been no communications from the centre on this subject, but we remain focused on compliance across the Trust. **ACTION CLOSED**
Actions for the 25th of March 2021							

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2020-March 2021)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
03.03.20	19/20/346	Key Issues/Reflections and items for information	Invite the new Nurse cohort from India to the Trust Board lunch and write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff.	Pauline Brown	25.2.21	On Track	This item has been deferred until further notice due to the Covid-19 crisis.
02.06.20	20/21/60.1	Freedom to Speak Up	Compile a breakdown of the issues that SALS have addressed during the current year.	Kerry Turner	25.2.21	On Track	23.1.21 - This item has been deferred to March due to the governance light committee approach that has been taken as a result of the 3rd wave of the pandemic.
26.11.20	20/21/188.1	Board Assurance Framework	Submit the Risk Management Strategy to the Board for ratification in January.	Erica Saunders	28.1.21	On Track	23.1.21 The Risk Management Strategy is to be submitted for ratification in March 2021. **ACTION TO REMAIN OPEN**
26.11.20	20/21/188.2	Board Assurance Framework	Submit the risk appetite to the Board in March 2021 for ratification.	Erica Saunders	25.3.21	On Track	
17.12.20	20/21/205.1	Corporate Report Divisional Updates	Division of Surgery - Provide an update on the 'Step Programme' in March 2020.	Alfie Bass	25.3.21	On Track	
Actions for the 25th of April 2021							

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2020-March 2021)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
07.07.20	20/21/93.1	Serious Incident Report	Compare recent Serious Incident figures against data from previous years to ascertain improvement.	Pauline Brown	29.4.21	On Track	**24.9.20** - A comparison of figures has been conducted against data from the previous year and included in the Serious Incident report. Kerry Byrne asked if a comparison of the last two to three years could be carried out to look at whether the Trust has more or fewer serious incidents. It was agreed to provide this information via a line graph in the next report. **22.10.20** This will feature in December's report. **ACTION TO REMAIN OPEN** **17.12.20** - It was agreed to amend this action and provide a themes and trends analysis of the last three years in order to carry out a comparison with the Trust's peer groups rather than the national system. It was confirmed that this information will be included in the Serious Incident report for Q4 or at the very latest Q1 in 2021/22. **ACTION TO REMAIN OPEN**
Status							
Overdue							
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
25th February 2021

Report of	Development Director
Paper prepared by	Associate Development Director- (20/01/2021) Sue Brown
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development report on the Programme for Delivery

February 2021

1. Introduction

The purpose of this report is to keep the Board informed of progress, risks and actions on the key capital projects as they arise.

As of Month 2 in Quarter 4 of 2020/21 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2019-2023 (financial years).

Table 1.	19/20	20/21				21/22				22/23
Scheme	Qtr. 4	Qtr.1	Qtr.2	Qtr.3	Qtr.4	Qtr.1	Qtr.2	Qtr.3	Qtr.4	Year
Initial Park Reinstatement (Phase 1)										
Alder Centre occupation **COMPLETE**										
Acquired buildings occupation Future use under review										
Police station (Lower Floor) occupation										
Commence relocations from retained estate.*							*		Final phase	
Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks)										Final phase
Main Park Reinstatement (Phase 2/90%)										
Mini Master plan (Eaton Rd Frontage) 2 phases to plan										
Infrastructure works & commissioning										
Clinical Hub Construction										
Clinical Hub Occupation										
Dewi Jones Construction										
Dewi Jones Occupation										
Demolition Phase 4 (Final)										
Final Park Reinstatement (Phase 3)										
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										

- Although buildings have been vacated this has been achievable due to staff mainly working from home due to COVID19, there is the requirement to agree on the future office accommodation which will consist of some off site premises (business case submission to the February RABD) is currently the subject of executive level discussions.

An Executive design review group has been set up first meeting took place in December 2020; the next meeting will occur in March 2021, it entails a quarterly review of the whole campus development to ensure executive contribution and agreement.

3. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Planned works to sow the grass seed will be completed by April 16th. The formation of the Multi-Use Games Area (MUGA) is still in delay and materials are currently in storage for when a decision is reached. Work continues by Capacity Lab and the local community in the setting up of a Charitable Benefit Organisation. Members of the Friends and Community of Springfield parks groups have had an opportunity to walk the development over the last month.	Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9) Public perception that the park phase one is not being delivered.	Continued meetings with planners, residents and LCC parks officers to resolve the location. Capacity lab continues to engage with groundworks on a regular basis and involve stakeholders.

Acquired Buildings Occupation (neighbouring sites)

Current Status- on hold	Risks/issues	Action/next steps
Knotty Ash Nursing Home **Acquired future plan/usage currently under review.**		Keep up to date with business future plans/lease and potential for purchase of said buildings. Seek to maintain an interest and respond accordingly to any opportunities which present.

Police Station (lower floor) occupation

Current status- no update since last report	Risks/issues	Actions/next steps
Status unchanged since last report The Police have recently postponed any discussion about the Trust taking space in their building as they intend to use it themselves over the Covid crisis. It is unclear at present how long this postponement is likely to last but its anticipated this will not move forward until the Cluster is complete and the Police occupy the new build.	Police do not release the space while decisions are made in regards to additional police funding and its use. (Risk 2088, risk rating 12)	Development team agreed a contingency plan which has been actioned on a temporary basis. A long term plan is now required and will be formed as part of the work on relocation of staff.

Relocations

Current status	Risks/issues	Actions
The Trust requires additional space for office accommodation, options have been explored and a value for money exercise conducted. Following discussion at the executive level, a paper is going to the Resource and Business Development on the 22nd February which will be seeking support for the plan.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	Take recommendation to purchase an offsite building to Resource and business development for approval.

Demolition Phase 3 (Oncology, boiler house, old blocks)

Current status	Risks/issues	Actions
Works are now progressing on temporary services and diversions to enable demolition. Oncology, genetics and management blocks have all now been vacated and fully decommissioned this is however slightly behind plan by 1 month. Extensive asbestos surveys will be completed by the end of February, then the HSE will be informed so strip-out can commence in April.	Asbestos removal cost/time	Complete required works to make the land safe. Work with Finance colleagues to find the additional financial commitment and reduce the financial risk.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
An exercise on the costing is currently in progress and when concluded will go to the Resource and Development Group for review. The plan is to go to tender by the end of Qtr. 4 for the works. Capacity Lab have two major parties interested is supporting enhancement to the park through provision of a café/changing area. They are currently looking at how a modular design could make this an affordable option and will be looking at an initial design with the local stakeholder over the next 6 weeks and have it costed.	Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 16) Budget for Phases 2 & 3 is inadequate.	Working with landscape designer to reduce costs within the parameters of the Land Exchange Agreement. Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress. Share the design and costs with interested parties in view they could agree to fund the development.

NEW Mini Master Plan for Eaton Rd frontage

Current status-	Risks/issues	Actions
Turkington Martin, have been engaged for the initial design which will take in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). Work on the design continues, with involvement of the Arts group. A review and report has been commissioned and to be completed by Curtin's (Traffic management consultants)	If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8)	Add to risk register. Continue design work and receive report on advised traffic management from Curtins (due March 2021)

Initial Budgets have been costed; a design review meeting with executive colleagues occurred in December 2020 when it was decided that we undertake a review of the potential traffic control options for the entrance both now and when future developments are completed. This will provide options on works and costs. The favoured option would require Liverpool City Council Highways approval.		Confirm total costs and identify any gaps in the allocated budget.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
Roads and landscaping – the Trust is currently working with Turkington Martin landscape designers to shape the East/Eaton Road end of the new campus (as per Mini masterplan section The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments. Electricity new supplies; • Now Received an offer from Scottish Power for our HV supply which we are looking to accept • Proceed with new energy centre • Tender will then go out by the end of February for associated works which require a high level of quality to ensure all work reaches relevant safety standards.	Early indication is that to complete all of the work	Value engineer the proposed plans with the architect. Explore estimated costs and market test/tender. Submit planning application for the new energy centre to Liverpool City Council planning department by the end of February 2021

Clinical Hub and Dewi Jones Construction

Current status	Risks/issues	Actions

Contract with Galliford Try remains on programme with good visible progress.	Ongoing design development potentially could raise issues of quality leading to increases on cost.	Continue with weekly meetings with Galliford Try and challenge design where necessary.

Demolition Phase 4 (Final)

Current status	Risks/issues	Actions
N/A at current time, planned for Qtr. 4. 21/22	Cost may exceed current allocated budget.	Monitor demolition budget management on a monthly basis and work up contingency plan.

Neonatal Development

Current status	Risks/issues	Actions
Currently within the agreed delay period of 8-12 week whilst further design work on emergency care facilities are planned with the Emergency department teams for the capacity on the ground floor of the planned build (shell and core area). On the Neonatal element of the project the design is currently at stage 3 and will ready to tender at conclusion of the stage, continued work will then progress to stage 4. Three parties interested in the construction Interserve, Morgan Sindell and Galliford Try	Project Co engagement extending the programme and increasing costs; Planning and any unknown Section.106 or section S.278 costs Potential lack of capacity for increased demand for medical oxygen (risk 2353, rating 20) and medical air (risk 2355, rating 16)	Continue working with Project Co to mitigate impact. Work with LCC planners to minimise impact Continue to Investigate capacity and future supply demand of evaporator and Medical Air Plant with view to provide options appraisal for solutions to both risks.

	Planning permission fails to be achieved within the timescale of the overall programme delivery.	Maintain open communication with the LCC planning departments.

North East Plot Development

Current status- static	Risks/ Issues	Actions/next steps
StepPlaces, the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support Several work streams are taking place to review potential service enhancements. Business cases for each of the work streams will be brought forward over the next 4 to 6 months.	Change process with Staff will present some challenges Cost of providing the developments do not match income from commissioners	Maximise our offering/ support /negotiation on development content and opportunities. Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability. Produce robust business cases to highlight any issues/risks. Ensure Colleagues from HR are involved in any proposed changes along with all stakeholders.

Communications

Current status-	Risks / issues	Actions/next steps
Regular dialogue between development team and Communications department are now in place to cover the park development. Fortnightly meetings established to discuss wider campus development progress.	Loss of reputation, locally and regionally.	Maintain links with community and support their development work.

	Lack of engagement internally and externally	

Car Parking

Current status	Risks/Issues	Actions/next steps
The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday. The initial lighting installed did not meet our needs, these where replaced during the month with hired lights and the car parking group will make a case to either purchase these later in the year or re-hire in the autumn as this car park is only open during office hours and lighting will not be needed during the spring and summer months. A member of the Development team is commencing work this month on how we can implement developments which support a green travel plan.	Staff resistance to change. Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	Review car parking requirements in view of the home working currently in play due to COVID 19 and what the future requirements might look like. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan.

4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 17th February 2021.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2021

Paper Title:	**Access and Restoration**
Report of:	**Chief Operating Officer**
Paper Prepared by:	Lachlan Stark, Associate Chief Operating Officer Planning & Compliance

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	Additional resources being spent increasing capacity with evening and weekend working. Non-delivery of restoration targets could lead to a reduction in income; although presently the adjustment to income is not being applied.

1. Introduction

Our phase 3 COVID-19 plan has continued to sustain a high-level of planned care to children and young people, as well as maintaining urgent, emergency and critical care services. In January we established an adult intensive care unit (AICU) on the Alder Hey site; this has had an adverse effect on waiting times and levels of restoration. In order to safely staff the AICU it was necessary to adjust the theatre schedule: in January we delivered 100- 110 sessions per week relative to the usual schedule of 149 sessions. Sustaining two-thirds of the theatre schedule whilst providing intensive care to adult patients with COVID-19 was a notable achievement and testament to the commitment and planning of colleagues.

Our goal remains to reduce waiting times and improve access to care. In Q4 we expect additional capacity to come online including the use of independent providers to deliver care on the Alder Hey site. Furthermore, we have a strategy support each specialty to have a plan for delivering outstanding access to care in 2021-22. This approach will enable each specialty to put in place the right capacity for their service and explore opportunities for improving our service models in light of the waiting list backlog.

2. Summary of progress in restoring services

Our performance for restoration of services from August to January is as follows:

Service	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Outpatients	13,108	16,581	16,656	17,441	14,988	15,768
Daycase	1464	1532	1675	1780	1726	1522
Elective	370	378	422	423	400	353
IP/DC	1,834	1,910	2,097	2,203	2126	1875
Diagnostics	1,413	1,608	1,554	1,552	1589	1556

Service	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Outpatients	86%	87%	84%	95%	95%	86%
Daycase	83%	74%	85%	92%	94%	81%
Elective	86%	88%	98%	92%	102%	87%
IP/DC	84%	76%	87%	92%	95%	82%
Diagnostics	92%	90%	86%	90%	105%	97%

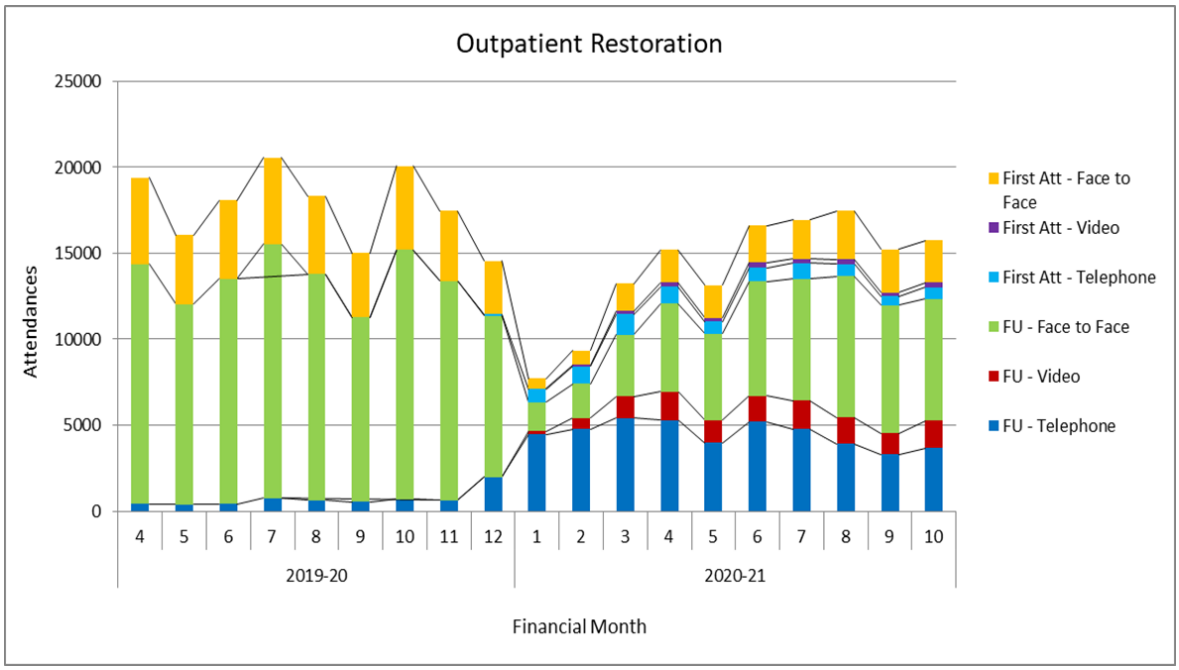
In **outpatients** we have increased overall activity, as expected, relative to December but the proportion of activity restored fell in-month. In **elective and daycase**, we have reduced activity following the provision of mutual aid. In **diagnostics,** we maintained a high-level of activity relative to the previous January. Progress against restoration is tracked through a live-app and reported to Gold Command.

3. Restoration by service area

3.1 Outpatients

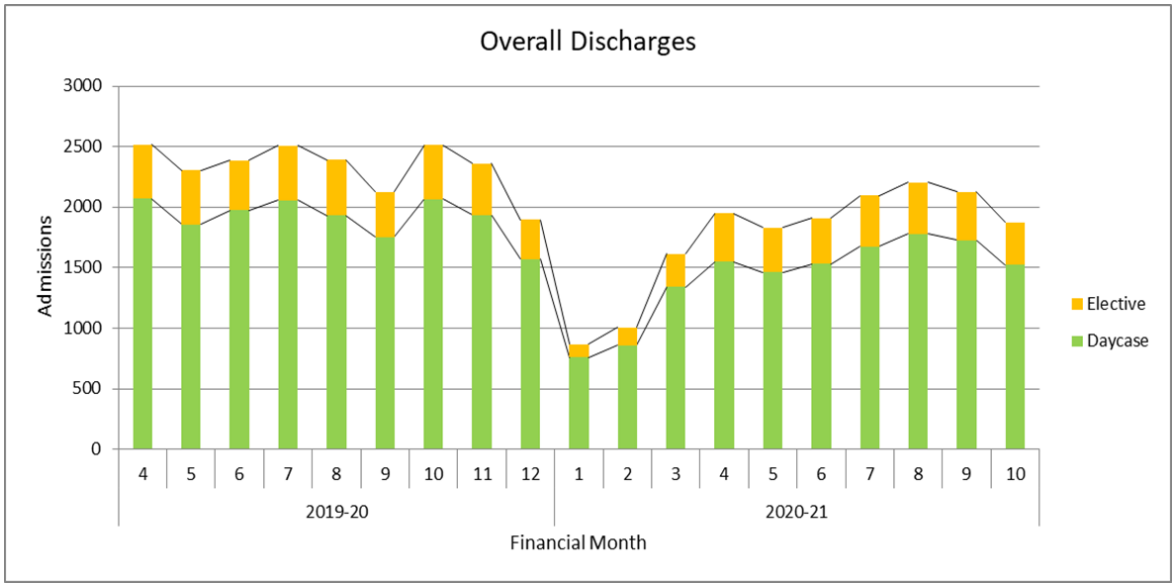
We are looking to take additional actions to achieve 100% level of restored outpatient activity by Q1 2021-22. This includes:

- Use of the independent sector and LLP to increase capacity
- Outpatient transformation programme focused on booking and scheduling to improve use of clinics, digital adoption and specialty-based improvement
- Specialty-based actions include continuous improvements around cleaning, testing new outpatient models of care and additional sessions.



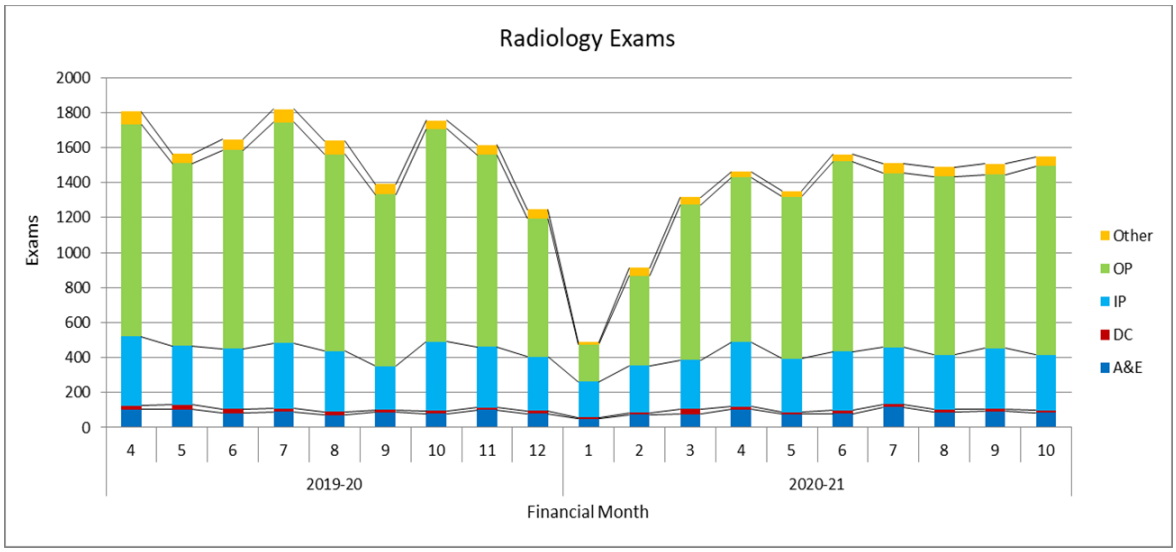
3.2 Elective & Day Case Activity

Elective activity restoration has reduced following the commencement of mutual aid and the reduction of 49 theatre lists per week. In late February we will restore a high proportion of the theatre schedule as the AICU will close. We also have plans to commence additional theatre sessions in March through the independent sector and LLP. A day surgery improvement group is reviewing improvements that support patient experience and in-session productivity.



3.3 Diagnostics

The Clinical, Radiology and Day Case Teams continue to work to improve access by refining the suite of initiatives to maintain safety and to reduce the waiting times. The Diagnostic (Restoration / 7 of the 15) activity has been clinically reviewed to ensure we are capturing all activity associated with this target and this is reflected in our performance. In terms of DM01 (all 15 diagnostics), the percentage of diagnostic tests performed within 6 weeks was 93.7% in January.

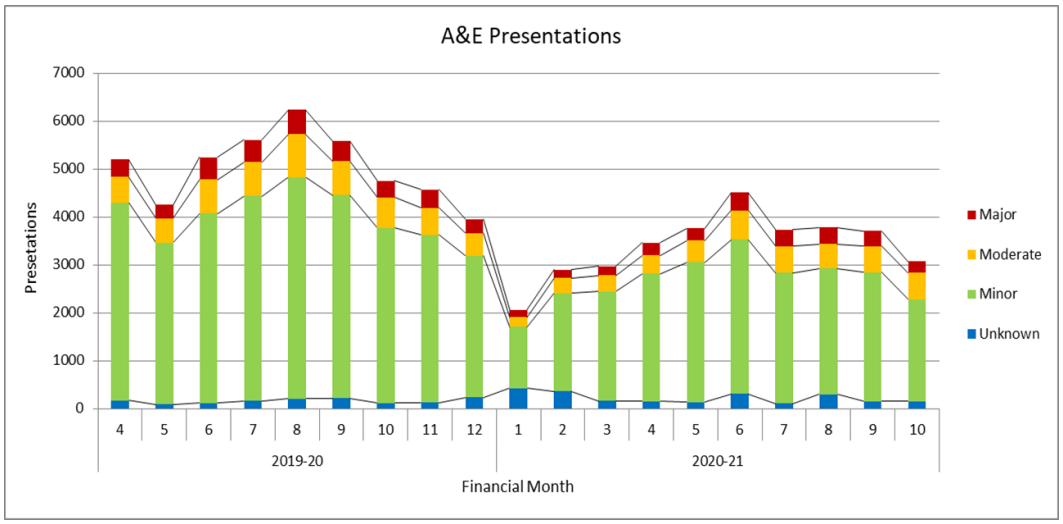


Diagnostics (DM01) Performance against 99% standard

DM01	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan
%perf	42.8%	67%	81.9%	82.9%	78.9%	87.0%	91.8%	97.1%	92.3%	93.7%

3.4 ED attendances

ED performance for the year has been consistently above the 95% standard despite the challenges of social distancing. Attendance has remained consistently below pre-COVID levels for several months, as demonstrated in the graph below.



ED 4hr access standard performance:

Month	Total	Type 1
Aug-20	97.79%	97.79%
Sep-20	95.43%	95.43%
Oct-20	96.92%	96.92%
Nov-20	97.51%	97.51%
Dec-20	98.63%	98.63%
Jan-21	98.47%	98.42%

3.5 Cancer Performance

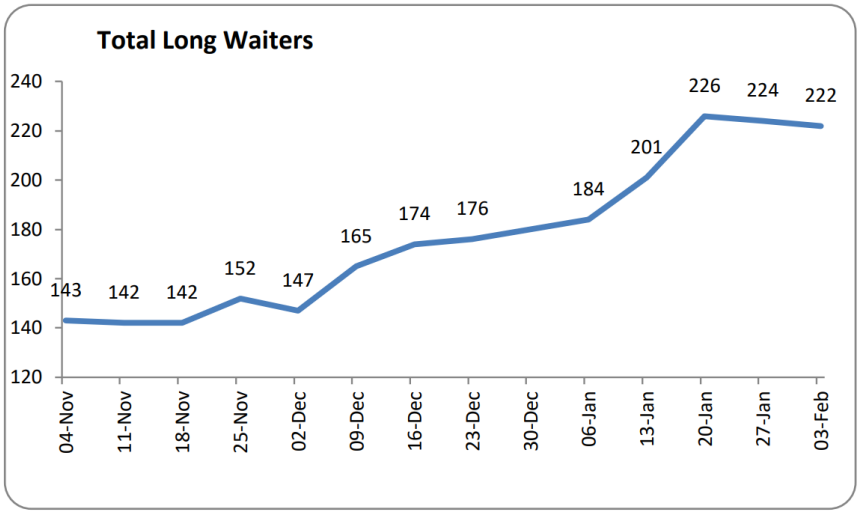
Throughout the pandemic we have maintained outstanding access to children's cancer care despite the pressures on theatre and critical care provision.

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%

4. Waiting time analysis: planned care

4.1 52 weeks waiting time performance and RTT performance

In January the number of patients waiting over 52 weeks for treatment increased relative to December. The cause is twofold: validation of records relating to safe waiting list management and the contraction in the theatre schedule leading to an increase in waiting times for inpatient care.



	Jan
Open pathway RTT performance (18 weeks)	↑ 61.3%
Total number of patients > 52 weeks	↑ 222

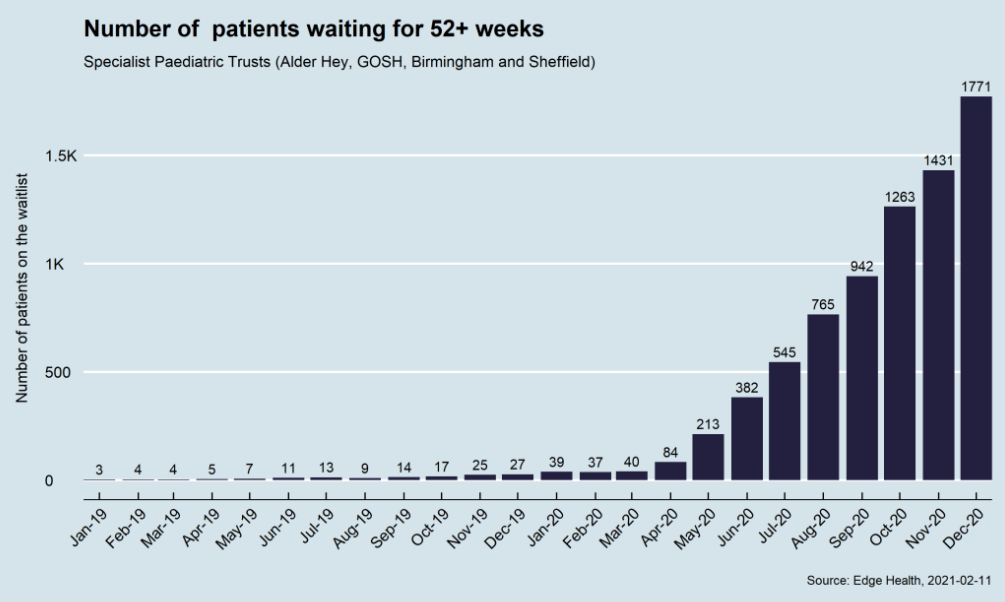
4.2 Benchmarking

We have undertaken some benchmarking analysis of other specialist paediatric Trusts.

	Total patients waiting > 52 weeks
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	201
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	736
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	474
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	486

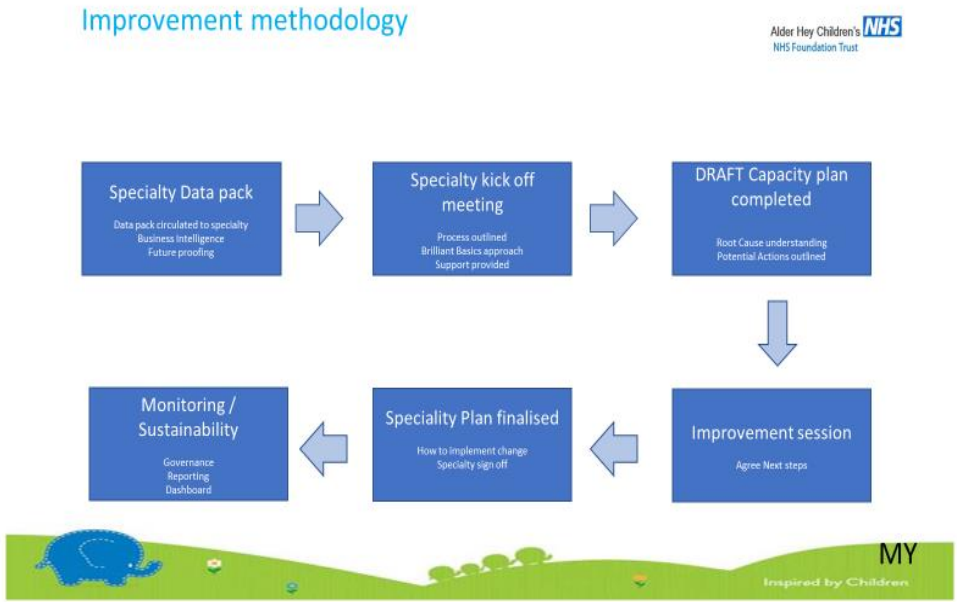
Source: access January 2021, NHSE national waiting time data

The challenge of an increasing number of children and young people waiting over 52 weeks for treatment is replicated nationally:



4.3 Our response: delivering outstanding access to care

In March we will start to develop service plans with all specialties that will set out the high-impact actions that improve waiting times in that specialty. It will focus on four themes:



5. Conclusion

A relatively high-level of service restoration has been maintained despite the commitment to care for adult patients with COVID-19 requiring intensive care. Pressure on waiting times for planned care remains high and we will develop specialty-based plans for 2021-22 to set out the actions, capacity required, resources and approach to reducing backlogs and delivering outstanding access to care for children and young people.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2021

Paper Title:	**DIPC Monthly Exception Report**
Report of:	**Infection Prevention & Control Exceptions**
Paper Prepared by:	***Dr Beatriz Larru*** *DIPC,* ***Joanna McBride*** *Interim ACN Corporate Services,* ***Carly Quirk*** Data Analyst

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	N/A
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	N/A
Associated risk (s)	636, 637, 654, 795, 1506, 1919, 2081, 2118

Alder Hey Children's NHS
NHS Foundation Trust

INFECTION PREVENTION & CONTROL EXCEPTION REPORT 2020-21 JANUARY 2021

Metrics

For 2020-21 we have agreed targets for each of the metrics set out below in table 1 for hospital acquired cases. Figures below show status up to 31st January 2021.

Metric	Target 2020-21	Target Figure	Actual Figure	Current Status
HA - MRSA (BSI)	Zero Tolerance	0	0	✓
C.difficile	Zero Tolerance	0	3	✗
MSSA	10% Reduction from 19-20	6	8	✗
CLABSI (ICU Only)	Match 2019-20	12	16	✗
Gram-Negative BSI	10% Reduction from 19-20	19	13	✓
RSV	Match 2019-20	7	0	✓

COVID Vaccination

Alder Hey Staff

No of Staff	3890
First Dose Administered	3119
% Complete	80

Breakdown of Professional Groups

Staff Group	Number of Staff	First Dose Administered	% Complete
Add Prof Scientific and Technic	315	245	78
Additional Clinical Services	501	357	71
Administrative	843	680	81
Allied Health Professionals	298	255	86
Estates and Ancillary	232	179	77
Healthcare Scientists	132	116	88
Medical and Dental	335	298	89
Nursing and Midwifery	1234	989	80

	Total
AH staff	2757
Other Orgnaisations	579
Total	3336

Additional Activity/Achievements/Issues

Fit Testing
Increased capacity in the team. At the end of January 2021, this has achieved fit testing compliance to be at 91%.

Policy and Guideline
Chicken Pox guideline has been reviewed and approved at IPC Committee.

Track, Trace and Swabbing Team
Team fully established with a robust testing programme for patients, staff and families.

Self-Testing
Lateral Flow Testing continues to be successful with more than 3,000 kits have been distributed to staff.

COVID-19 Outbreaks
Outbreak management (four in total in two in December and two in January). No impact to service provision. Bespoke training regarding PPE given to staff within the said areas.

Critical Care support to the Adult population
During the month of January 2021, critical care has provided Level 3 intensive care support to 10 adult patients from the North West region in total.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2021

Paper Title:	COVID 19 Risk Report
Report of:	John Grinnell, Deputy CEO/Director of Finance
Paper Prepared by:	Cathy Umbers, Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Background Papers and/or supporting information:	COVID 19
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** **Strong Foundations**
Resource Impact:	Identified in the report.

1. Purpose

The purpose of this report is to enable the Trust Board to scrutinise the current COVID 19 risk position and provide assurance that the risks are being managed effectively.

2. Summary.

There are currently **19** risks identified on the COVID 19 risk register. There are zero high risks on the register. The risk profile is outlined at appendix 1 table 1.

Number of closed risks removed from the risk register = **6** (refer to appendix 1, table 2)

Number of new open risks = **0**

Number of risks with an overdue review date = **0**

Number of risks with overdue actions = **0**

Number of risks with no agreed action plan = **0**

Number of open risks with increased risk scores = **0**

Number of open risks with no risk rating = **0**

3. Themes

3.1. Access to services

Risk ref 2178: **2x3 =6** *"Risk of not seeing C&YP who need treatment, the associated risk of late or no presentation and associated potential for harm*.*When first identified in May 2020 this risk was rated as 4x5 = 20,,currently rated 2x3 = 6. Late Presentation Ulysses report shows no harm incidents reported. Controls in place outlined in previous reports remain effective.

Risk ref: 1560, 3x4 =12 "*Risk of patients breaching 18 weeks referral to treatment target (CHAMS)"* This risk was first identified in 2018 and at that time was rated 3x3=9. It increased significantly at the start of the Pandemic in April 2020, to a rating of 3x5=15, risk level now 3x4 = 12, same as last reporting period. Telephone risk assessment are in place for children and young people waiting for partnership appointment, staff are clinically reviewing and assessing the child or young person's current risk and need for service. Waiting are times reviewed as a regular item on the Weekly Management meetings. Interventions – the service are offering single session therapy and group therapy groups - available for children and young people on the waiting list. Risk advice is given to all families and 24/7 Crisis Care telephone number to contact is provided if families require input while waiting for an appointment. COVID virtual peer support group has been set up funded by the Lottery to support up to 80 children and young people who are on waiting lists to help reduce waiting times. The service has a Psychiatry Lead supporting whose focus is to improve RTT and reducing long waits. Liverpool & Sefton

Risk ref. – 2228: 3x3=9 "*Risk of delay in access to Theatre will result in suboptimal outcome for children and Young people*". This risk remains at a risk level of 9 since first identified in July 2020. This risk is linked to two high risks on the Corporate Risk Register (CRR), *risk ref 2265: Risk of Children and young people on the waiting list experience an avoidable delay to care* (3x5 = 15) and risk refer 2235: *"risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list",* (3x5

=15). Both these risks are being robustly managed with numerous controls and actions in place to mitigate as quickly as possible.

Risk ref. – 2287: 4X3=12. *"Risk that complex neurodisability patients who require aerosol generating procedures (AGPs) physical condition will deteriorate further over time",* Regular meetings chaired by the strategic send lead continue to take place. Small number of children did return to school before Christmas and other barriers were being discussed to support others to return at that time. Since the latest lockdown this group of children are not attending school again. In the meantime, these children at being seen at home where appropriate. No change to risk position since last reporting period.

Risk ref 2285: 4x3 =12. This is a cardiology network risk identified on the Trust risk register. "*Risk to Operational Delivery Network function as pandemic impacts on the ability of providers within the North West Congenital Heart Disease Network to continue to provide normal services*". This risk was first identified in September 2020. There are 6 clear controls in place, but these are not sufficiently robust to enable reduction in the risk rating. For example, North West Congenital Heart Disease Network is actively monitoring backlogs across the all age service (level 1 & 2). Surgical/Interventional/Electrophysiology waiting lists and capacity including outpatient backlogs. Data is being shared on a monthly basis with Regional Commissioners and Central NHS England Team. Patient listed for surgery/intervention and electrophysiology procedures are being triaged regularly. Clinical prioritisation of outpatient's services being done across some services. Inconsistency around clinical prioritisation across the Network. Level 1 service not currently using Royal College of Surgeons classification as recommended by NHS England. No change in position since last reporting period.

3.2. Staff welfare/resilience (short and long term, including staff absence, BAME, PTSED etc.).

Risk ref: 2138 3x3 = 9 *"Risk that front line nurse availability to work will be significantly compromised during winter 2020 the second COVID peak and that compliance with national nursing standards for safe staffing levels on wards and departments will not be met (RCN / PICS / BAPM / QNIC / NQB) and / or the ability to have beds / services will be significantly affected"* Risk level reduced from 4x4 =16 to 3x3 = 9, since last reporting period. Staffing has remained at green status throughout January and February despite higher sickness levels than normal; low bed occupancy and planned bed closures due to adult intensive care facility. Alder hey has also been able to support staffing the Nightingale Hospital and assisted in short notice mutual aid requests for staff at other hospitals - on a strictly voluntary basis by the staff members. ICU staffed throughout the period of caring for adult patients with Bed Buddies; adult offer due to complete on 19th February; deployment of staff back to their substantive role and subsequent debrief and learning from experience to take place. 10 nurses have joined the Trust from India; due to undertake OSCE in March. NMC have introduced ECP students again for 3rd year final placement student nurses; 48 students have opted in and all placed and commenced 12 weeks paid. placement in line with NMC and HEE guidelines at Band 4. All vacancies, ML and LTS therefore covered.

3.3. Infection to CYP, families and our staff.

Risk ref: 2180, 4x2 = 8 "*Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained"* At time of initial risk identification and assessment in April 2020 this risk was rated as 5x3 =15, current rating 8. There is reliable national supply in place sufficient to meet Trust needs. In the event any products are not available, the Trust have robust contingency measure in place (alternative products or practices)' to ensure that it can still operate effectively. No change in risk position since last reporting period

There are **3** low moderate risks identified relating to Staff becoming infected with COVID 19 i.e. 2268, 2263, 2267 However, all COVID secure risk assessments have been completed and all areas are deemed COVID secure, with action plans to further mitigate risks where relevant.

Appendix 1 Risk Register Profile – 18th February 2021 (Total 19)

Table 1

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk				No risk rating
1	2	3	4	5	6	8	9	10	12	15	16	20	25	
0	**0**	**0**	**0**	**1**	**6**	**2**	**5**	**2**	**3**	**0**	**0**	**0**	**0**	**0**
0 (0.00%)			**7 (37%)**			**12 (63%)**				**0 (0.00%)**				**(0.00%)**

1 - 3	Very Low
4 - 6	Low
8 - 12	Moderate
15 - 25	High/extreme

Table 2 Closed risks 6

Risk reference	Risk description	Target
2143	Risk of delay in imaging and subsequent delay in treatment".	5
2118	Risk of Staff acquiring COVID 19 in the workplace	4
2343	"Risk that standard of care for adult patients in paediatric hospital might not be equivocal to that received within a district general, adult care focussed environment".	5
2182	Risk of Insufficient financial resource to meet demand. this risk has been closed on the operational risk register as the risk is a duplicate of the BAF risk 3.4 .	Closed at risk rating 4x4 = 16. BAF risk 4X4 =16
2181	Increased risk to staff mental health and emotional wellbeing – this risk has been closed on the operational risk register as the risk is a duplicate of BAF risk 2.2	Closed at risk rating 3x3 = 9 . BAF risk 3X3=9
2128	Failure to comply with Clinical Trial Regulations	3

END

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2020

Paper Title:	Serious Incident Report
Report of:	Nathan Askew, Chief Nursing Officer
Paper Prepared by:	Cathy Umbers Associate Director of Nursing and Governance
Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Background Papers and/or supporting information:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. Revised Never Events Policy and Framework (NHSI 2018) Never Events List 2018. NHS Patient Safety Strategy. NHS Improvement. July 2019.
Action/Decision Required:	To note ■ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	n/a

1. Purpose of the report

The purpose of this report is to provide the Trust Board with an overview of open and closed incident investigations reported externally to the Strategic Executive Information System (StEIS), that met the serious Incident criteria, in this reporting period, (1st January – 31st January 2021).

2. Summary

Section 1- **StEIS reported incidents performance**
Shows there were **14** incidents StEIS reported in total during 2019/20, including 4 Never Events. The start of the financial year 2020/21 shows that in April 2020, there were 4 open StEIS reported incident, of which **3** had been carried forward from the previous financial year.
.

Section 2 - open ongoing investigation - shows there are **8** ongoing incidents currently under investigation, **6** previously reported to Board, that meet the SI criteria, There were **2** new investigations open during this reporting period, i.e. 2021/1899, 2021/1919, 72 hour reviews completed, both duty of candour compliant.

Section 3 – closed investigations – shows there were 2 closed investigations during this reporting period.

Note: No moderate harm incidents reported.

Section 1

Table 1 StEIS reported Incidents and Never Events performance data 2019/20

Serious Incidents													Cumulative
Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	
New	0	0	2	2	0	4	1	0	3	1	1	0	14
Open	3	2	0	4	4	7	5	5	3	4	4	4	4
Closed	2	1	2	0	0	1	3	5	2	2	1	0	19
Never Events													
Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	
New	0	0	0	0	0	2	0	0	1	0	1	0	4
Open	0	0	0	0	0	0	0	0	0	1	1	0	1
Closed	0	0	0	0	0	0	0	0	2	0	0	0	2

Table 2 StEIS reported Incidents and Never Events performance data 2020/21

Serious Incidents												
Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
New	1	0	0	3	5	1	1	0	2	2		
Open (Total)	4	4	1	4	8	9	8	6	8	8		
Closed	1	0	3	1	0	1	2	2	0	2		
Never Events												
Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
New	0	0	0	0	0	0	0	0	0	0		
Open (Total)	1	1	0	0	0	0	0	0	0	0		
Closed	0	0	1	0	0	0	0	0	0	0		

Note* 3 cases carried over from the previous financial year.

Section 2 : Open ongoing investigations Table 3

StEIS Reference	Date reported	Incident	Agreed date of completion
2021/1899 (new)	24/01/2021	Unexpected death of a patient (HDU)	22/04/2021
2021/1919 (new)	02/01/2020	Patient under care of Bangor, who contacted Neurology Team at AHCH for telephone advice. Patient treated according to advice provided, patient suffered raised intracranial pressure requiring shunt, queries around treatment pathway advice provided.	23/04/2021
2020/23808	09/12/2020	Grade 3 pressure Ulcer under halo jacket.	05/03/2021
2020/23828	09/12/2020	Waiting list data quality issues	05/03/2021
2020/608	07/01/2020	Misdiagnosis of the grading of a tumour in 2011 - Diagnostic incident ,including delay, meeting SI criteria	01/04/2021
2020/15939	21/08/2020	Removal of Kidney	19/03/2021
2020/16210	26/08/2020	Patient death following catastrophic and irreversible brain haemorrhage	19/03/2021
2020/19439	12/10/2020	Inappropriate clearance of C-Spine	12/03/2021

Section 3: Closed Investigations Table 4

StEIS Reference	Incident	Duty of Candour
2020/16208	Patient death, following posterior vault expansion for an atypical presentation of multiple suture synostosis (i.e. patient did not appear to have any of the classic craniosynostosis syndromes). No root cause identified, awaiting post mortem report.	Completed -Compliant Date submitted to CCG 30/01/2021 – agreed date
Actions Review the pathway for pre-operative anaesthetic assessment as part of the pre-operative process for craniofacial surgery Review the consent process for all patients undergoing craniofacial surgery Review the environmental temperature control in theatres		

StEIS Reference	Incident	Duty of Candour
2020/18368	Teeth replanted in incorrect sockets (UR1 &UR2)	Completed - Compliant
		Date submitted to CCG
		30/01/2021 – agreed date

Actions

1. Information leaflets for patients receiving treatment in Emergency Department for families including contact details for Dental department to be developed and available for patients, parents/carers.
2. Discharge information for dental patients need to be available for General Dental Practitioners. To discuss with Meditech (Trust Electronic Patient Record system) development team to scope this work and put timescales in place. As an intermediary mitigation, establish facility for printed summaries to be provided to patient family prior to leaving Emergency Department/ manually sent to GDP's.
3. More training for General Dental Practitioners in management of dental trauma required, therefore plan this with Dental Commissioning Team to arrange training sessions and communicate with regional General Dental Practices

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2021

Paper Title:	**Mortality Report, Q2 – 2020/21**
Report of:	Medical Director
Paper Prepared by:	Karl Edwardson, Deputy Head of Information

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ■ ☐
Background Papers and/or supporting information:	N/A	
Action/Decision Required:	To note To approve	■ ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	■ ■ ■ ☐ ■
Resource Impact:	N/A	

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

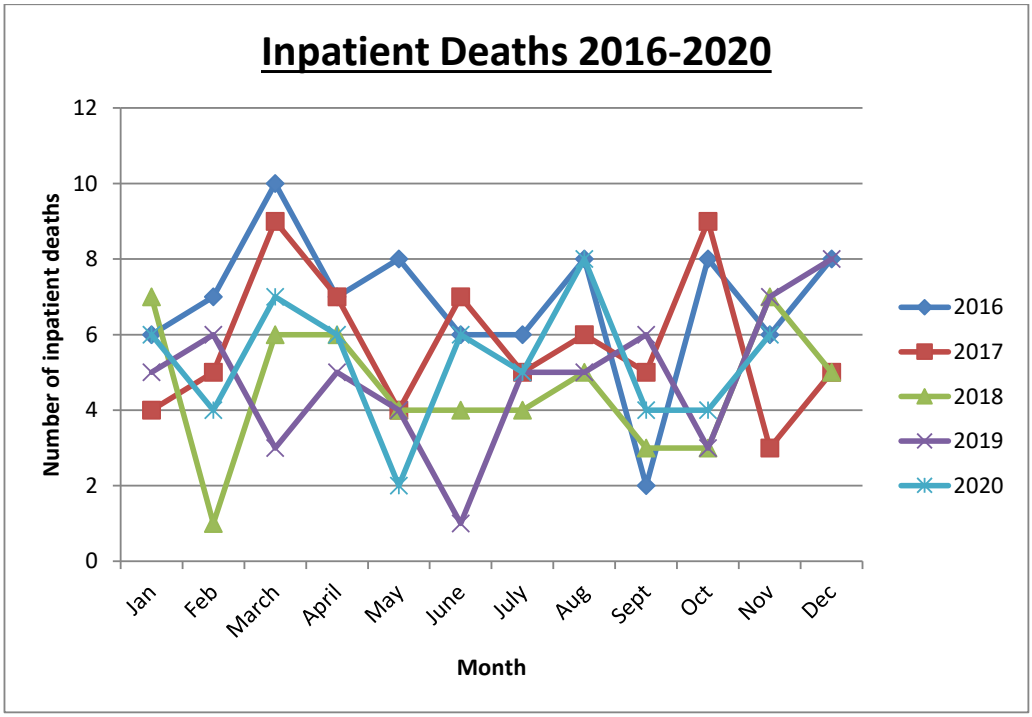
Section two is the Quarter 2 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG)

National Changes to the Child Death Mortality Process

The most significant change for mortality reviews is the introduction of the Medical Examiner system which was launched in hospitals across England and Wales last year. This system introduces a new level of scrutiny whereby all deaths will be subject to either a Medical Examiner's review or a Coroner's investigation. AHCH is currently considering which would be the best model for the organisation to adopt and how it will work alongside the processes already in place. These are currently being evaluated as it is vital to avoid replication or any additional stress to the family at this difficult time.

Mortality Figures for the last 5 years (inpatient deaths excluding adult deaths)



By looking at the table it can be seen that there has been no increase in the inpatient mortality rate at this time due to the impact of the COVID pandemic. This should be put in context with paediatric deaths in the region and the group will continue to monitor going forward.

Current Performance of the HMRG

Number of deaths (Jan. 2020– Dec. 2020)	52
Number of deaths reviewed	30
Departmental/Service Group mortality reviews within 2 months (standard)	45/52 (85%)
HMRG Primary Reviews within 4 months (standard)	26/36 (72%)
HMRG Primary Reviews within 6 months	23/25(92%)

The HMRG performance target of 4 months was 100 % in the last report which has now dropped to 72%. The main cause of this was that one of HMRG monthly meetings reviewed only the 4 adult COVID reviews resulting in delay in paediatric case reviews. This was essential as it enabled a thorough and complete review of the adult deaths and required additional time as it was different paperwork and initiated discussions 'out of our normal workload'.

The use of TEAMS for the meetings continues to increase the ability of people to attend within the Trust and outside, enabling more thorough discussions of the cases.

Outputs of the mortality review process for hospital deaths for 2020

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review / AAR	Learning Disability
							INT	EXT		
Jan-20	6	6	6	6	6	1				1
Feb-20	4	4	4	4	4	1				2
Mar-20	7	7	5	7	7	1				3
Apr-20	6	5	5	4	4	1			1	
May 20	2	2	2	0	2					1
Jun-20	6	4	5	3		2			1	2
Jul-20	5*	2	4	2		1			1	
Aug-20	8*		6							
Sep-20	4		4							
Oct-20	4		4							
Nov-20	6									
Dec-20										

Potentially Avoidable Deaths

Over this quarter there have been no potentially avoidable deaths in the cases that the group have reviewed.

Learning disabilities

The output table of the mortality process above records any children/YP that were identified as having learning disabilities. Out of the 30 cases reviewed, 9 have been identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages is to check there is no trend /issues in patients with learning disabilities which can occur at any age not just over 4.

In the last report there was a review of all the cases which did not demonstrate any concerning trends or recurrent

One of the main points identified was consistent communication with the families is needed from all the teams involved in the care; and the possibility of some written communication to be given, so the families can review when ready and ask questions.

Family

The bereavement team at Alder Hey provide an exceptional service and support for the family for a considerable time period after a patient has passed away (if wanted). There is ongoing work between HMRG, palliative care team and the bereavement team to improve the feedback that the group receives from families to continue to improve the care we provide.

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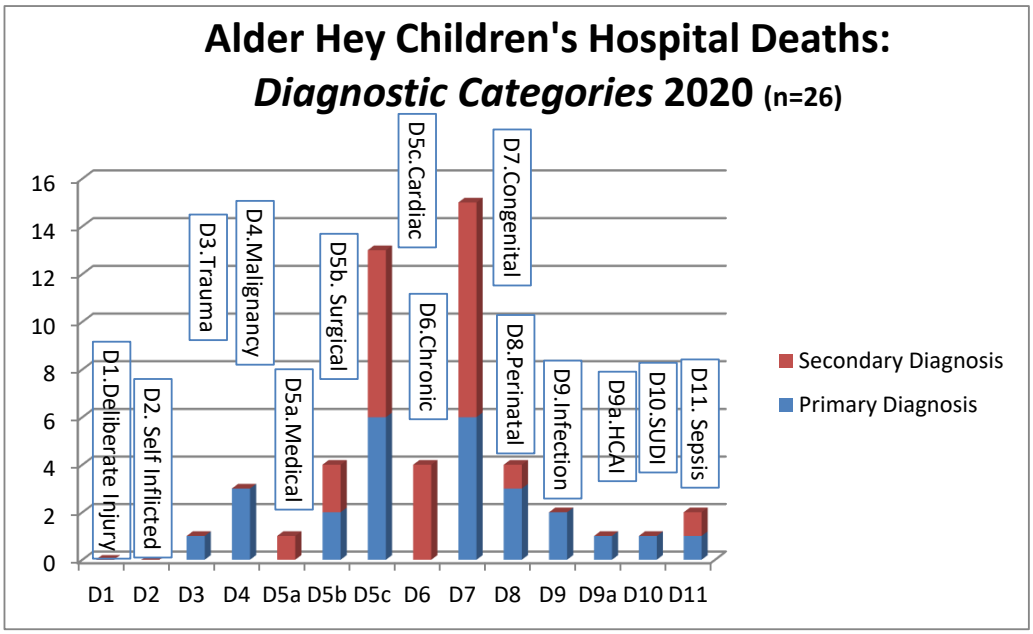
One concerning aspect that has been fed back from families is the impact that the limited visiting due to COVID is having upon them and indeed the staff involved. The Trust is following national guidance but it is in contrast to our usual visiting policies. Discussion is on – going as to how this can improved whilst not increasing the risk to staff or patients. This continues to be an issue raised by a number of families and staff especially with acute presentations

Adult COVID Deaths

There was an in-depth meeting reviewing these deaths as it is clearly not the usual Alder Hey Caseload. At the meeting, there were a number of individuals with adult expertise and familiarity with reviewing adult mortality cases. There were some areas that AHCH excelled at namely the communication with the

families and the support given by our bereavement/end of life care teams which some of the families' passed on their gratitude in this terrible time.
Clinically, there were issues faced by the AHCH ICU team that were also experienced by intensive care teams world -wide and practice was changed as more knowledge of this complex disease was gained. There was a steep learning curve prior to the arrival of adult patients re techniques and ensuring the correct equipment was available but as time progressed the team became more familiar. There was clinical support provided by adult colleagues across the region as there are understandably some areas that we are less experienced in due to not providing adult care regularly. At the meeting there was recognition that it had been a very difficult time for the staff involved and support had been organised by the Trust to ensure the well- being of all involved.

Primary Diagnostic Categories



Diagnostic /Disease Categories (based on CEMACH categories - ref Arch Dis Child 2011; 96:922-6 + 927-31)

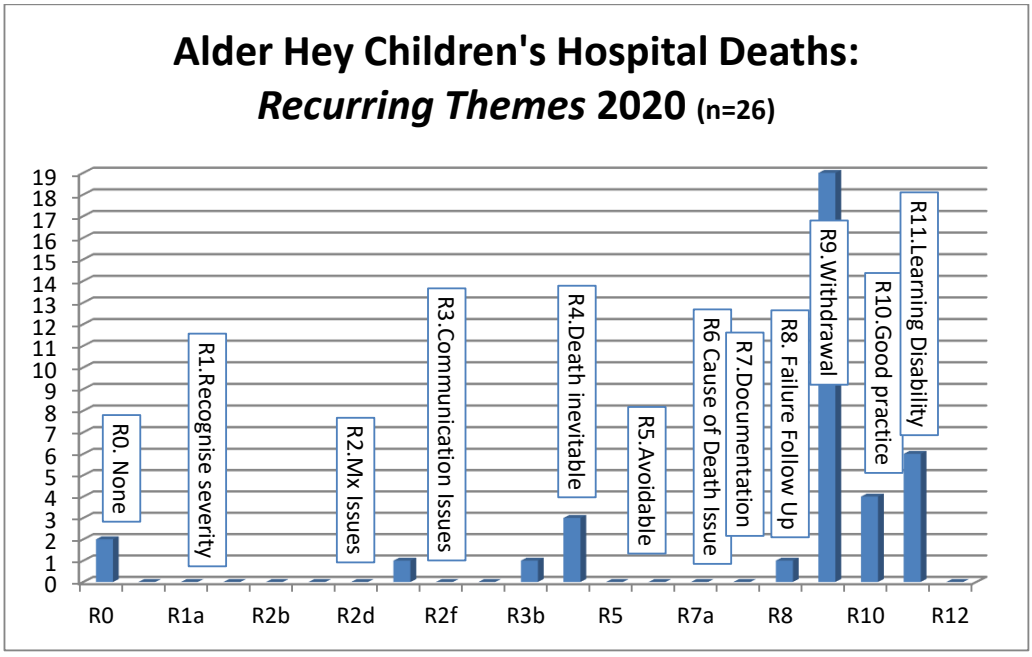
D1	Deliberately inflicted injury, abuse or neglect			
D2	Suicide or deliberately self-inflicted harm			
D3	Trauma & other external factors (excludes deliberate self-harm (D2)			
D4	Malignancy			
D5	Acute Medical or Surgical condition			
	subcategory	D5a. Medical	D5b. Surgical	D5c. Cardiac
D6	Chronic Medical Condition			
D7	Chromosomal, genetic & congenital anomalies			
D8	Perinatal/Neonatal Event			
D9	Infection/Sepsis (proven or clinical)			
	subcategory	D9a. Healthcare-associated infection (home or away)		
D10	Sudden unexplained, unexpected death/SUDI/SUDC - excludes SUDE (D5)			
D11	Sepsis			

The diagnostic codes cover only 26 deaths because although 30 cases have been reviewed 4 have not yet been closed and coded due to further information being required before completion.

The leading categories are cardiac and congenital at 23% followed jointly by perinatal causes and malignancy.

There were one hospital acquired infection identified, which was a fungal infection in a case where there was a necessity for long term antibiotics and a complicated medical history. There were no concerning features or learning points that we were able to identify as a group from it.

Primary Recurrent Themes



R0	No RT	
R1	Recognise Severity	R1a Failure to ask for Senior/Consultant review
R2.	Mx Issues	R2a Before Arrival
		R2b Delay in transfer
		R2c In Alder Hey
		R2d Delay in supporting services or accessing supporting services
		R2e Difference of Opinion re: Rx - Patients & families
		R2f Difference of Opinion re: Rx - Clinical teams
R3.	Communication	R3a Patients & families
		R3b Clinical teams
R4	Death Inevitable	
R5	Avoidable	R5a Alder Hey
		R5b Medical
		R5c External
R6	Cause(s) of Death Issue	R6a incomplete or inaccurate MCCD
		R6b Should have had post-mortem
		R6c Not agreed
		R6d Failure to discuss with HM Coroner
R7	Documentation	R7a Recording
		R7b Filing
R8	Failure of Follow Up	
R9	Withdrawal	
R10	Good Practice	
R11	Learning Disabilities	
R12	Known to CAMHS	

The commonest recurring theme was the withdrawal of care in 73 % of cases which demonstrates that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with the full agreement of the family, withdrawing intensive care whilst ensuring the child is comfortable.

The next commonest recurrent theme at 35% is the children /young people identified with learning disabilities, whom follow the process described earlier

on. There are no worrying recurrent themes apparent but we will closely monitor the learning disability theme to ensure that there are no concerning trends developing.
In the future, there will be review of the themes over a 5 year period to increase the numbers and so highlight any potential trends so we can scrutinise and ensure that we achieve all possible learning and so provide the best possible care that we can as an organisation.

Learning

The aim of the review process is to ensure that any learning that can be gained from any child/YP's death occurs and is widely shared both within the organisation and outside. This can cover any aspect of care whether it relates to car parking issues or clinical care which can be equally impactful on the family. Communicating this learning effectively throughout the Trust can be difficult and we aim to do this in a number of ways but it is definitely an area which can be improved upon.

The current methods:

1) Via the HMRG members feeding back to their departments
2) Through the divisional governance meetings
3) HMRG web page

Options going forward:

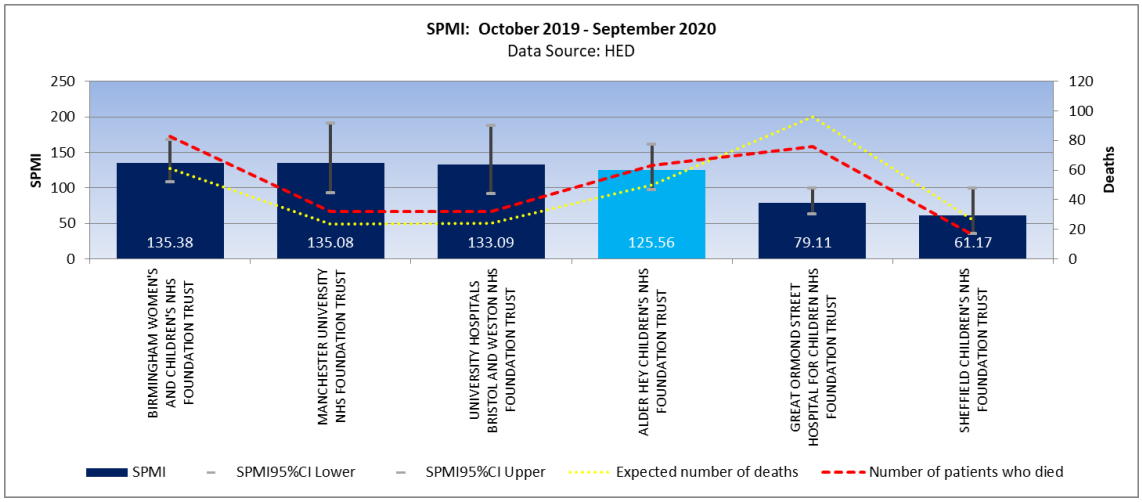
1) Podcasts would be very accessible and are extremely popular. This may take some time to organize but would offer an opportunity to maximize the learning across the organisation. There would be huge potential for learning across many aspects if done correctly.

Section 2: Quarter 2 Mortality Report: July 2020 – September 2020

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

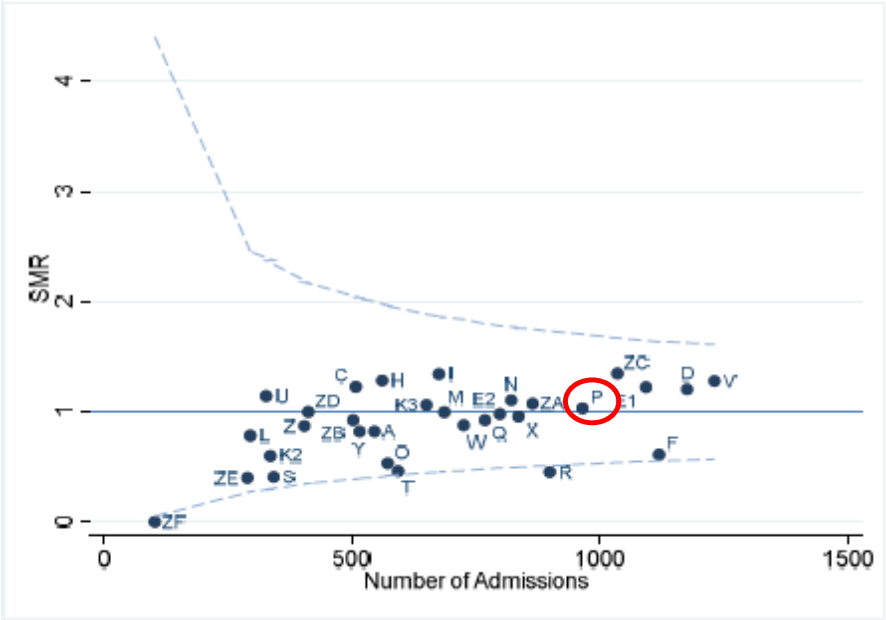
HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the period October 2019 to September 2020.



The chart shows that Alder Hey has performance of 63 deaths against 50.2 expected deaths, which is in line with Birmingham and Manchester mortality levels.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (2019 Annual Report of the Paediatric Intensive Care Audit Network January 2016-December 2018), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
The chart below is taken from PICANet's most recent report, and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.

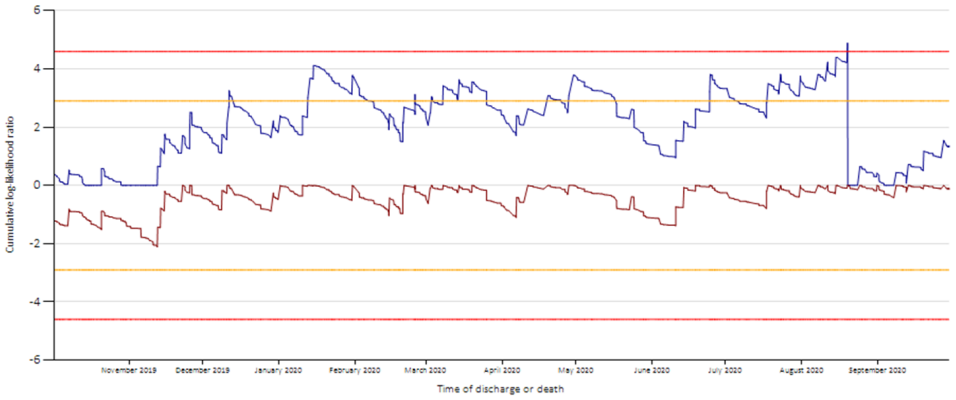


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.

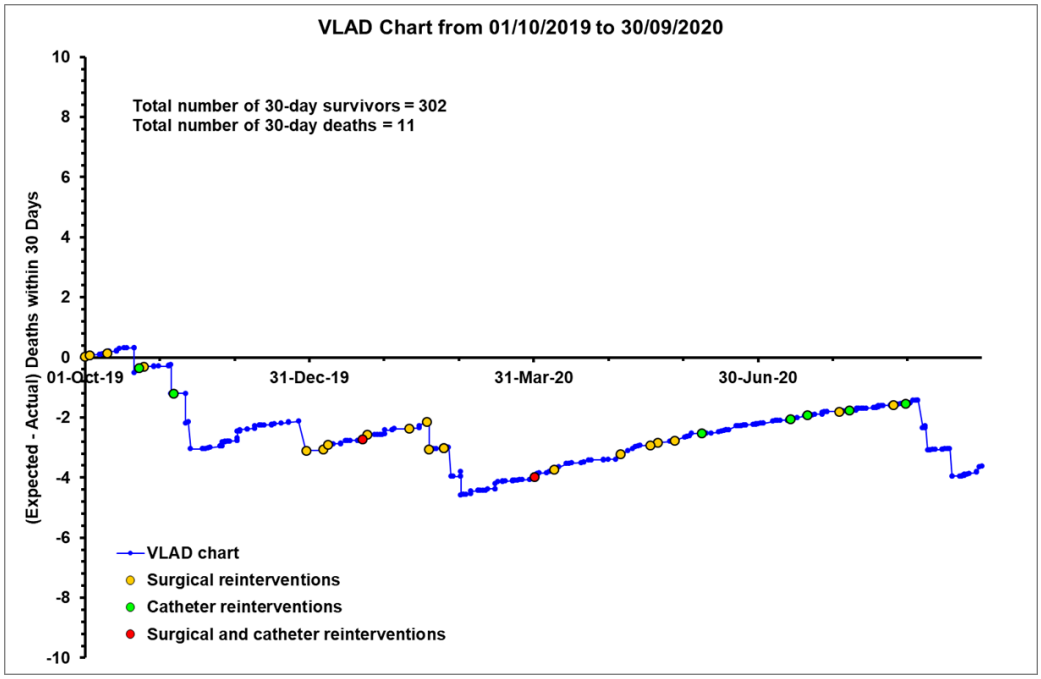


The above RSPRT chart indicates that the cumulative effect of deaths early in 2020 continued to maintain the RSPRT around the 'safe zone'-'warning zone' divide (upper orange line), until deaths in July-August drove it up to the red line. The RSPRT then reset and thereafter remained in the 'safe zone'. We had 44 deaths from January 2020 to October 2020. Of these 44 deaths, 31 deaths belonged to the group "Death inevitable" at the time of admission, in retrospect. 6 deaths belonged to the group of patients with "Chronic disease and multiple comorbidities". 7 deaths belonged to the group of "Unexpected death" at the time of admission. Of these 7 unexpected deaths, 6 patients had complex congenital heart disease who had cardiac surgery or intervention. One patient had left sided diaphragmatic hernia who developed refractory pulmonary hypertension post-operatively due to sepsis. All PICU deaths and RSPRT chart trends are reviewed regularly every month in our PICU multi-disciplinary mortality meeting.

b) Statistical analysis of mortality in Cardiac Surgery: PRAiS and VLAD charts

A risk adjustment model Partial Risk Adjustment in Surgery (PRAiS) has been developed to calculate the estimated risk of death within 30 days of a primary paediatric cardiac procedure in children under 16.

The PRAiS risk model has also been used to develop variable life-adjusted display (VLAD) charts for each centre. VLAD charts display the cumulative difference between expected and observed mortality over time.

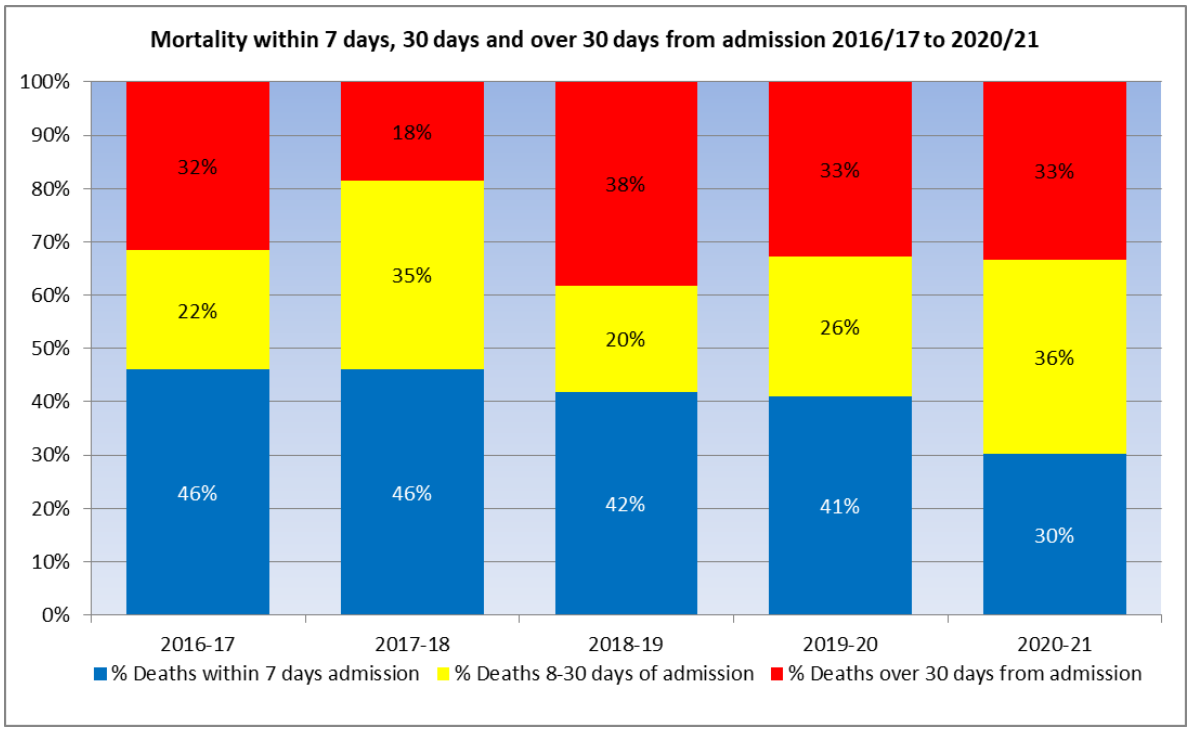


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from October 2019 to September 2020. The survival rate at 30 days was 96.5% against an expected rate of 97.6%.

Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the current financial year (April 2020 – September 2020) 30% occurred within 7 days of admission, 36% occurred within 8-30 days from admission, and 33% deaths occurred over 30 days from admission.

Conclusion

The HMRG is functioning well and reviewed the adult deaths effectively ensuring that the Trust learnt from these as to improving the care of COVID patients going forward, which is reflected by the NHS as a whole.
There is no apparent rise in mortality related to COVID in the cases reviewed.
There are a number of complex cases that the group is working through currently and these require more information and discussion to review
Immediate issues are the establishing of the Medical Examiner system in whichever format the Trust decides to take and reviewing trends over the last 5 years to check no concerning issues are highlighted.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 9**

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology. **Pg 9**

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 12**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2020

Paper Title:	Digital and Information Technology Update
Report of:	The purpose of this report is to provide Trust Board with an update on Digital and Information Technology programmes including performance on operational IT delivery.
Paper Prepared by:	Robin Clout, Deputy Chief Digital and Information Officer

Purpose of Paper:	Decision Assurance **Information** **X** Regulation
Background Papers and/or supporting information:	Digital Futures Strategy
Action/Decision Required:	**To note** **X** To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** **X**
Resource Impact:	N/A

1. Introduction

The purpose of this report is to provide the Trust Board with an update on Alder Hey Digital and Information Technology progress and to report key areas of digital transformation.

2. Current Progress

In the last reporting period, good progress has been made against a number of key areas including:

- Go live with 111 First via Meditech and becoming the first trust in the North West to deliver this virtual ED service
- Launch of the Meditech Expanse / AlderC@re test system to all trust staff
- Commissioning of phase one of the digital outpatient booths
- Launch of a new Ask the Trainer service
- Maintaining service support levels to front line teams
- Achievement of Cyber Essentials accreditation
- High levels of adoption of video consultations nationally and regionally

From the start of 2021 the Business Intelligence, Information and Clinical Coding services have been aligned under the Digital Services and are led by a new Associate Chief Information Officer.

A review has also been undertaken with the Medical Director and Chief Nurse with regards to the formalisation of the digital clinical leadership function. This includes the formalisation of existing arrangements and the development of senior nursing leadership in digital and innovation with a Chief Nursing Information Officer post due to be advertised in February.

Other highlights include the formation of a joint Cyber Security post in collaboration with Liverpool Heart and Chest and from January, formalised partnership working between the 2 organisations PACS and Radiology IT services.

Key Programmes including AlderC@re, Informatics Skills and Development Network Level 2 accreditation and HIMSS 7 accreditation remain on track for their respective delivery dates.

3. Digital Transformation Progress

3.1 AlderC@re

AlderC@re is the programme of work which will see a significant upgrade to the Trust's Electronic Patient Record programme in 2021. The programme was formally launched to staff in February 2021 and a full communication and engagement plan is in place.

Progress to date is good with the development of the system prototypes of the new system progressing. A new approach to training and engagement has been presented and supported through the Programme Board.

Risks are proactively managed and partnership working with the supplier is positive. NHS Digital are supporting the programme through undertaking a programme health check and regular attendance at the Trusts Digital Oversight Collaborative.

During a challenging year we have achieved:

- Implementation of new hardware to enable the web modules
- Clinical safety strategy and a focus on the areas of risk within the current version of Meditech with 7 areas of work:
    - Notifications

  - Theatres
  - CAMHS
  - TCI to Theatre
  - DNR/CPR and Advanced Care Planning
  - Safe Waiting List & Data Quality
  - Fluid Balance
- A triumvirate approach to training which will revolutionise training both for AlderC@re but also for future digital training

3.2 Digital Children, Young People and Families

Work progresses with regards to the development of the Digital Front Door and interacting digitally with our Children, Young People and Families. A range of virtual services are being progressed including:

- Virtual ED: Circa 600 patients have now attended through 111 First since go live. A meeting is planned in for the end of February to plan Phase 2 with the aim of integrating video consultations into the current 111 workflow
- Children and Young People as One: Platform now on UAT. Digital booking contract with HC Comms signed. Final clinical and user testing planned for end of February

Alder Hey adoption of video consultations through Attend Anywhere is significant. Benchmarked nationally Alder Hey is the 12th highest user of video consultations, regionally we are the 2nd highest provider and the highest Acute provider in terms of adoption.

There were 4738 Outpatient appointments conducted virtually through Attend Anywhere in January, demonstrating an increase from December's figures. A review of digital booth usage has taken place. Overall – there has been continual positive feedback supporting these spaces for digital consultations. Work continues to expand this facility across Alder Hey.

The Telemedicine proof-of-concept with Arrowe Park continues to progress well with positive feedback from clinicians and families involved. A plan for the next areas to be included as part of the trial has been approved by clinical leads with Bronchoscopy next on the list of opportunities to be explored.

3.3 Digital Safety Programme / HIMSS Level 7

Most projects within the Digital Safety Programme remain on track to reduce human errors relating to patient care and to evidence this with HIMSS Stage 7 accreditation in 2021.

Work continues on the adoption of bedside verification and improving experiences for staff. Additionally, a programme of digital developments with PICU is progressing, however has experienced some delays due to the impact of Covid.

Digital Pharmacy projects continue to make good progress. The server build is underway to support the WellSky upgrade, which is a pre-requisite for both the stock control interface and stock management projects. A comms plan for all digital pharmacy projects has been produced with input from the Pharmacy Systems Lead to ensure all pharmacy stuff understand the timescales and benefits of each project.

The OKKO Health App, which provides a platform for children to remotely complete vision testing, is now live in Ophthalmology with a number of potential benefits for both patients and staff.

Initial training sessions for eConsent have been delivered to all surgical specialties, as well as theatre staff to support the transition to digital consenting. We are in line to move to paperless towards by the end of March 2021. A device strategy has been agreed to support checking consent, and

devices are being rolled out this week. Since the introduction of eConsent, we are seeing a marked decrease in on the day consenting, supported by remote signing of consent.

3.4 Health Records and Transcription

Plans are progressing well with regards to health records and scanning transformation. These include the acceleration of scanning the live medical records library into a digital solution with the scanning service operating 24/7 over a 6-month period. To date, 6.2m of 18m planned images from the libraries have been scanned within the 4-year contract.

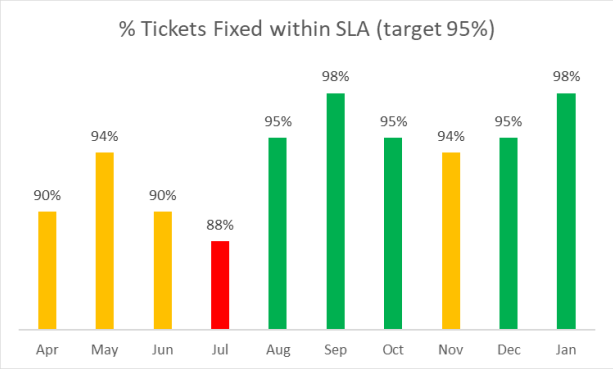
Scanning of In and Outpatient records are consistently within target of 48 hours service level agreement.

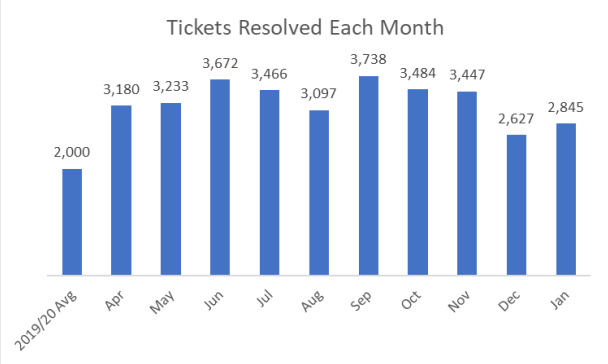
Work is progressing with transcription developments, with the prototype robotic process automation "bot" being built and in test phase. Time in motion is being undertaken to establish a phased go live roll out, this will ensure we remain within SLA and allow the "bot" to learn. Plans are for this to go live by April 2021.

4. Operational IT Performance

This report provides performance up to January 2021. Key highlights include:

- Despite, on average supporting over 50% more devices and handling 50% more tickets for requests from our staff over the last 12 months, the service has regularly achieved its targets; this includes for January 98% of all 2,845 tickets resolved within agreed target times
- New high of 73% of tickets now resolved within 1 day compared to 56% in April
- Average time to fix a ticket is at new low of 2.12 days compared to over 4 days in April





5. Technology Roadmap Update

A significant number of programmes and improvements continue to be worked on and delivered to improve the digital services delivered to the trust, including the following:

- Extension of the Alder Hey and Clatterbridge EPR Data Centre to support Liverpool Womens Hospital – Due for Feb/March
- Pilots for Phase 2 Office 365 for One Drive and new versions of Microsoft Office due for phased deployment from January and ending in March
- A review has been completed of mobile phone coverage and solutions for optimising the performance and coverage across the hospital site. The emergency department will be the first pilot area which is expected to be completed within the next 2 to 3 months
- Collaboration work commenced with Liverpool Heart and Chest regarding shared infrastructure

6. Digital Partnership

The digital partnership with the Liverpool Specialist Trust Alliance continues to progress well with a range of areas progressed including joint input into the refresh of the Cheshire and Merseyside Digital Strategy.

Key developments in relation to the partnership to date include extensive collaboration between a number of organisations on infrastructure, data centres and resources to ensure good value for money, sharing of scarce skills and resilience of services.

Immediate developments include:

- Joint Cyber Security Manager between Alder Hey and Liverpool Heart and Chest and the potential of a collaborative cyber service across all 4 specialist trusts
- Alder Hey and Liverpool Heart and Chest working together with regards to PACS and Radiology Digital services
- Shared resilient EPR data centre between Alder Hey, CCC and LWH
- Shared resilient data centre developments between Alder Hey and LHCH
- Good progress regarding direction of travel to design future operating model and integrated services for some areas during 2021

6. Digital Services Staff Development

We continue to put our staff at the front of our service delivery, transformation and development. The service has gone through a significant cultural change. We are pleased to report:

- In 2020 staff formed a staff council which is led by a member of staff on a rotational basis. This meets monthly and is attended by a large number of staff. The aim of this group is to support staff development, well-being, organise staff events and act as an additional support mechanism for staff and link to the leadership team
- Teams within the digital service are meeting mandatory training and PDR compliance targets with sickness under the trust target
- BI, Information, and clinical coding staff were welcomed into the digital service from 2021.
- Started at the beginning of the pandemic to support staff working from home, the service continues with twice weekly all staff team brief sessions. This allows us to help keep in contact with staff, disseminate information, showcase new work and developments, have a Team of the Day, High 5s and staff recognition and feedback
- A ‘Stampys High 5 Board’ was developed in memory of our colleague Andy Stamp who passed away from Covid in 2020. It is used as part of the twice weekly briefings to say thankyou and recognise excellence and celebrate good work. There are generally over 60 ‘high 5’s’ each month where staff recognise each others work
- In early 2021 the digital service has appointed an Equality Diversion and Inclusion lead for the service. This is linked into the Trust wide BAME taskforce developments. Key activities include getting involved with the wider local community, potentially providing summer internships (volunteering) specially targeting BAME women of school age to provide them insight to what the tech world has to offer, especially within the NHS. Engaging in more wider community events to encourage and make people aware that there are wonderful and exciting Digital careers available at Alder Hey. We are also linked into the work of the national Shuri network
- Plans are ongoing for Informatics Skills and Development Level 2 accreditation, recognising the prioritisation and importance of digital and health informatics as a profession with clear standards, education, training and engagement for staff

7. Summary and Recommendations

In summary, progress with digital developments and delivery at Alder Hey remain good and on track against plans. Performance of operational key performance indicators are good and customer service satisfaction is high.

Digital staff development and engagement has been a key area of development and success.

Trust Board is asked to:

- Note operational updates and progress with technology and digital maturity programmes

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report January 2021

How Did We Do?

Executive Summary **Month: January** **Year: 2021**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Clinical Incidents reported resulting in near misses and no harm remain high
- Still reporting a very high number of our clinical incidents resulting in minor or no harm
- Much improved performance with regard to patients being treated for sepsis both within AED and inpatients.

Highlight

- 0 category 3 or 4 pressure ulcers
- 0 never events

Challenges

- 1 clinical incident resulting in death related to a child on HDU with NEC who deteriorated suddenly and sadly passed away.
- 1 clinical incident resulting in severe harm relating to inappropriate telephone advice given by one of our clinicians that led to the child requiring surgery. RCA level 2 to be commenced
- 2 clinical incidents resulting in moderate harm. Both related to circulatory issues after arterial line insertions on PICU. RCA's in progress to consider any other contributory factors.
- 5 medication incidents resulting in harm - A patient received an overdose of fluoxetine requiring ECG monitoring, no problems detected. This was reported twice. An adverse drug reaction occurred which resolved with antihistamines. An under dose of heparin reached the patient due to incorrect preparation of the infusion. This required additional boluses and blood tests to resolve. Miscommunication of a sedation weaning plan resulted in an infusion being weaned too quickly and a patient having increased withdrawal scores
- 3 hospital acquired MSSA's- 2 cardiac babies and 1 medical. 1 is likely to be line related, 1 is surgical site infection and the other patient has a tracheostomy and PEG in situ and is known to be colonised with MSSA. Bacteraemia reviews are planned on all 3 patients.

The Best People Doing their Best Work

Caring

- Overall percentage of 95.3% of families completing the FFT recommended the Trust, the 2nd highest total of the year
- Consistently high scores across the Trust for the FFT in terms of service users recommending the Trust

Highlight

- PALS referrals significantly reduced in comparison to January 20; 67 compared to 124

Challenges

- 15 complaints in month still predominantly relating to the Neuro Tics and Tourette service issue

Delivery of Outstanding Care

Effective

We continue to deliver timely care in the ED for January treating 98.5% of patients within 4 hours, good access to cancer care and there were a low number of cancelled operations.

Unfortunately 3 patients who were cancelled on the day were not re-accommodated within 28 days.

Highlight

- Access to cancer care
- Timeliness of care in the ED
- Low number of on-the-day cancellations

Challenges

- Number of patients waiting over 52 weeks.
- RTT performance in surgical specialties.

Delivery of Outstanding Care

Responsive

- A really high (above 95%) performance in all areas but one for service users completing the in- patient survey

- The number of patients waiting over 52 weeks is 222. Covid-19 Wave 3 has had an adverse impact on waiting times as the contraction in the theatre schedule, to support the establishment of the adult ICU, has led to an increase in the number of surgical long wait IPs. There are also long patients identified in our significant validation programme in Safe Waiting List Management. The specialty with the highest volume of long wait patients is ENT and action has been taken to offer all long wait patients an outpatient appointment in February.

- Referral to treatment times against the 18-week standard has improved, for the sixth consecutive month, marginally to 61.3%.

- The timeliness of access to cancer care.

Highlight

- 94% of patients completing the In Patient survey said they were involved in learning. A significant increase from last month and the highest percentage of the year. Clearly the plans that have been put in place to better engage children and young people in learning are starting to take effect.
- 100% of those completing the in- patient survey knew who was in charge of their care and said they were treated with respect.
- Highest score of the year for service users completing the in-patient survey relating to receiving information enabling them to make choices about their care (99.3%)

Challenges

- We still have some challenges in relation to patients involved in play as the IP survey score is only at 80%. This is in part related to the staffing impact of COVID, but further actions are being put in place to ensure we are reporting correctly and a comprehensive action is in place, implemented by the Head of Play and monitored by the Head of Patient Experience

The Best People Doing their Best Work

Well Led

For the Month of January (Month 10), the Trust is reporting a deficit of £0.8m which is £0.2m ahead of plan. The year to date deficit is now £3.2m which continues to improve and now stands at £0.9m favourable to plan. The Trust is currently forecasting a £4.5m deficit which is in line with NHSI's expectations.

Elective & Daycase activity in January was 624 spells down on the same period last year, outpatient activity was also lower than the corresponding period in 2020 (4,759 attendances), however non-elective activity was also 500 spells below the prior year.

Mandatory Training continues to sit below the 90% target, currently at 85%. It is essential that this rate improves over the coming months and the required targets are achieved.

Sickness levels saw a steep increase in January, predominantly linked to Covid-19 (3rd Wave) which also peaked in the Community. The HR team are working in collaboration with Divisions to support managers with staff absences in partnership with the SALS Team who are providing support and guidance to managers and employees.

PDR compliance has risen 3% to 75% overall but this remains below our usual target of 90% across the Trust, this rate will need to improve in future months.

Highlight

- Financial Performance

Challenges

- Activity Levels
- Mandatory Training
- PDR's

Game Changing Research and Innovation

Research and Development

Month 10 Research Activity:

- 116 research studies currently open (incl. 10 Urgent Public Health studies)
- 504 patients recruited to research studies (4742 in 20/21)
- 1 new study opened (35 in 20/21)
- 1 study reactivated (72 to date)

Divisional Participation:

- Division of Medicine - 99 open studies
- Division of Surgical Care - 16 open studies
- Division of Community & Mental Health - 1 open study

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 96%

Highlight

- First UK patient recruited to Remdesivir study

Challenges

- Capacity to open new studies and to reactivate suspended studies

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Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis - A&E
1	0	0	5	0	89.47 %
Jan 2021	Jan 2021	Jan 2021	Jan 2021	Jan 2021	Jan 2021

Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
87.50 %
Jan 2021

CARING

Friends & Family: Overall Percentage Recommended Trust
95.32 %
Jan 2021

EFFECTIVE

ED: 95% Treated within 4 Hours
98.50 %
Jan 2021

RESPONSIVE

31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	All Cancers: 31 day wait until subsequent treatments	Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	Diagnostics: % Completed Within 6 Weeks
100 %	100 %	100 %	93.69 %
Jan 2021	Jan 2021	Jan 2021	Jan 2021

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	RTT: Open Pathway: % Waiting within 18 Weeks	Waiting Greater than 52 weeks - Incomplete Pathways	Waiting List Size
100 %	61.34 %	222	10721
Jan 2021	Jan 2021	Jan 2021	Jan 2021

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
110776	242.55	86.05 %	90.47 %	7.06 %
Jan 2021	Jan 2021	Jan 2021	Jan 2021	Jan 2021

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.0%	99.8%	100.0%	99.6%	100.0%	100.0%	98.9%	99.1%	100.0%	100.0%	100.0%	99.8%	99.1%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	72	72	48	39	48	60	86	54	50	80	104	78	53		No Threshold	
Clinical Incidents resulting in No Harm	D	342	335	237	138	261	285	380	318	338	321	400	308	288		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	D	88	82	62	48	57	89	92	83	72	69	87	75	80		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	D	4	1	0	1	0	0	6	1	0	0	0	1	1		No Threshold	
Clinical Incidents resulting in severe, permanent harm	D	1	0	0	0	0	0	0	2	0	0	0	0	1		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	1	0	0	0	0	1		0 N/A >0	✔
Medication errors resulting in harm	D	0	2	2	1	5	7	6	2	8	1	11	0	5		<=2 N/A >2	✔
Pressure Ulcers (Category 3)	W	0	0	0	1	0	0	2	0	0	0	0	1	0		0 N/A >0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Never Events	W	0	1	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	83.9%	86.5%	83.3%	60.9%	95.5%	96.2%	79.2%	77.3%	85.2%	74.1%	79.2%	73.7%	89.5%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	87.5%	88.2%	88.9%	93.8%	87.5%	90.9%	88.5%	85.2%	86.1%	94.3%	80.8%	70.8%	87.5%		>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	0	1	0	0	0	0	1	1	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	0	2	0	1	0	0	1	4	1	0	1	0	3		No Threshold	

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	94.3%	94.3%		96.9%	94.2%	94.9%	94.6%	93.8%	90.6%	94.7%	93.7%	91.5%	95.3%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	88.0%	87.6%		96.1%	92.9%	92.3%	90.7%	91.5%	84.4%	92.1%	89.2%	91.5%	93.2%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	92.0%	91.8%		100.0%	100.0%	95.2%	95.2%	92.3%	89.1%	94.7%	98.8%	100.0%	92.7%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	97.1%	95.7%		94.4%	90.8%	93.3%	97.0%	95.1%	92.4%	94.5%	95.5%	93.4%	94.2%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	90.7%	80.0%		100.0%	90.9%	100.0%	100.0%	82.4%	92.3%	89.7%	91.3%	100.0%	96.3%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	95.6%	96.1%		97.4%	96.9%	96.6%	96.0%	95.7%	94.1%	95.5%	93.9%	90.4%	96.1%		>=95 % >=90 % <90 %	✔
Complaints	W	10	10	9	8	6	10	5	20	11	19	15	10	16		No Threshold	
PALS	W	124	114	74	45	44	86	105	105	77	96	71	65	67		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%		>=95 %	N/A	<95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	20	41	36	6	5	3	7	18	17	19	16	10	5		<=30	N/A	>30	✔
28 Day Breaches	W	10	4	7	24	1	2	0	0	8	2	1	3	3		0	N/A	>0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	97.3%	97.8%	96.4%	91.5%	93.2%	94.1%	99.3%	95.9%	95.4%	95.4%	95.7%	97.5%	99.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	98.7%	97.6%	98.1%	100.0%	97.7%	94.1%	98.5%	97.9%	96.0%	98.3%	98.6%	97.5%	100.0%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	90.5%	89.6%	91.1%	87.3%	95.5%	95.8%	98.5%	93.2%	97.1%	96.7%	97.8%	95.0%	98.5%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	98.0%	97.6%	96.1%	88.7%	90.9%	90.8%	91.1%	99.3%	98.3%	100.0%	99.3%	91.7%	100.0%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	95.6%	92.5%	94.2%	60.6%	78.4%	64.7%	72.6%	81.5%	82.3%	83.3%	84.9%	76.7%	80.3%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	85.4%	78.0%	79.2%	74.6%	61.4%	84.0%	83.0%	78.1%	75.4%	88.3%	71.9%	81.6%	94.9%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.0%	86.7%	66.7%	58.1%	45.9%	39.6%	43.1%	48.2%	54.2%	59.0%	60.8%	61.3%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,885	12,895	12,162	11,046	10,909	11,248	11,022	11,402	11,000	10,939	10,832	10,520	10,721		<=12899 N/A >12899	✔
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	5	15	52	82	149	127	145	145	148	184	222		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	42.8%	67.0%	81.9%	82.9%	78.9%	91.8%	96.4%	97.1%	92.3%	93.7%		>=99 % N/A <99 %	✔
PFI: PPM%		99.0%	95.0%	99.0%	99.0%	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	98.0%	99.0%	99.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	-172	-488	693	0	0	0	0	0	0	-358	332	687	243		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	3,126	3,820	300	1,287	1,792	3,503	936	-483	4,518	187	-1,733	1,610	-1,979		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	76,536	76,536	90,030	107,738	111,270	107,221	107,221	107,763	108,756	109,084	110,503	110,776	110,776		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	1,439	30	6,889	3,146	-692	1,342	1,825	1,077	2,492	-792	748	235	228		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	394	-627	-709	-1,433	691	-312	-340	-291	-1,160	20	492	-192	-373		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-2,005	110	-5,487	-1,713	1	-1,029	-1,485	-786	-1,333	414	-909	644	387		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W	1,245	1,181	953	11	0	0	0	0	-349	-398	-456	-402	-499		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W	426	404	318	0	0	-2	0	-1	49	9	11	51	-44		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W	2,060	1,926	1,563	0	2	5	2	2	-62	-183	38	68	-341		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W	23,888	21,026	17,984	165	286	1,041	1,363	1,366	1,088	-1,131	2,274	2,514	-1,881		>=0	N/A	<0	✔
PDR	W	90.1%	90.1%	90.1%	90.1%	1.3%	5.4%	13.4%	20.7%	29.5%	62.6%	72.4%	74.6%	74.4%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	W	82.7%	90.6%	95.1%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.9%	95.9%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	W	94.3%	95.1%	93.2%	92.1%	90.8%	91.0%	90.5%	90.6%	89.3%	88.6%	85.8%	85.0%	86.0%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.8%	5.7%	6.2%	5.9%	5.3%	5.0%	5.2%	5.0%	5.2%	6.0%	5.4%	5.5%	7.1%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.7%	1.7%	2.3%	1.6%	1.0%	0.9%	1.0%	1.1%	1.4%	1.9%	1.3%	1.1%	2.3%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	4.1%	4.0%	4.0%	4.4%	4.3%	4.1%	4.1%	4.0%	3.9%	4.1%	4.2%	4.4%	4.8%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	775	974	1,514	990	740	565	934	946	1,015	1,061	1,365	1,392	1,383		<=800	<=960	>960	
Staff Turnover	D	10.5%	10.6%	10.3%	9.8%	9.8%	10.0%	9.6%	10.2%	10.0%	9.6%	9.4%	9.3%	9.3%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	90.6%	92.8%		92.2%		95.6%	90.3%	91.3%	94.2%	94.2%	94.9%	93.6%	90.5%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	100.0%	97.7%				100.0%	85.6%	97.0%	93.8%	90.0%	87.5%	90.4%	94.4%		>=85 %	N/A	<85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	166	165	146	21	23	43	47	50	61	66	71	76	80		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	46	46	42	21	19	20	25	27	28	34	37	36	36		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	3	1	0	4	3	3	1	3	4	1	4	4	1		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	1	0	1	0	0	1	2	0	2	1	0	0		>=1	N/A	<1	✔
Number of patients recruited	W	982	917	665	407	537	560	134	508	413	665	832	182	504		>=100	>=86	<86	✔

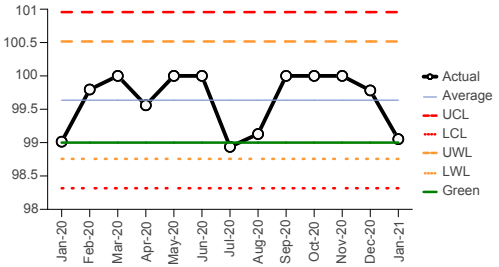
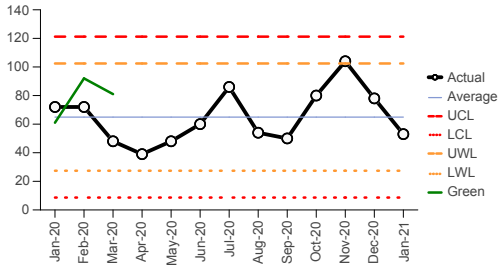
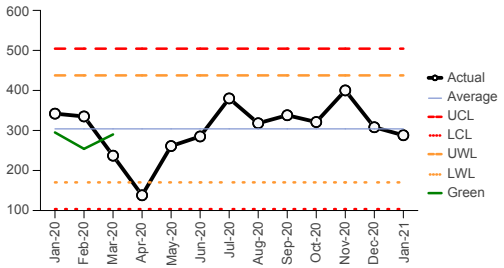
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.05 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nicki Murdock **Committee:** SQAC	53	No Threshold		
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	288	No Threshold		

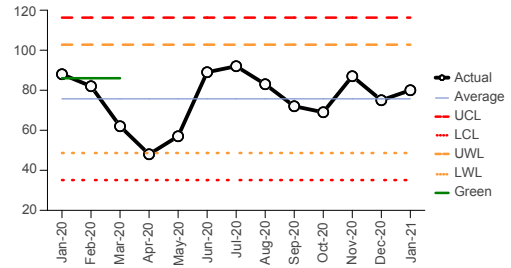
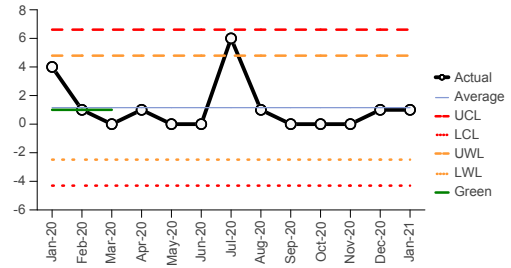
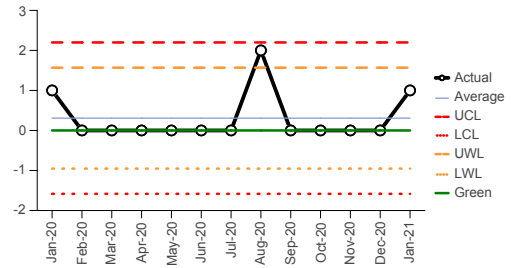
Delivery of Outstanding Care

7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	80	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	R >0 A N/A G 0		Incident reported to StEIS, 72 hour review completed, duty of candour completed in line with regulation 20. . Level 2 investigation underway.

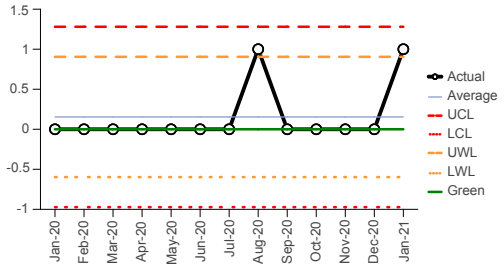
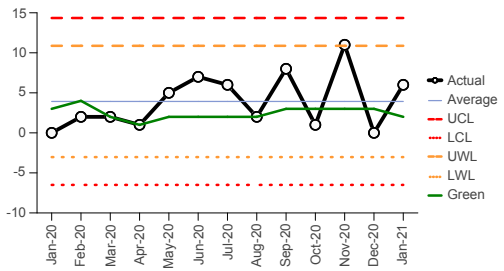
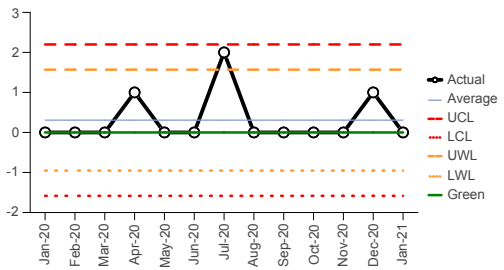
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

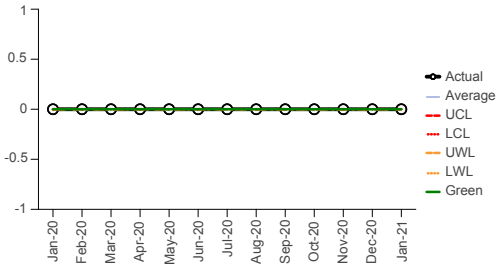
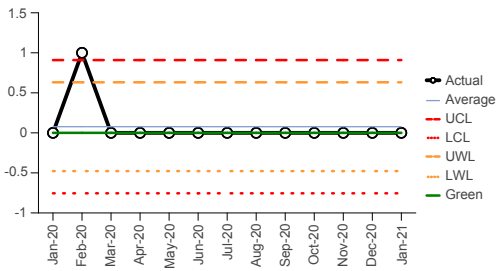
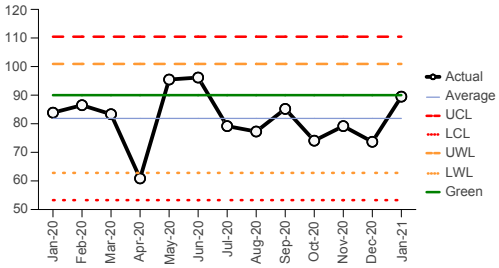
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	R >0 A N/A G 0		Incident reported to StEIS, 72 hour review completed, duty of candour completed in line with regulation 20. Cause of death unknown at time of reporting, waiting for results of tests and post mortem findings.
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 19 - Mar 20, on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 20/21 aim is less than 27 annually for the trust. **Exec Lead:** Nicki Murdock **Committee:** SQAC	5	R >2 A N/A G <=2		A patient received an overdose of fluoxetine requiring ECG monitoring – no problems detected. This was reported twice. An adverse drug reaction occurred which resolved with antihistamines. An underdose of heparin reached the patient due to incorrect preparation of the infusion. This required additional boluses and blood tests. Miscommunication of a sedation weaning plan resulted in an infusion being weaned too quickly and a patient having increased withdrawal scores.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 20/21 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	89.47 %	R <90 % A N/A G >=90 %		Two patients did not receive antibiotics within 60 minutes. 1 due to difficult intravenous access and parent initially refusing treatment. 1 due to difficult intravenous access who required intramuscular antibiotics.

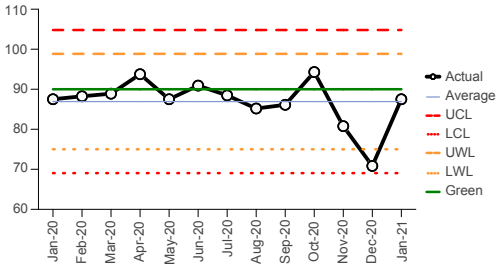
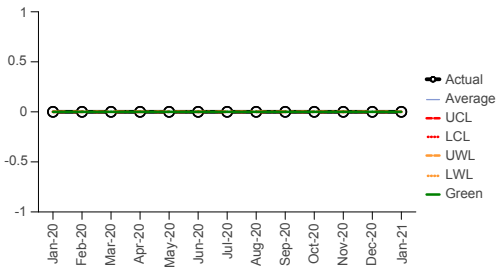
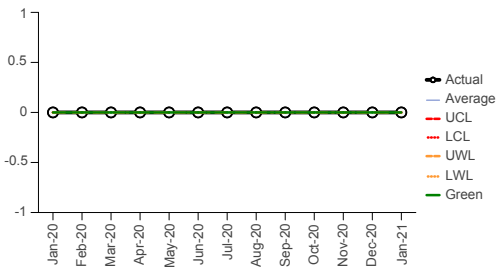
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 20/21 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	87.50 %	R <90 % A N/A G >=90 %		Improvements made based on actions from the December review. 24 patients identified with 3 delays. Time for delays 65min, 72min, 94min. Reasons for delays difficult IV access needed senior support and other clinical stabilization requiring IV fluid bolus. Improvements in times across all patients. Feedback given to divisional leads.
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 20/21 is zero. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

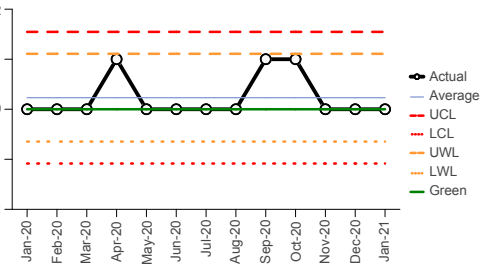
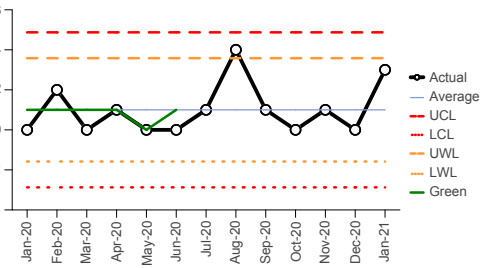
Delivery of Outstanding Care

7.6 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** D Hospital Acquired Organisms - MSSA . 20/21 aim is to reduce by 10% or more. **Exec Lead:** Nicki Murdock **Committee:** SQAC	3	No Threshold		

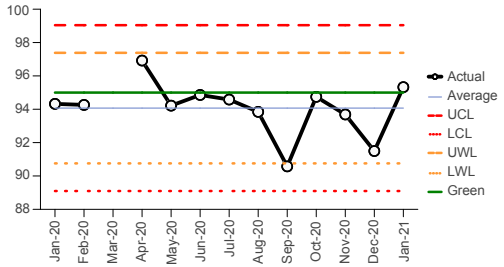
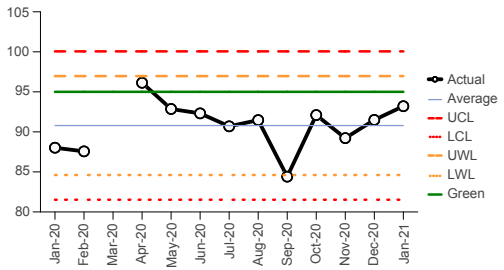
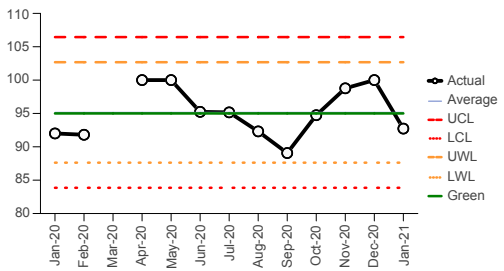
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.32 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	93.20 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 1.71% from December 2020. There were 206 responses for January 2021. 13 (6.31%) responses were either poor or very poor. When asked how we could have improved, 7.69% of respondents mentioned waiting times as a major issue, 6.29% of respondents also mentioned staff attitude and lack of respect as a key issue. Comment analysis shown no additional themes.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	92.73 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 2.19% since December 2020. There were 228 responses for January 2021, 93.2% increase from the number of responses in December 2020 (110). There were 12 (5.26%) responses that were either poor or very poor in January 2021. In December 2020, the number of poor or very poor responses accounted for 2.54% of total FFT score. Communication in Blood Test clinic, Complex Care North Sefton, and Liverpool Fresh CAMHS were identified as areas for improvement for this month.

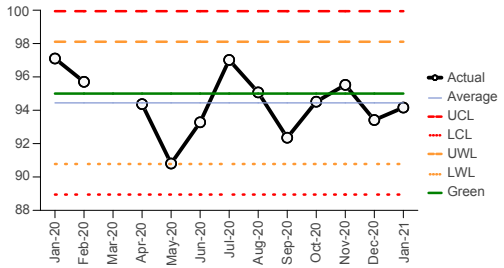
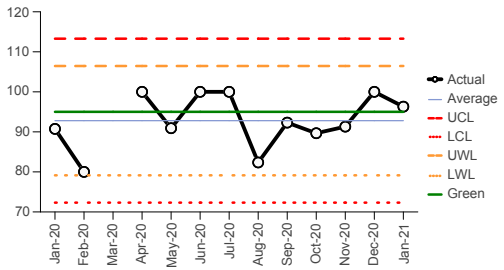
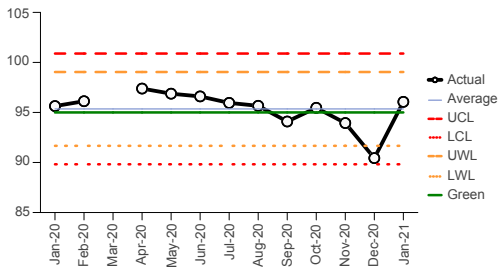
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.16 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 0.75% since December 2020. There were 137 responses for January 2021. Out of these responses, there were zero poor or very poor responses. Overall percentage was mainly affected by respondents who found their experience neither good nor poor (4.38%). Significant improvement for Learning in January (94.89%) compared to December 2020 (81.76%). Still room for improvement in Play (80.29%). There were no recurring themes identified through comment analysis.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	96.30 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	96.06 %	R <90 % A >=90 % G >=95 %		No Action Required

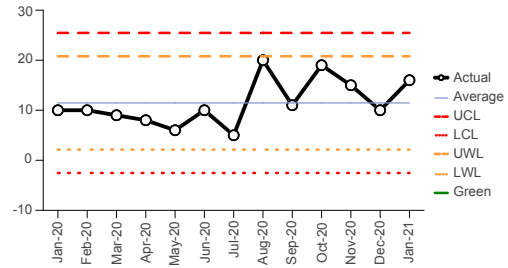
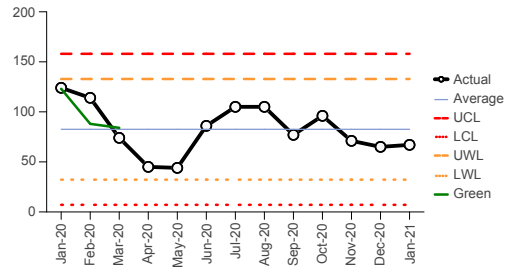
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	16	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	67	No Threshold		

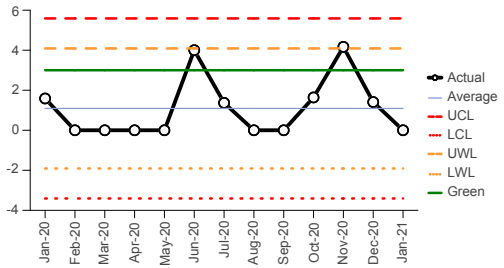
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

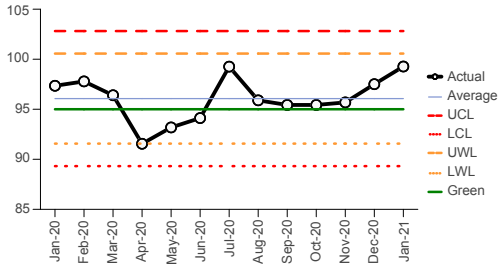
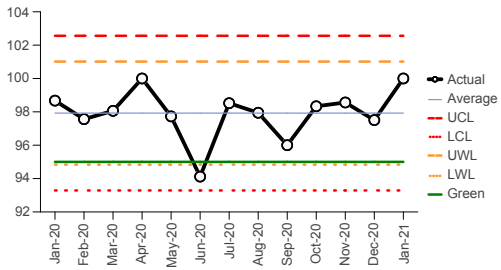
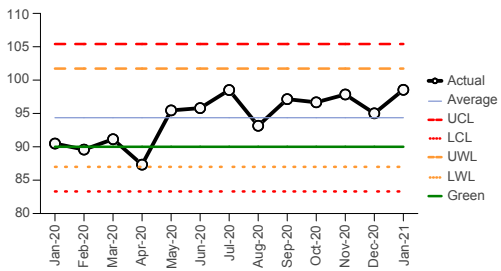
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Nicki Murdock **Committee:** SQAC	0 %	R >3 % A N/A G <=3 %		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

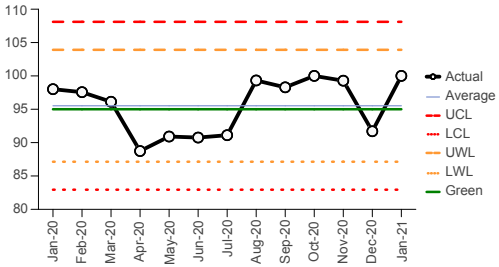
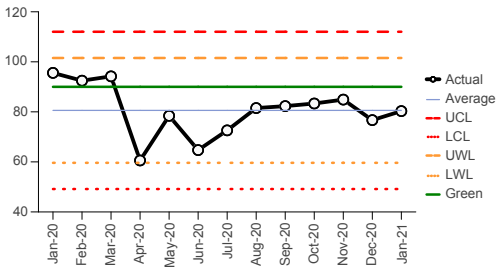
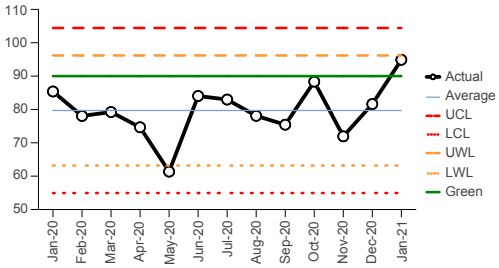
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.27 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 20/21 is 100%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.54 %	R <85 % A >=85 % G >=90 %		No Action Required

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	80.29 %	R <85 % A >=85 % G >=90 %		Percentage of patients that report engaging with play this month was 80.29%, an increase of 5.59%. Percentage increase can be attributed to the Play team focusing efforts on inpatient activity now the Christmas period is over. An action plan has been put in place to increase overall FFT percentage, whilst maintaining a COVID safe experience. The action plan involves recruiting more Play Specialists to the Trust and using volunteers to specifically help with Play on every ward.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.89 %	R <85 % A >=85 % G >=90 %		No Action Required

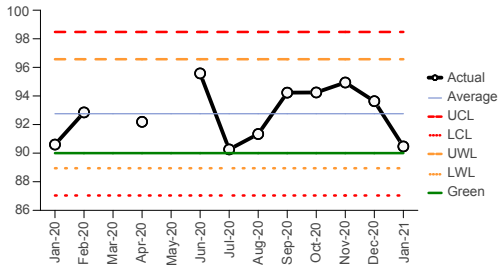
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

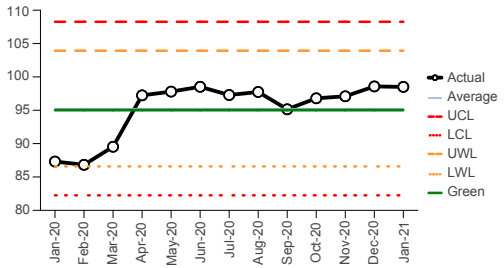
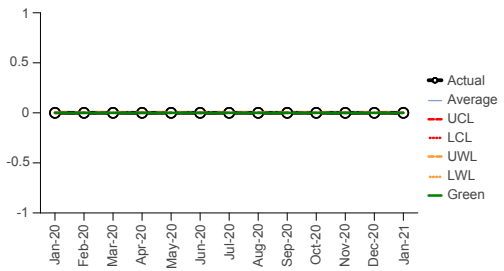
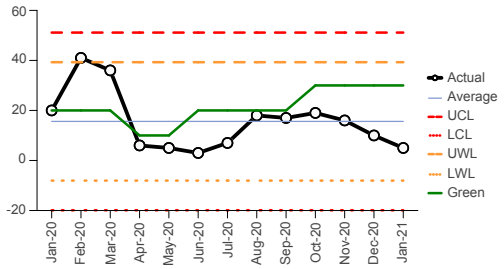
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	90.47 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	98.50 %	R <95 % A N/A G >=95 %		No Action Required
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	5	R >30 A N/A G <=30		No Action Required

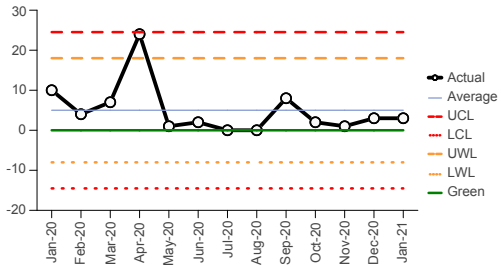
Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

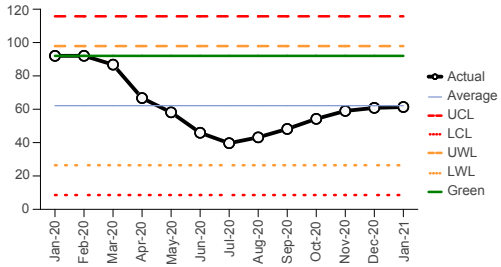
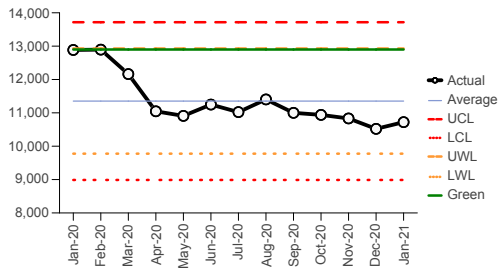
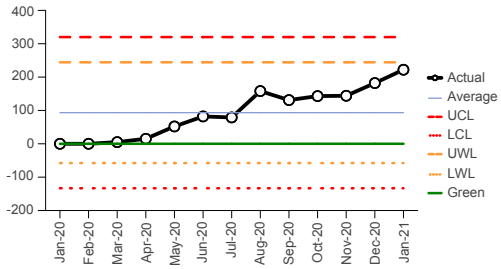
	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	3	R >0 A N/A G 0		Unfortunately three children were not rescheduled within 28 days of their pervious cancelled procedure. This was primely owing to families requirement to isolate owing to COVID19 and the reduced theatre schedule in operation during this time to support the regional COVID19 response. All patients now have a scheduled TCI date within the next month.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

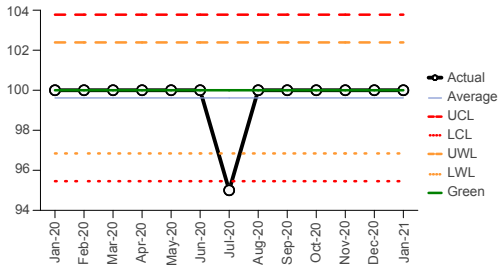
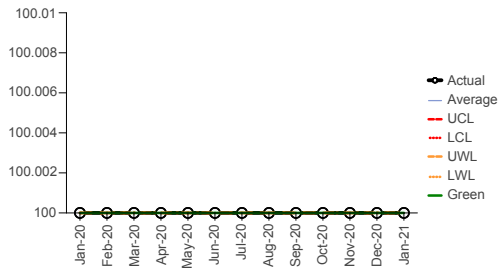
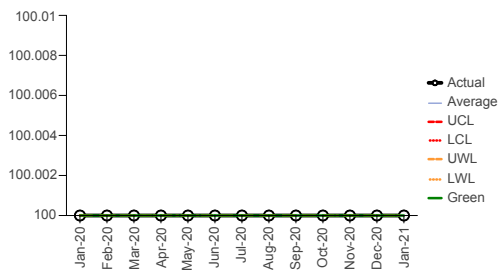
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	61.34 %	R <90 % A >=90 % G >=92 %		Performance continues to improve with notable progress against our restoration targets. Continued challenges remain primely within surgical specialities. As phase 3 activity improves an increase in RTT performance will also continue with this trajectory.
Waiting Times	**Waiting List Size** W National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	10721	R >12899 A N/A G <=12899		No Action Required
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Adam Bateman **Committee:** RABD	222	R >0 A N/A G 0		Unfortunately during January the number of children and young people increased who've waited over 52 weeks for treatment. Majority of these patients are waiting for surgical treatment. All of which have received a clinical review and continuous plans are in place in attempt to treat these children's as soon as possible. The reduction in theatre schedule during January has posed a greater challenge in treating these patients however all continue to be reviewed/monitored weekly. Some of these children have been established via additional validation associated with the Safe Waiting List Programme

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

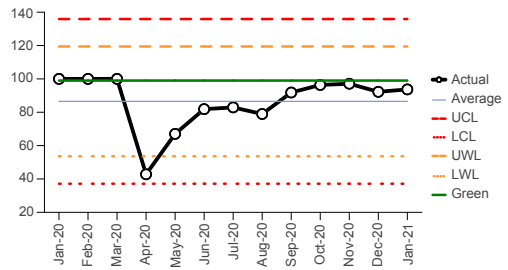
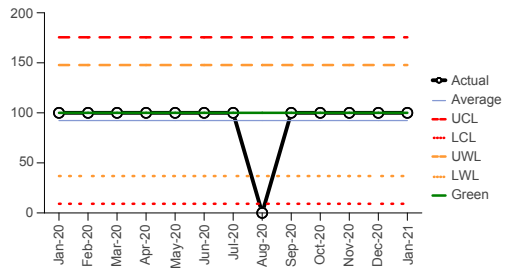
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Cancer RTT	**Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	93.69 %	R <99 % A N/A G >=99 %		Whilst still adhering to social distancing and IPC guidelines, Radiology has seen their activity returning to between 90-95%, week on week, of pre-Covid 19 capacity. Fluctuations in unplanned activity have resulted in variations of activity
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

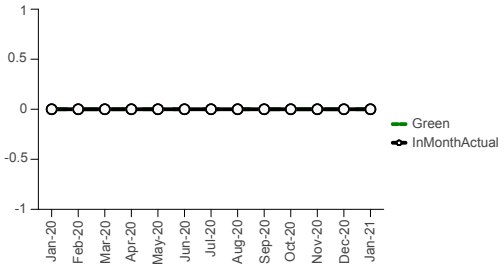
The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**NHS Oversight Framework** W Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** SQAC	0	R >1 A <=1 G 0		No Action Required

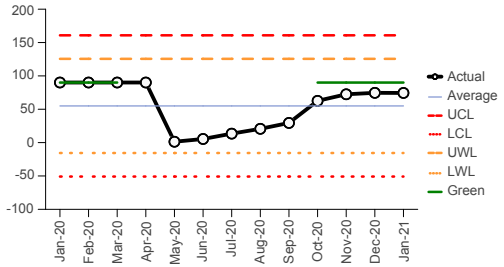
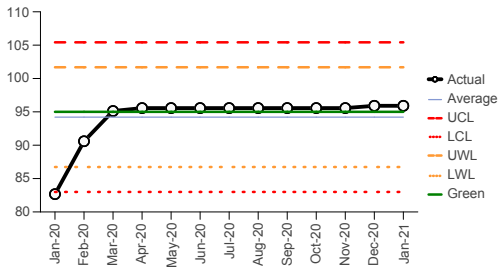
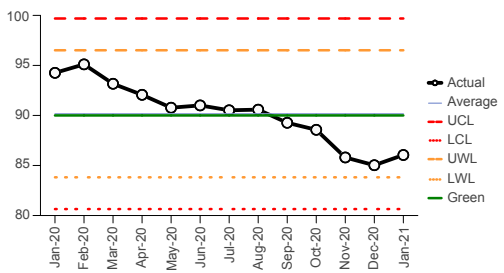
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	74.43 %	R <85 % A >=85 % G >=90 %		PDR compliance has risen 3% to 75% overall but I still 15% below our usual target of 90% across the Trust.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	95.90 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	86.05 %	R <80 % A >=80 % G >=90 %		Mandatory Training continues to sit below the 90% target, currently at 85%. The biggest areas of low compliance is our Estates and Ancillary staff and therefore our Facilities division as a whole and annual refresher for Resuscitation topics. We are working with SMEs from all topics to identify ways to reach the Estates and Ancillary staff group who appear to not be utilising the e-Learning packages due to lack of access to computers and also working specifically with the Resus team to identify ways to improve compliance for BLS and PLS/APLS updates.

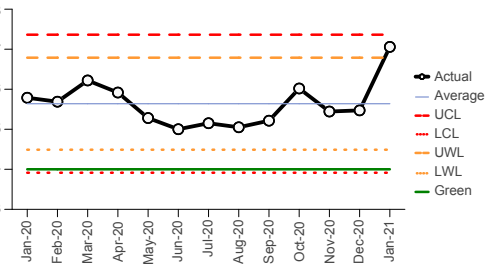
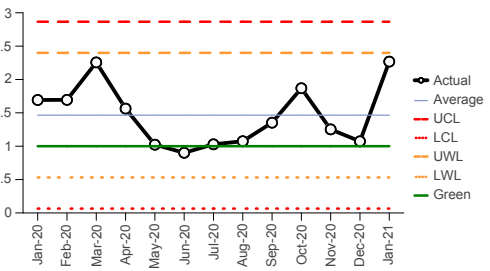
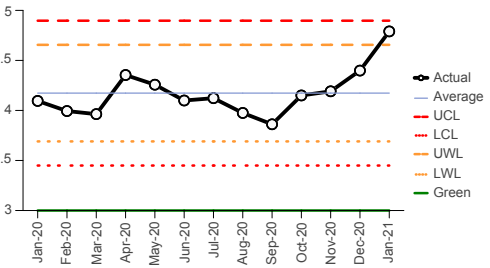
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	7.06 %	R >4.5 % A <=4.5 % G <=4 %		Sickness saw a steep increase in January, predominantly linked to Covid-19 which also peaked in the Community. The HR team are working in collaboration with Divisions to support manager with staff absences in partnership with the SALS Team who are providing support and guidance to managers and employees. The Wellbeing team as of October have been aligned to divisions to further support staff and managers with sickness absence.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	2.27 %	R >1 % A N/A G <=1 %		As above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.79 %	R >3 % A N/A G <=3 %		As above

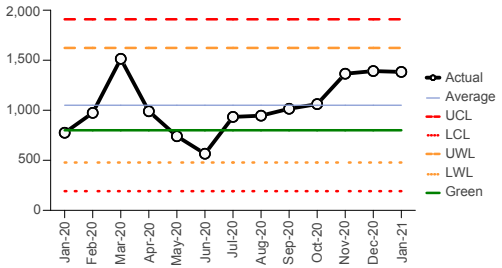
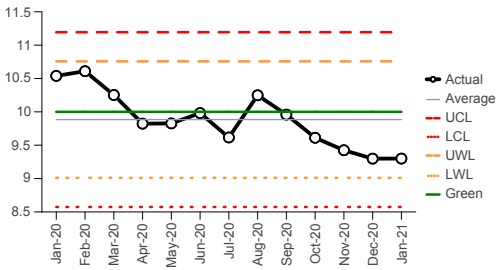
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1382.93	R >960 A <=960 G <=800		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	9.30 %	R >11 % A <=11 % G <=10 %		No Action Required

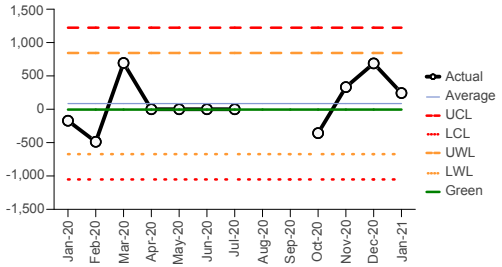
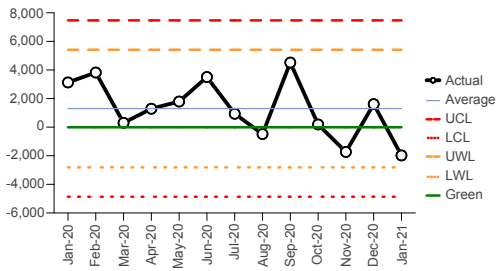
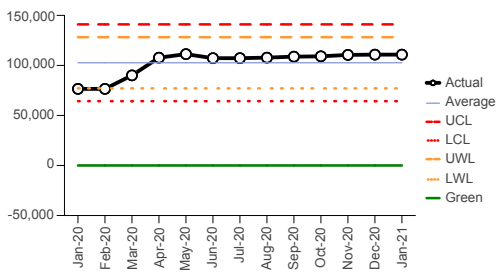
The Best People doing their best Work

16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	243	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-1,979	R <-10% A >=-10% G >=-5%		£2m (this is a favourable variance, and therefore shown as a negative number in the CR)
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	110,776	R <-20% A >=-20% G >=-5%		No Action Required

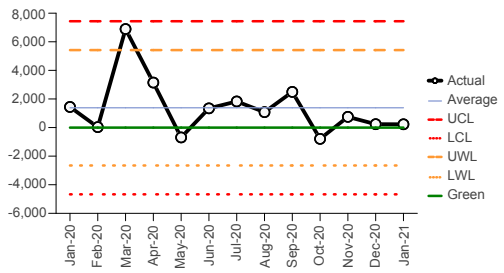
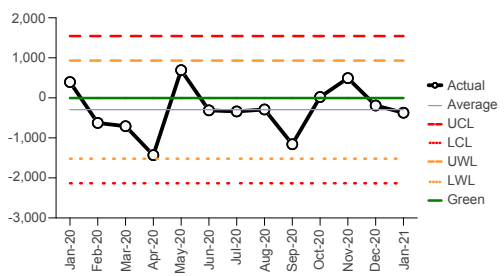
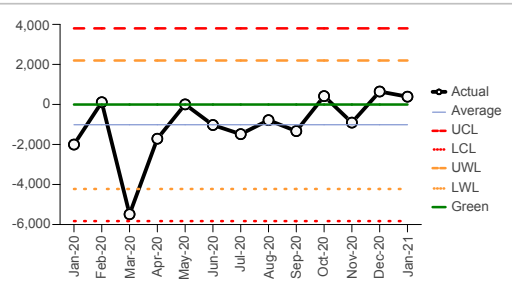
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	228	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-373	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	387	R <-20% A >=-20% G >=-5%		No Action Required

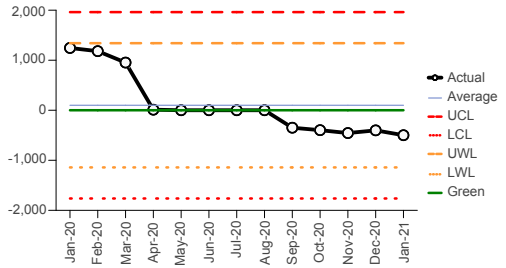
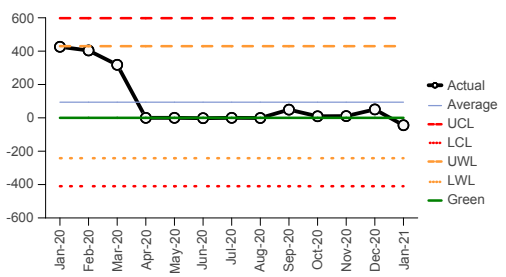
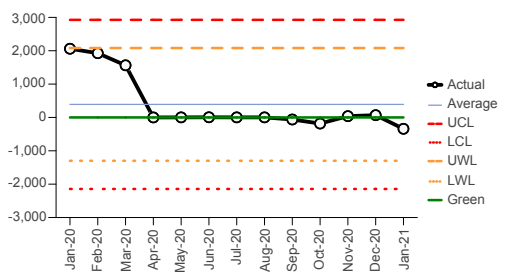
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

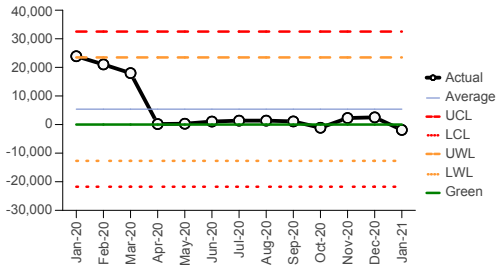
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-499.00	R <0 A N/A G >=0		Non Electives continue to be affected by the impact of COVID, below Planned and Last Years levels.
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-44.30	R <0 A N/A G >=0		Electives continue to be affected by capacity restrictions due to the impact of COVID regulations.
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-340.70	R <0 A N/A G >=0		Daycase continue to be affected by capacity restrictions due to the impact of COVID regulations.

The Best People doing their best Work

16.4 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-1881	R <0 A N/A G >=0		Outpatients continue to be affected by capacity restrictions due to the impact of COVID regulations.

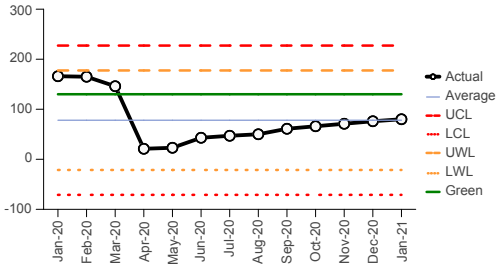
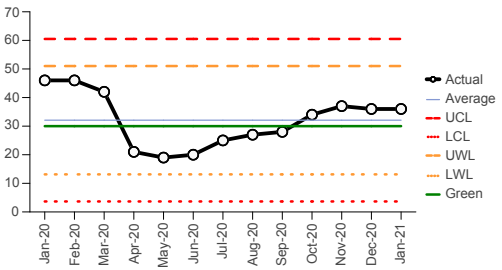
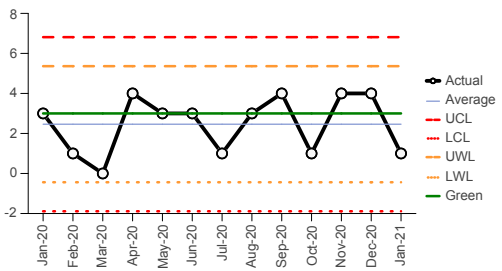
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	80	R <111 A >=111 G >=130		Pipeline of new and suspended studies in the process of being opened or reactivated in line with delivery capacity.
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	36	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	1	R <2 A >=2 G >=3		Opening of new studies largely paused due to reduced delivery capacity.

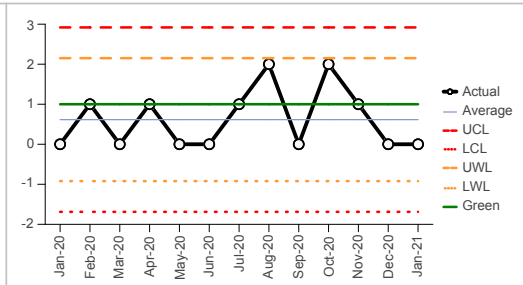
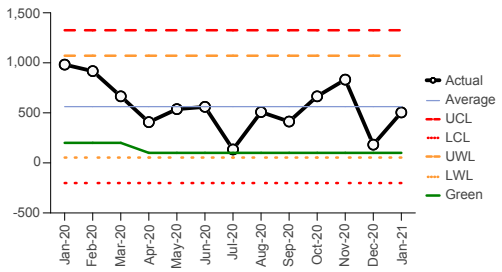
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

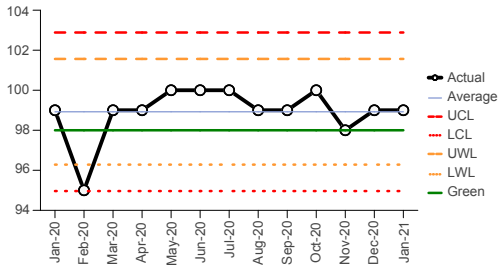
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	0	R <1 A N/A G >=1		Opening of new studies largely paused due to reduced delivery capacity.
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	504	R <86 A >=86 G >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	99 %	R <98 % A N/A G >=98 %		No Action Required

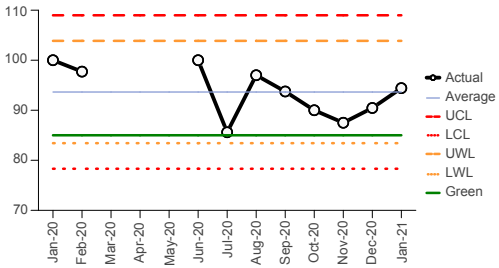
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.42 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	4	17	26	No Threshold
Clinical Incidents resulting in No Harm	D	65	85	108	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	11	22	36	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	1	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	1	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	1	0 / N/A / >0
Medication errors resulting in harm	D	0	4	1	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	0	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		83.3%	91.7%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	1	2	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	5	8	2	No Threshold
PALS	W	14	21	12	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			0.0%	<=3 % / N/A / >3 %
ED: 95% Treated within 4 Hours	D		98.5%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	0	5	No Threshold		
28 Day Breaches	W	0	1	2	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		100.0%	99.0%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		100.0%	100.0%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		96.9%	99.0%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		100.0%	100.0%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		75.0%	81.9%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		93.8%	95.2%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	66.2%	89.5%	54.6%	>=92 %	>=90 %	<90 %
Waiting List Size	W	785	1,731	8,131	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	1	221	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		100.0%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks	W		94.6%	50.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	321	189	-245	No Threshold
Income In Month Variance (£'000s)	W	148	10	0	No Threshold
Pay In Month Variance (£'000s)	W	65	-61	-364	No Threshold
Non Pay In Month Variance (£'000s)	W	108	241	119	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		-411	-89	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	2	-47	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		-74	-268	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	368	-408	-3,467	>=0	N/A	<0
PDR	W	83.1%	74.2%	66.1%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	100.0%	94.1%	96.8%	>=95 %	>=90 %	<90 %
Mandatory Training	W	89.2%	88.1%	86.7%	>=90 %	>=80 %	<80 %
Sickness	D	5.3%	6.4%	8.0%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.9%	2.1%	3.1%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.5%	4.3%	4.9%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	226	247	434	No Threshold		
Staff Turnover	D	9.4%	6.8%	7.9%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	99.9%	91.2%	89.6%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Zero Never Events; One clinical incident resulting in severe or permanent harm. No grade 3 or 4 pressure ulcers. No hospital-acquired Infections For MRSA and C Difficile.	**Highlight** • Sustained period with no hospital acquired infections **Challenges** • One clinical incident with permanent and serious harm • Fall in Sepsis compliance • Increase in medication errors resulting in harm
CARING	8complaints and 21 PALS	**Highlight** • Small reduction in complaints **Challenges** • Number of complex complaints still to be resolved related to Tics and Tourette's service
EFFECTIVE	ED performance was reported at 98.5% in December against a comparison of 87.5%% at the same time last year. Year to date performance remains stable at 97.5% showing a sustained improvement in Urgent and Emergency Care.	**Highlight** • Continued improvement in ED performance. **Challenges** • WNB rate of 11.3% • 28 day hospital cancellation breach
RESPONSIVE	RTT compliance continues to improve at 89.5% (against 85% in December). This highlights the improved access to care for patients in all medical specialties	**Highlight** ▪ Continued improvement in RTT performance ▪ Material reduction in long waiting patients (40+ weeks) **Challenges** ▪ Reporting times in radiology for outpatients remains challenging. ▪ DM01 performance for EEG and endoscopy
WELL LED	The Division remains underspent. Sickness has spiked due to Covid 19 Wave 3 impact.	**Highlight** • Safer staffing rates • Staff turnover rate **Challenges** • Sickness rate remains over 4% • Mandatory training – basic life support for medical staff • Pay overspend

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	34	28	15	13	19	18	29	19	16	29	34	23	17		No Threshold
Clinical Incidents resulting in No Harm (D)	135	93	71	33	64	75	104	75	93	69	123	97	85		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	24	19	7	12	13	19	26	21	16	11	18	19	22		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	0	0	0	0	0	2	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	1	0	0	0	0	0	0	1	0	0	0	0	1		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	0	1	0	1	5	3	2	0	4	0	0	0	4		No Threshold
Medication Errors (Incidents)	48	30	15	13	25	29	26	23	18	24	30	36	32		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	5	1	2	1	1	0	0	2	2	0	0	1	0		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	100.0%	100.0%	88.9%	100.0%	83.3%	92.3%	100.0%	84.6%	91.7%	100.0%	75.0%	90.9%	83.3%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	1	0	0	0	0	0	1	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	1	1	0	1	1	1	0	2	0	0	0	2	0		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	0	0	0	0	0	0	0	0	0	1		No Threshold
Cleanliness Scores	97.8%	97.6%				98.5%	97.7%	97.8%	98.0%	98.0%	96.0%	95.1%	98.1%		No Threshold
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.	99.9%	99.8%	99.7%	99.3%	99.3%	99.6%	99.8%	99.8%	99.8%	99.8%	99.7%				>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.			55.7%	55.7%	57.4%	60.0%	63.8%	63.8%	63.8%						>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	47.0%	53.0%	58.0%	65.0%	65.0%	64.0%	78.5%	84.0%	77.3%	85.0%	85.0%	85.0%			>=90 % N/A <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	84.0%	88.0%	67.0%	67.0%	69.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.0%				>=90 % N/A <90 %

CARING

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Complaints (W)	7	5	4	7	2	6	1	11	7	8	7	6	8		No Threshold
PALS (W)	45	44	34	13	18	21	32	49	27	24	28	27	21		No Threshold

EFFECTIVE

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Referrals Received (Total)	2,019	1,959	1,548	838	994	1,435	1,666	1,567	2,273	2,010	2,083	1,682	2,048		No Threshold
ED: 95% Treated within 4 Hours (D)	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	4.0%	3.8%	2.7%	0.2%	0.8%	1.1%	1.5%	0.8%	2.0%	0.8%	1.0%	0.6%	0.5%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	8.3%	8.0%	7.4%	8.2%	8.4%	7.5%	7.8%	8.3%	7.0%	7.9%	7.8%	7.9%	9.0%		No Threshold

Medicine

D Drive W Watch P Programme

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
ED: Number of patients spending >12 hours from decision to admit to admission W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised W	80.7%	85.8%	76.2%	73.9%	76.7%	75.4%	82.0%	82.1%	81.3%	83.6%	82.2%	84.7%	84.0%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	2	5	0	1	2	0	0	3	2	1	1	2	0		No Threshold
28 Day Breaches W	0	0	0	0	1	2	0	0	3	2	0	0	1		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	22	41	67	175	1	2	12	55	20	33	20	47	16		No Threshold
OP Appointments Cancelled by Hospital %	12.8%	15.3%	25.8%	46.0%	21.8%	15.6%	13.1%	11.3%	12.2%	11.1%	12.3%	13.6%	11.9%		<=5 % N/A >10 %
Was Not Brought Rate W P	9.1%	10.6%	10.8%	7.4%	8.7%	11.4%	11.9%	12.2%	12.2%	11.7%	9.8%	11.7%	11.0%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	11.3%	14.3%	15.0%	15.6%	13.8%	14.2%	15.1%	13.5%	16.1%	12.5%	11.8%	13.1%	13.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	8.4%	9.5%	9.8%	5.9%	7.7%	10.7%	11.2%	12.0%	11.4%	11.5%	9.3%	11.5%	10.6%		<=14 % <=16 % >16 %
Coding average comorbidities	4.77	5.05	5.18	5.54	5.46	5.39	5.33	5.28	5.17	5.31	5.45	5.50	5.44		No Threshold

RESPONSIVE

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Convenience and Choice: Slot Availability	95.9%	89.6%	66.7%												
IP Survey: % Received information enabling choices about their care W	95.5%	97.1%	95.0%	95.0%	100.0%	81.5%	100.0%	95.6%	92.9%	92.9%	96.9%	95.8%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	98.9%	97.6%	98.1%	100.0%	100.0%	88.9%	96.8%	97.8%	100.0%	97.2%	100.0%	95.8%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	86.4%	83.5%	91.2%	90.0%	97.1%	85.2%	100.0%	93.3%	95.2%	88.9%	100.0%	91.7%	96.9%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	97.7%	97.1%	95.0%	87.5%	97.1%	85.2%	90.3%	100.0%	97.6%	100.0%	100.0%	87.5%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D	94.4%	92.9%	93.1%	60.0%	74.3%	63.0%	77.4%	80.0%	88.1%	77.8%	84.4%	81.2%	75.0%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	81.6%	78.2%	76.1%	77.5%	68.6%	77.8%	87.1%	82.2%	76.2%	63.9%	62.5%	81.2%	93.8%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	94.0%	92.2%	88.1%	68.8%	60.1%	46.3%	40.6%	45.0%	55.5%	68.0%	81.0%	86.1%	89.5%		>=92 % >=90 % <90 %
Waiting List Size W	3,043	3,495	3,361	3,381	3,266	2,791	2,484	2,420	2,151	1,916	1,778	1,785	1,731		
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	0	0	0	0	0	0	0	0	1		0 N/A >0
Waiting Times - 40 weeks and above	2	9	14	90	121	127	147	181	137	81	63	24	9		
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks W	100.0%	100.0%	100.0%	39.1%	64.9%	82.1%	84.6%	77.9%	91.4%	96.2%	97.7%	91.7%	94.6%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	90.2%	91.0%	86.1%	90.3%	90.4%	90.0%	90.4%	92.7%	89.7%	90.0%	90.6%	90.4%	90.4%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	99.8%	100.0%	99.9%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	85.0%	88.0%	95.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%	95.0%	99.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	86.0%	90.0%	86.0%		98.0%	98.0%	97.0%	97.0%	98.0%	93.0%	98.0%	92.0%	99.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	89.0%	95.0%	75.0%	100.0%	98.0%	97.0%	81.0%	69.0%	71.0%	74.0%	72.0%	51.0%	75.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	64.0%	86.0%	84.0%	16.8%	63.6%	62.6%	82.4%	59.1%	98.0%	98.8%	100.0%	94.2%	100.0%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks				11.6%	17.2%	35.4%	88.2%	77.8%	100.0%	100.0%	100.0%	90.0%	100.0%		>=99 % N/A <99 %

Medicine

D Drive W Watch P Programme

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks				21.6%	70.7%	83.8%	86.4%	95.0%	92.0%	100.0%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	124	-361	-81	-2,544	-1,842	-1,048	278	-1,111	-1,201	-264	153	41	189		No Threshold
Income In Month Variance (£'000s)	W	1,315	80	271	-2,416	-2,220	-1,103	347	-1,170	-622	-647	561	142	10		No Threshold
Pay In Month Variance (£'000s)	W	15	-67	-297	59	99	92	196	62	-211	-143	338	30	-61		No Threshold
AvP: IP - Non-Elective	W	817	826	610	0	0	-1	0	1	-222	-333	-421	-355	-411		>=0 N/A <0
AvP: IP Elective vs Plan	W	133	107	87	-1	-1	0	0	0	24	7	25	46	2		>=0 N/A <0
AvP: OP New		1,443.00	1,132.00	853.00	3.00	6.00	5.00	-1.00	11.00	-462.00	-17.00	48.00	-135.05	-327.00		>=0 N/A <0
AvP: OP FollowUp		4,287.00	3,649.00	3,619.00	5.00	19.00	17.00	28.00	23.00	1,272.00	663.00	838.00	1,023.29	527.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	1,202	1,084	980	0	1	2	0	2	15	-5	141	105	-74		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	7,166	6,073	5,600	8	25	22	30	36	560	165	665	672	-408		>=0 N/A <0
PDR	W	87.1%	87.1%	87.1%	87.1%	3.1%	10.7%	12.1%	23.0%	21.8%	60.2%	69.1%	74.6%	74.2%		>=90 % >=85 % <85 %
Medical Appraisal	W	84.1%	91.5%	94.9%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	94.1%	94.1%		>=95 % >=90 % <90 %
Mandatory Training	W	94.1%	94.6%	93.1%	92.3%	91.9%	91.6%	91.3%	91.3%	89.9%	90.2%	88.9%	86.7%	88.1%		>=90 % >=85 % <80 %
Sickness	D	5.8%	6.3%	6.0%	5.6%	4.8%	5.4%	5.6%	5.1%	5.0%	5.8%	4.8%	4.9%	6.4%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.9%	2.0%	2.4%	1.6%	0.9%	1.0%	0.9%	1.1%	1.4%	2.2%	1.5%	1.3%	2.1%		<=1 % N/A >1 %
Long Term Sickness	D	3.9%	4.3%	3.6%	4.0%	3.9%	4.4%	4.7%	4.1%	3.6%	3.6%	3.3%	3.7%	4.3%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	250	265	347	201	157	108	167	217	266	235	239	213	247		No Threshold
Staff Turnover	D	9.8%	9.7%	9.8%	9.6%	9.1%	8.2%	7.5%	7.5%	6.6%	6.6%	7.0%	7.3%	6.8%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	91.6%	94.6%		96.5%		97.7%	96.4%	94.9%	94.9%	93.2%	93.6%	93.2%	91.2%		>=90 % >=85 % <90 %

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	28	29	22	18	18	30	42	26	24	32	48	34	26		No Threshold
Clinical Incidents resulting in No Harm D	145	166	115	76	96	114	175	147	140	151	184	141	108		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	39	40	38	22	26	48	48	51	40	39	49	42	36		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	3	0	0	1	0	0	4	1	0	0	0	1	1		No Threshold
Clinical Incidents resulting in severe, permanent harm D	0	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death D	0	0	0	0	0	0	0	1	0	0	0	0	1		0 N/A >0
Medication errors resulting in harm D	0	0	2	0	0	4	4	1	4	1	11	0	1		No Threshold
Medication Errors (Incidents)	43	38	38	16	22	34	61	36	38	37	70	42	25		No Threshold
Pressure Ulcers (Category 3) W	0	0	0	1	0	0	2	0	0	0	0	1	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events W	0	1	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P	57.1%	80.0%	88.9%	88.9%	91.7%	88.9%	83.3%	85.7%	75.0%	86.7%	90.0%	53.8%	91.7%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	1	0	0	2	0	0	0	0	1	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile D	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA D	0	2	0	1	0	0	1	4	1	0	1	0	2		No Threshold
Cleanliness Scores	99.1%	96.3%				97.9%	98.4%	96.0%	98.2%	98.0%	96.0%	97.9%	98.8%		No Threshold

CARING

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Complaints W	1	2	3	1	2	2	0	7	2	10	4	2	2		No Threshold
PALS W	29	30	20	13	7	37	39	33	22	29	21	23	12		No Threshold

EFFECTIVE

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs D	1	0	0	0	0	2	1	0	0	1	2	1	0		No Threshold
% Readmissions to PICU within 48 hrs W	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%		<=3 % N/A >3 %
Referrals Received (Total)	3,731	3,641	2,818	1,371	1,783	2,257	2,842	2,594	3,179	3,021	2,943	2,767	2,640		No Threshold
Theatre Utilisation - % of Session Utilised W	89.7%	88.4%	86.2%	66.4%	68.1%	86.6%	88.6%	89.1%	88.8%	89.2%	88.6%	85.0%	87.6%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	18	36	36	5	3	3	7	15	15	18	15	8	5		No Threshold
28 Day Breaches W	10	4	7	24	0	0	0	0	5	0	1	3	2		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	29	41	140	194	2	0	16	70	52	58	38	45	38		No Threshold
OP Appointments Cancelled by Hospital %	14.0%	13.0%	28.6%	55.9%	30.2%	17.3%	14.9%	11.9%	11.2%	10.9%	11.7%	10.4%	10.7%		<=5 % <=10 % >10 %
Was Not Brought Rate W P	9.5%	9.6%	10.6%	9.6%	10.3%	7.7%	9.1%	10.2%	10.4%	9.3%	9.4%	10.6%	11.1%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	9.3%	10.6%	11.0%	9.9%	11.2%	8.8%	10.9%	11.5%	12.1%	9.8%	10.0%	11.7%	11.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	9.6%	9.3%	10.4%	9.5%	9.9%	7.2%	8.5%	9.7%	9.9%	9.2%	9.2%	10.2%	10.9%		<=14 % <=16 % >16 %
Coding average comorbidities	4.16	4.02	4.23	5.20	4.89	4.19	4.06	4.49	4.46	4.39	4.40	4.48	4.30		No Threshold
CCAD Cases	33	28	36	21	26	24	29	23	30	31	27	26	25		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		99.0%	89.2%	64.6%														
IP Survey: % Received information enabling choices about their care	W	98.5%	98.2%	97.5%	87.1%	88.7%	97.8%	99.0%	96.0%	96.2%	96.2%	95.3%	99.2%	99.0%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	98.5%	97.5%	98.0%	100.0%	96.2%	95.7%	99.0%	98.0%	94.7%	98.8%	98.1%	99.2%	100.0%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	93.1%	93.2%	91.1%	83.9%	94.3%	98.9%	98.1%	93.1%	97.7%	100.0%	97.2%	98.4%	99.0%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	98.2%	97.9%	97.0%	90.3%	86.8%	92.4%	91.3%	99.0%	98.5%	100.0%	99.1%	95.9%	100.0%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	96.4%	92.2%	95.0%	61.3%	81.1%	65.2%	71.2%	82.2%	80.5%	85.7%	85.0%	72.1%	81.9%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	87.7%	77.9%	81.7%	71.0%	56.6%	85.9%	81.7%	76.2%	75.2%	98.8%	74.8%	82.0%	95.2%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	93.5%	94.4%	89.0%	69.0%	59.6%	47.8%	40.3%	43.2%	46.8%	50.9%	53.4%	54.3%	54.6%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,651	8,238	7,567	6,655	6,630	7,186	7,431	7,840	7,737	8,127	8,221	7,858	8,131				
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	7	31	60	137	121	135	143	147	183	221		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	100.0%	92.9%	66.7%	53.3%	100.0%	100.0%	100.0%	87.5%	100.0%	50.0%		>=99 %	N/A	<99 %

WELL LED

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	-567	-141	-1,187	-4,229	-3,714	-1,773	-1,983	-1,540	-1,990	-487	54	-502	-245		No Threshold		
Income In Month Variance (£'000s)	W	-184	367	-502	-4,173	-4,172	-1,908	-1,964	-1,428	-1,460	15	1	34	0		No Threshold		
Pay In Month Variance (£'000s)	W	60	-342	-241	-133	-111	32	67	35	-457	-68	-67	-398	-364		No Threshold		
AvP: IP - Non-Elective	W	428	355	343	0	0	1	0	-1	-127	-65	-35	-47	-89		>=0	N/A	<0
AvP: IP Elective vs Plan	W	292	297	230	1	1	-2	0	-1	25	3	-16	4	-47		>=0	N/A	<0
AvP: OP New		2,923.00	2,507.00	2,003.00	5.00	3.00	4.00	14.00	13.00	-688.00	-1,261.00	-631.00	-463.19	-975.00		>=0	N/A	<0
AvP: OP FollowUp		7,884.00	7,137.00	5,626.00	-1.00	6.00	11.00	11.00	39.00	-672.00	-1,604.00	-280.00	-202.57	-1,945.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	856	842	581	0	1	2	1	0	-78	-178	-103	-37	-268		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	12,521	11,112	8,782	4	9	15	23	53	-1,793	-3,567	-1,265	-797	-3,467		>=0	N/A	<0
PDR	W	94.3%	94.3%	94.3%	94.3%	0.0%	1.1%	17.1%	24.7%	35.5%	57.8%	67.5%	67.6%	66.1%		>=90 %	>=85 %	<85 %
Medical Appraisal	W	84.1%	89.7%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	96.8%	96.8%		>=95 %	>=90 %	<90 %
Mandatory Training	W	93.0%	92.9%	92.1%	90.6%	88.5%	89.6%	89.1%	89.3%	88.0%	87.1%	84.8%	85.6%	86.7%		>=90 %	>=85 %	<80 %
Sickness	D	6.3%	5.9%	6.3%	6.5%	6.7%	5.8%	5.8%	6.1%	6.1%	6.8%	5.7%	6.0%	8.0%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	2.0%	2.0%	2.2%	1.6%	1.5%	1.1%	1.4%	1.4%	1.7%	2.0%	1.2%	1.3%	3.1%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.3%	3.9%	4.2%	4.9%	5.2%	4.8%	4.4%	4.7%	4.4%	4.8%	4.5%	4.7%	4.9%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	343	397	504	457	322	204	310	332	286	446	505	415	434		No Threshold		
Staff Turnover	D	10.6%	11.0%	10.6%	10.3%	9.7%	9.3%	9.5%	9.4%	9.4%	8.7%	8.2%	7.8%	7.9%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	89.4%	91.9%		90.3%		94.4%	86.8%	89.1%	93.6%	94.4%	95.3%	93.5%	89.6%		>=90 %	>=85 %	<90 %

Community & Mental Health Division

SAFE	• Incident 47280 (ASD/ADHD) – delayed medication follow up **Learning** - The need for all clinicians on prescription duty to check last clinical letter to ensure patient plan for follow up arrangements is being followed. • Incident 46951 (Rainbow Centre) – Child booked to attend exam – Social Worker and family not aware of appointment. **Learning** - The importance of ensuring all agencies and carers are clear on any actions they may have responsibility for and importance of Rainbow Team contacting Social Worker and family prior to appointment to confirm arrangements. • One incident of restricted intervention reported on the Tier 4 children's inpatient unit reported: Sudden physical assault on staff following search of child's room and removal of sharp objects found. Parents informed.	**Highlight** • Zero incidents resulting in moderate or severe harm • Zero incidents resulting in death • Zero Pressure Ulcers (Category 3 and above) • 137 incidents reported (80 x clinical, 57 x non-clinical) **Challenges** • Increasing numbers of incidents relating to data protection – accidental disclosure of information. Divisional Director requested formal review of all incidents and Deep Dive to be completed. • Access and delayed appointments continues to be a theme for ASD/ADHD and CAMHS – this remains on the divisional risk register • Staff absence due to COVID accounted for 21 non-clinical incidents in January 2021
CARING	• SO11950 – Formal Complaint Sefton locality Mental Health Services – Complaint due to referral to the service being rejected. **Learning** – Where a young person falls across two services e.g. ASD/ADHD and Mental Health, teams need to communicate effectively and work together to ensure the young person has a clear pathway between services. A working group has been set up between Mental Health Services, Community Paediatrics and ASD/ADHD to enhance joint working.	**Highlight** • 14 PALs received in January, which is the lowest number of recorded PALS since January 2020 • 18 Excellence Reports recorded in January 2021 – 3 highlighted at Patient Safety Meeting • 9 Compliments recorded in January 2021 • FFT Scores – 90% of families scored services in the Community & Mental Health Division 'Very Good' or 'Good' **Challenges** • 6 formal complaints received in January 2021 • 2 x ASD/ADHD – Delay in assessment and receiving diagnosis. • 2 x Mental Health Services – One complaint relating to communication with a social worker and one complaint relating to discharge of child from hospital. • 1 x Outpatients - Complaint that security were not called when a parent challenged another parent for not wearing a face mask and was verbally abused • 1 x Rainbow Centre - Challenging content of report
EFFECTIVE	Go live of new contract monitoring pack - 18 month project completed to enable Alder Hey to provide accurate contract monitoring information on all community services to commissioners	**Highlight** • Crisis Care continue to provide 24/7 service. The service has now received over 970 calls outside of the service pre-COVID opening hours.

		Challenges • Booking and Scheduling: Referral turnaround time for routine referrals continues to be a challenge. This is an improving position from 20 days above target in December to now 8 days above target at the end of January.
RESPONSIVE	Improvements in waiting times across the division: • ASD and ADHD new pathways continue to deliver against the maximum 30 week timescale and continue to reduce the backlog in line with the agreed plan. • Continued improvement in RTT for Community Paediatrics which is now at 66.2% • All Sefton therapy services achieving the waiting time standard of 18 weeks and SEND indicators	**Highlight** • No urgent breaches for Eating Disorders pathway in January • Continued reduction in pre April 2020 cohorts for ASD and ADHD **Challenges** • Referrals are down YTD but there are month on month increases for locality based Mental Health Services who are experiencing increased demand and a higher number of urgent and high risk presentations of deteriorating mental health. Remodelling of data and targets underway to include the nationally predicted 30% increase in referrals.
WELL LED	Alder Hey Youth Forum and the NSPCC launched the #ClassofCOVID19 Video 34 staff in the Community & Mental Health division have signed the Black Lives Matter pledge as part of the Divisional BAME and White Allies Network	**Highlight** • Staff turnover remains within Trust target at 9.3% • 58% staff survey completion • Medical Appraisal rates are at 100% **Challenges** • Increase in sickness absence to 5.2%, with the main increase being short term sickness. Fortnightly meetings and drop in sessions have been arranged by divisional HR representatives to support service leads.

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	8	5	5	4	6	6	8	4	8	16	10	15	4		No Threshold
Clinical Incidents resulting in No Harm	D	46	57	42	29	92	84	83	73	88	84	75	52	65		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	6	10	4	4	3	10	6	5	9	11	12	9	11		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)		1	2	6	6	7	6	11	10	20	33	26	16	19		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores		100.0%					78.3%	100.0%		98.8%	98.8%					No Threshold
CCNS: Advanced Care Plan for children with life limiting condition		8	8	8												No Threshold
CCNS: Supported early discharges from hospital care		100.0%	100.0%		100.0%	100.0%	100.0%									No Threshold
CCNS: Prescriptions		15	22	17	16	12	15									No Threshold

CARING

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Complaints	W	2	3	2	0	2	2	4	2	2	1	4	2	5		No Threshold
PALS	W	44	36	18	19	19	26	29	22	26	32	17	15	14		No Threshold

EFFECTIVE

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Referrals Received (Total)		920	950	796	433	464	620	874	634	855	978	1,050	844	767		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		18	18	19	17	0	0	4	25	25	18	2	5	7		No Threshold
OP Appointments Cancelled by Hospital %		10.9%	11.3%	18.4%	24.3%	11.8%	6.4%	6.3%	10.5%	10.1%	10.0%	11.3%	8.1%	11.8%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	9.7%	9.5%	9.6%	9.3%	10.2%	11.4%	10.6%	10.4%	6.9%	11.6%	8.4%	8.3%	18.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	11.2%	10.2%	10.8%	13.0%	14.8%	14.3%	15.1%	13.6%	13.9%	13.3%	11.0%	13.0%	19.8%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		12.5%	11.7%	9.1%	9.3%	12.5%	11.5%	8.9%	12.1%	9.1%	14.7%	9.9%	9.6%	22.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		9.6%	7.8%	8.2%	13.2%	13.3%	11.0%	14.7%	14.1%	17.5%	15.0%	11.9%	14.8%	39.7%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		9.5%	13.1%	24.9%	26.1%	22.4%	28.3%	25.7%	23.6%	9.7%	12.8%	13.3%	13.6%	19.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		12.4%	11.9%	12.1%	13.6%	15.8%	16.0%	15.8%	13.9%	13.1%	13.3%	11.6%	13.2%	12.3%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		92.6%	76.8%	82.5%	90.5%	91.2%	85.7%	87.6%	75.6%	91.4%	107.8%	91.0%	109.7%	114.3%		No Threshold
CAMHS: Tier 4 DJU Bed Days		340	256	296	322	386	360	380	328	384	470	382	478	496		No Threshold
Coding average comorbidities		3.00		5.00	3.00	3.00		2.00	6.00		4.50	3.33	3.00			No Threshold
CCNS: Number of commissioned packages		10	10	10	9	9	9									No Threshold

RESPONSIVE

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1	1	1	1	1		1	1	1		2	2			No Threshold
CAMHS: Referrals Received		354	383	315	110	163	259	262	257	356	348	416	339	268		No Threshold

Community

D Drive W Watch P Programme

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
CAMHS: Referrals Accepted By The Service	207	230	169	67	93	144	154	146	268	193	232	197	158		No Threshold
CAMHS: % Referrals Accepted By The Service	58.5%	60.1%	53.7%	60.9%	57.1%	55.6%	58.8%	56.8%	75.3%	55.5%	55.8%	58.1%	59.0%		No Threshold
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%		100.0%										>=96 % N/A <96 %
RTT: Open Pathway: % Waiting within 18 Weeks W	76.3%	75.1%	69.3%	44.3%	42.5%	34.0%	32.3%	38.1%	40.2%	49.2%	64.3%	64.4%	66.2%		>=92 % >=90 % <90 %
Waiting List Size W	1,191	1,161	1,234	1,010	1,013	1,184	1,032	1,109	1,051	795	756	800	785		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	5	8	21	22	12	6	10	2	1	1	0		0 N/A >0
CAMHS: Crisis / Duty Call Activity				288	422	413	550	494	516	596	718	697	649		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks W	58.3%	59.6%	58.6%	53.0%	53.6%	49.3%	44.0%	53.2%	59.1%	68.8%	70.0%	69.9%	65.9%		>=92 % >=90 % <88 %
ASD: Completed Pathways	69	63	53	23	25	80	110	132	88	104	79	35	39		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	81.2%	76.2%	67.9%	82.6%	72.0%	53.8%	62.7%	74.2%	71.6%	95.2%	88.6%	88.6%	38.5%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) P			90.9%	69.2%	90.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) P				66.7%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals W	109	102	131	107	134	149	188	122	144	146	151	127	119		No Threshold
CCNS: Number of Contacts D	821	830	986	748	859	812	1,083	803	1,035	1,038	877	844	783		No Threshold

WELL LED

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	-58	-65	165	-92	-27	175	-26	0	-70	369	270	45	321		No Threshold
Income In Month Variance (£'000s) W	104	91	330	-30	-64	139	-49	-44	96	397	155	75	148		No Threshold
Pay In Month Variance (£'000s) W	-90	-87	412	18	131	-29	-64	-98	-31	-81	30	12	65		No Threshold
AvP: OP New	552.00	531.00	454.00	0.00	1.00	3.00	0.00	0.00	181.00	122.00	186.00	107.43	33.00		>=0 N/A <0
AvP: OP FollowUp	3,079.00	2,766.00	2,759.00	1.00	9.00	9.00	3.00	9.00	667.00	649.00	900.00	1,049.48	333.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan W	3,631	3,298	3,213	1	10	12	3	9	838	767	1,085	1,155	368		>=0 N/A <0
PDR W	91.3%	91.3%	91.3%	91.3%	2.1%	9.8%	16.6%	23.1%	41.3%	73.4%	81.9%	81.9%	83.1%		>=90 % >=85 % <85 %
Medical Appraisal W	69.7%	91.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %
Mandatory Training W	96.7%	95.9%	94.7%	93.8%	93.0%	92.8%	92.1%	92.0%	91.4%	91.7%	89.2%	88.4%	89.2%		>=90 % >=85 % <80 %
Sickness D	4.9%	4.7%	6.3%	4.0%	3.5%	2.7%	2.5%	2.7%	3.8%	4.0%	4.2%	4.3%	5.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness D	1.2%	1.1%	2.8%	1.4%	0.8%	0.5%	0.7%	0.9%	1.3%	1.5%	1.2%	0.9%	1.9%		<=1 % N/A >1 %
Long Term Sickness D	3.7%	3.5%	3.5%	2.6%	2.7%	2.2%	1.8%	1.9%	2.5%	2.4%	3.0%	3.4%	3.5%		<=3 % N/A >3 %
Temporary Spend ('000s) D	135	148	183	122	47	21	189	194	169	173	212	355	226		No Threshold
Staff Turnover D	11.8%	11.8%	10.8%	10.2%	11.5%	11.5%	10.8%	10.7%	10.5%	9.8%	9.1%	8.8%	9.4%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) W	101.0%	94.1%				96.2%	99.5%	99.8%	99.8%	100.1%	98.5%	98.6%	99.9%		>=90 % >=85 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF ICP (compliant) • All patients screened for potential COVID 19 prior to hospital visit using telephone triage • CRF ward compliant with all standards on Trust Dashboard • Good uptake from Staff covid vaccine • All Areas have been certified Covid Secure • Increase in incident reporting under data security, action plan re training to be arranged.	**Highlight** • Mandatory Training > 94% • GCP training 97% • ANTT compliance 100%-CRF Ward **Challenges** • All Covid RAs complete for CRD Keeping ward a Covid • Reduced space on CRF due to footfall. • Risk free area with Oxford F/U's and flu vaccine sessions • ANTT compliance score is incorrect and should be 98% • X1 incident reported • X1 new risk re staffing levels (oncology)
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience • Plans underway to capture experience patient experience data	**Highlight** • X 0 Complaints • New Children's PRES developed for 20/21 • Positive results from last survey reported **Challenges** • More work to do on local patient internal audits • Collation of survey questionnaires from patients
EFFECTIVE	• Studies selected based on best possible outcomes for children and young people. • Current portfolio regularly reviewed using NIHR stratification to allow for UPH prioritisation studies whilst maintaining all studies in level 2. • No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients. • Clinicians encourage children and young people to make informed decisions about participating in studies.	**Highlight** • Project restart on track current portfolio at 56% • Recruitment figures for UPH studies second highest • Achieved national KPI of 10% recruitment for recovery study • Have re-started CPP national study in line with increased covid activity • X 10 UPH studies open within Trust • Successful completion of Pilot of Lateral Flow Testing (LAVA study) **Challenges** • CRF housekeeping • Project restart to meet NIHR ambition of 80% • Staffing for LAVA study • Siren had been extended and increased national priority • Releasing delivery workforce capacity to allow the opening of new studies • Small team to cover 7 day staffing on Covid team to meet demand

RESPONSIVE	• All Staff Risk Assessments completed as required • New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local providers to offer joint training programmes.	**Highlight** • COVID secure certificates received • Agile working implemented to reduce footfall • A.H supporting the wider system with Covid UPH activity • Partnership working with external partners • Moved to 7 day working. • All adult patients offered alternative treatments under research whilst hosted at AH • Research nurses supported mass vaccination programme internal clinics and other sites such as Aintree • CRF have been selected for first adolescent vaccine study **Challenges** • Staff working offsite to support adult vaccine studies • Last minute requests for external support • Effective clinical space to deliver HCW study clinics • Research staff being released for redeployment internally
WELL LED	• PDR compliance increased to 83.58% • LTS absence rates have improved staff are supported through line managers and staff support. • Engagement with partners in relation to upcoming starting well initiatives.	**Highlight** • Shielding Staff have returned with reasonable adjustments in place • Division supporting staff with Flexible working • Sickness is improving • support arranged for staff with SALS **Challenges** • Sickness levels remain high due to Covid/SI • Increased numbers of staff having to self-isolate • Late requests for help can be challenging • Annual leave allowance for some staff

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

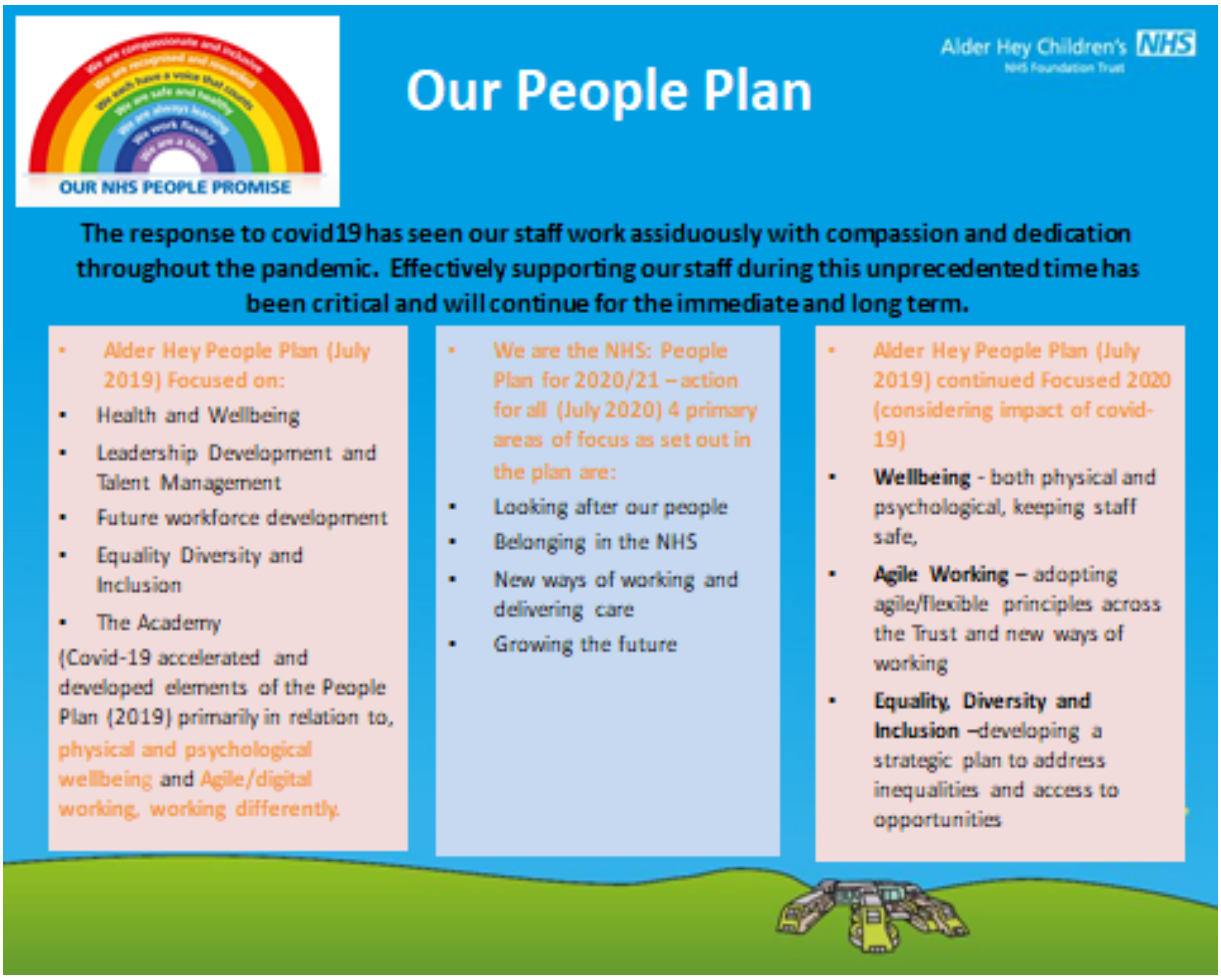
Thursday 25th February 2020

Paper Title:	**People and Wellbeing update**
Report of:	**HR and OD Department**
Paper Prepared by:	Deputy Director of HR & OD

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	
Associated risk (s)	1739; 2100; 2157; 2160; 2161; 2181

1. Purpose

The purpose of this paper is to provide the Board with a strategic update on the Alder Hey People Plan and our response to the requirements of the national NHS People Promise.



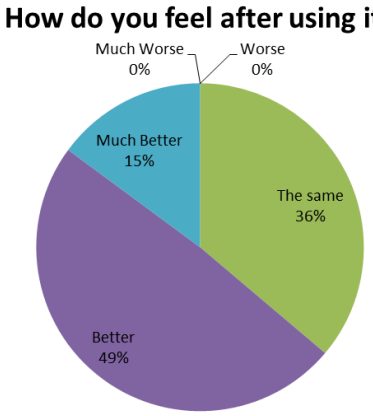
2. Wellbeing

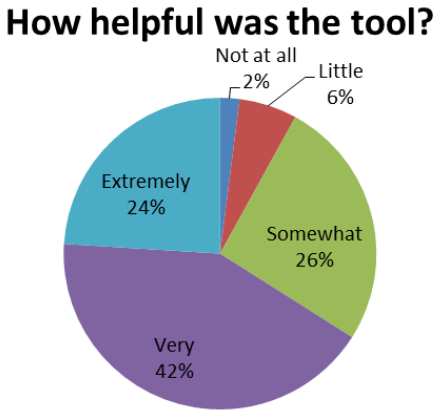
2.1 Staff Advice and Liaison

The Staff Advice and Liaison service continues to grow and develop with 950 contacts (up to 17/2/2021). Themes of contacts are varied, but the majority of support is focused around staff experiencing stress and anxiety. In response to the feedback from staff, the team have successfully facilitated Virtual Common Rooms every Wednesday for staff to have a place to network and connect.

In partnership with the Clinical Health Psychology team SALS have supported the wrap around support for staff working on ICU during the third wave of the pandemic. Moving forward the team will be supporting debriefing and learning sessions with staff who have been working on ICU over the last 2 months with dedicated support provided to the facilities teams

Utilising Ground Truth methodologies as a mechanism for gaining structured feedback the team have been able to identify trends and improvements and to readily provide feedback to staff. Within PICU the tool has been utilised 60 times with over half those using the team stating they found the tool helpful and that it had a positive impact on them.





- Mental Health First Aiders & SALS Pals.

The offer of Mental Health First Aid is being revamped with supervision and CPD being provided by the SLAS team. Funding has been identified for a further thirty Mental Health First Aiders specifically for our AHP and Nursing colleagues to be trained, and SALS are working in partnership with HR colleagues to develop this training. Concurrently, we have developed the role of SALS Pals – a network of staff who have a keen interest in emotional wellbeing to work alongside the team, offering support and signposting for staff and referring them into SALS when necessary.

In recognition of the impact the SALS service has had for staff the team are working with NHSEI , to produce a short film which will showcase the work that SALS undertake, and will be used as a case study to support other Trusts in developing their wellbeing support offer.

2.2 Health Wellbeing Steering Group

The Health and Wellbeing Steering group relaunched in 2021 focusing on the implementation of the People Plan. The key actions from the steering group are:

- Free Will writing support to all staff via the Charity.
- Bespoke Menopause Train the Trainer funding identified in order that we can offer regular training and support.
- Health and Wellbeing conversations as part of regular support and performance conversations
- Carers Passport- identified as part of the People Promise this will enable us to work with and support colleagues with caring responsibilities

- Doing our Bit – Virtual Platform for fitness for all staff within the organisation, with a task and finish group running to look at implementing a strategy for Physical health. , which is defined in the NHS People Plan.

In support of the Health and Wellbeing agenda Dr Fiona Marston has taken on the role of Health and Wellbeing Guardian and will be working with the steering group moving forward

2.3 Staff Availability

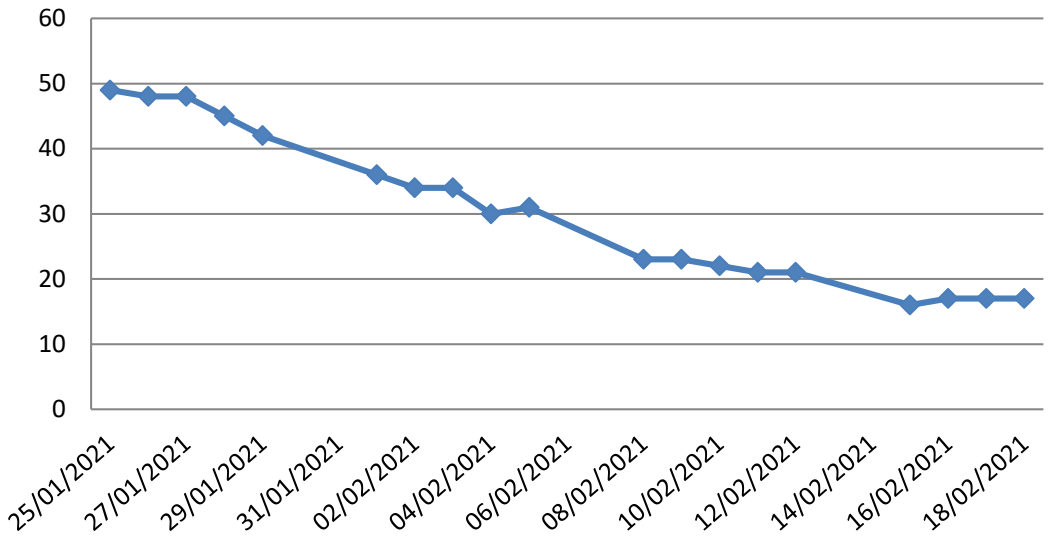
The staff availability position in February has improved with overall absences decreasing by 1.95% and COVID-19 related absences decreasing by 1.58%.

Table 1 - Sickness position 18th January 2021

Reason	Trust	
	%	No of Staff
Non Covid Related Sickness	5.02%	200
Covid Related Sickness	0.88%	35
Absence Related to Covid - not inc sickness	1.20%	48
Absence Related to Covid Inc Sickness	2.08%	83
All Absence (total of above)	7.10%	283

The graph below demonstrates the decrease in staff absences due to self-isolation as a result of contact for Test and Trace services or household infection.

Graph 1 – Infection Precaution Staff Absence



Following the changes announced by the Government on 4th January 2021 and the reintroduction of lockdown measures in England as of 5th January 2021 shielding precautions for those classified as clinically extremely vulnerable have been implemented. On 16th February 2021 the Government announced that following changes to how CEV is categorised an additional 1.7 million people will now be advised to shield, and that shielding will continue until 31st March 2021. The HR team are supporting the Trust to facilitate risk assessments and occupational health referrals for staff and advising on the facilitation of home working and temporary redeployment into alternative roles as appropriate. The team are continuing to monitor the release of updated advice and guidance ensuring that information is readily available for staff and managers across the Trust.

2.4 Staff Communication and Engagement

The Nation Staff Survey closed in November with a response rate of a 51%. The detailed staff survey feedback has been shared with the Trust and a full review will be provided to Board in March.

Detailed analysis of the data will also be shared at divisional and departmental level and a number of resources will be made available to support team to have 'big conversations' and identify divisional and local actions.

3. Flexible Working

Across the Trust we have a large proportion of staff (c1000), clinical and non- clinical, who have embraced the technology available and are supporting the Trust remotely in line with the advice and guidance from the Government.

Through out January a number of workshops took place for staff and managers to reflect on the experiences of agile working and looking at what agile working will look like for the workforce moving forward.

Phase 1 of the project has now been completed and phase 2 will commence in the coming weeks focusing on estates strategy, space, people needs, and optimising space. The Flexible Working policy is also being reviewed to capture learning and best practise and to also incorporate recommendations from the NHS England and Improvement People team as part of the NHS People Promise.

4. Equality, Diversity & Inclusion

A Taskforce led by Claire Dove OBE, commenced in October 2020, and is focusing reviewing and improving our people practices related to EDI across the organisation. A series of listening events have taken place to hear and learn from our colleagues about their experiences in the Trust and in the wider NHS. Supported by the Communications Team and communication and engagement strategy is being developed and implemented which celebrates the diversity of our workforce, this included a series of blogs to celebrate Black History Month.

Three key workstreams have been identified so far; recruitment, apprenticeships and zero tolerance. Task and finish groups have been established with representatives from across the Trust working collaboratively.

5. Governance and Ongoing Business

5.1 Case Management

In line with the national Social Partnership Forum (SPF) all cases continue to be managed on a case-by-case basis in partnership with staff side colleagues from all of our recognised Unions with appropriate measures and risk assessments but in place to ensure staff health and wellbeing continue to be prioritised.

In February there are 17 cases currently ongoing as detailed below.

Table 2- Employee relations activity per division as of 18th February 2021

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Total
Surgery	2	5	1	1	0	0	**9**
Medicine	1	0	2	0	0	0	**3**
Community	1	0	0	0	2	0	**3**
Corporate	0	2	0	0	0	0	**2**

Grand Total	**4**	**7**	**2**	**1**	**2**	**0**	**17**

5.2 Training

As of the 5th of February 2021, Mandatory Training was at 85% overall, 5% below the Trust target of 90% but up 1% from the previous month.

Since the last report there have been a number of changes to our Mandatory Training Needs Analysis resulting in 3 new topics being included in the overall compliance figure, Safeguarding Adults Level 1 and Level 2 and Preventing Radicalisation Awareness which were previously under the banner of Safeguarding Children. We have also rolled out 3 brand new topics; Fraud Awareness, Positive Behavioural Support and Conflict Resolution which are being monitored separately as new topics to give staff an opportunity to complete them.

Our key areas of focus continue be annual Resuscitation training (BLS & PLS/APLS Update) and supporting our Estates and Ancillary staff to be able to access training.

The Learning and Development Team have been working with the Resus team to re-develop their training calendar for the 2021/22 to ensure there is appropriate capacity for staff to attend and maintain their compliance whilst still meeting the social distancing guidelines required under COVID-19. This should dramatically improve compliance in the longer term and in the shorter term the Resus team are looking to schedule additional ad-hoc sessions for their lowest scoring topics.

In terms of supporting our Estates and Ancillary staff, we have asked all of our Subject Matter Experts to consider alternative delivery methods to support this area of the Trust such as workbooks, socially distanced face to face sessions, recorded videos etc and are collating their responses before arranging alternative training for this staff group with the departmental leads.

As well as the above hotspots we continue to encourage staff and managers to ensure their training compliance is up to date via our usual monthly reporting to divisions and departments and also recently sent all staff who were not 100% compliant an email informing them of their current compliance and how to access the relevant training to rectify it..

Table 3- Mandatory Training compliance 9th February 2021

Division	Overall Mandatory Training
Trust	**84.92%**
Alder Hey in the Park	65.09%

Community	87.73%
Corporate Other Department	85.77%
Facilities	49%
Finance	77.14%
Human Resources	85.58%
IM&T	89.39%
Innovation	72.83%
Medicine	86.89%
Nursing & Quality	88.94%
Research & Development	93.19%
Surgery	85.91%
Staff Group	Overall Mandatory Training
Add Prof Scientific and Technic	88.30%
Additional Clinical Services	88.46%
Administrative and Clerical	84.36%
Allied Health Professionals	87.21%
Estates and Ancillary	50.89%
Healthcare Scientists	92.00%
Medical and Dental	72.36%
Nursing and Midwifery Registered	89.42%

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th February 2021

Paper Title:	**Board Assurance Framework 2020/21 (January)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Monthly BAF Reports
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Impact:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2020/21

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 12 principal risks aligned to the Trust's strategic objectives.

A properly used BAF will drive the agendas for the Board and its Committees.
The board assurance committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.
The newly formed Care Delivery Board (monthly Risk Management Meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

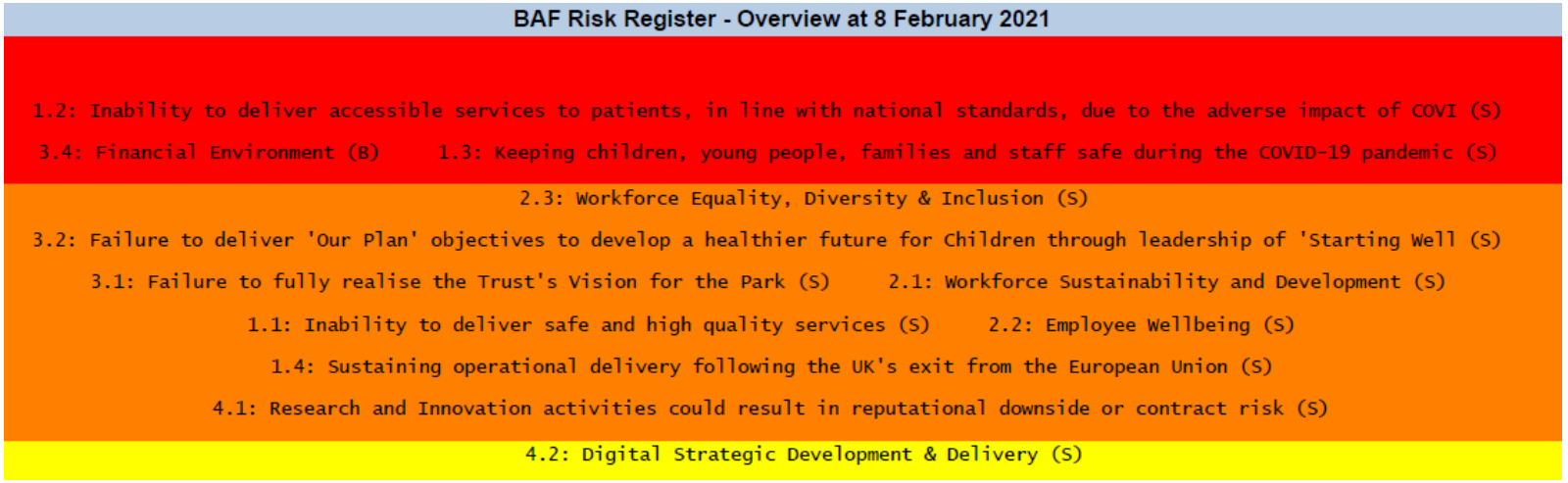
Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF Risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high quality services	Safety & Quality Assurance Committee
1.2	Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care	Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Research and Innovation activities could result in reputation downside or contract risk	Innovation Committee
1.3	Keeping children, young people, families and staff safe during COVID-19	Trust Board
1.4	Sustaining operational delivery following the UK's exit from the European Union	Trust Board

3. Overview at 8th February 2021

During the month a comprehensive review of the risk relating to research & innovation was undertaken including a revised risk title, risk description, thorough review of existing control measures and gaps in controls to more accurately reflect the strategic risk in terms of research and innovation activities.

The diagram below gives a high level heliview of the current version, followed by a summary and a brief on the changes since the last Board meeting.



Trend of risk rating indicated by: NEW, B - Better, S - Static, W – Worse
Report generated by Ulysses

Corporate risks are linked to BAF Risks – a summary of these risks can be found at appendix A. The full BAF document is included as Appendix B which reflects the active review of risks, any changes to risk ratings, progress against existing actions, gaps in controls and review of the adequacy of mitigations.

4. Summary of BAF - at 8th February 2021

The diagram below shows that all risks remained static in-month with the exception of 'Financial Environment' which improved due financial plan being accepted and confirmation of additional funding.

Ref, Owner	Risk Title	Board Cttee		Risk Rating: I x L		Monthly Trend	
				Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care							
1.1 NA	**Inability to deliver safe and high quality services**	SQAC		3x3	2x2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care**	SQAC		**4x5**	3x2	STATIC	STATIC
1.3 JG	**Keeping children, young people, families and staff safe during COVID-19**	Trust Board		**5x3**	3x3	STATIC	STATIC
1.4 JG	**Sustaining operational delivery following the UK's exit from the European Union**	Trust Board		4x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work							
2.1 MS	**Workforce Sustainability and Development**	PAWC		3x3	3x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**	PAWC		3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC		4x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships							
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	ARC		3x3	3x2	STATIC	STATIC
3.2 DJ	**Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships**	RABD		4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**	RABD		**4x4**	4x3	STATIC	**IMPROVED**
STRATEGIC PILLAR: Game-Changing Research And Innovation							
4.1 CL	**Research and Innovation activities could result in reputational downside or contract risk**	Innov.		3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Delivery**	RABD		4x1	4x1	STATIC	STATIC

5. Summary of January updates:

External risks

- ***Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships (DJ)***

  Risk reviewed; no change to rating in month. Wave 3 continues to delay local system transformation partnerships, but making progress across the developing C&M CYP Programme and NW Paediatric Partnership.

- ***Workforce Equality, Diversity & Inclusion (MS)***

  Actions reviewed and progressing.

- ***Sustaining operational delivery following the UK's exit from the European Union (JG)***

  Risk Reviewed. EU Exit Group continues to meet to monitor the ongoing situation. No major issues have been identified that require escalation.

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care (AB)***

  The number of children and young people waiting over 52 weeks in January is 224. The root cause of the increase in patients with a long waiting time is 1) review of records through safe waiting list management identify data quality adjustments in some cases 2) contraction in inpatient capacity caused by COVID-19 Wave 3 3) acute access pressures in ENT and spinal surgery. We are taking actions as follows: 1) increase in OPD sessions in ENT and patients seen per session 2) We are expecting to increase capacity through procurement of an LLP service in spinal and orthopaedic service in late February 3) use of the independent sector in March. 4) additional internal capacity in OPD Our key controls include: * weekly tracking to review chronological booking is leading to a reduction number of patients with a very long waiting time * Safe waiting list management review * clinical review of long wait patients. Overall we expect the actions will deliver a small reduction in the total number of patients waiting over 52 weeks at the end of February. In ENT we are forecasting to go from > 60 patients waiting 52 weeks for an OP appointment to less than 5.

- ***Keeping children, young people, families and staff safe during COVID-19 (JG)***

  Wave 3 response signed off by Board and implementation going well. Adult critical care facility now in situ and responding to system needs. As predicted, hospital occupancy dropped across the system focus shifting to improving access to services for children & young people.

- ***Inability to deliver safe and high quality services (NA)***

  This risk has been reviewed in the context of the wave three pandemic. The current mitigations in place are effective at this time. This risk is planned to be presented to March board following a full review in light of a changed health and social care landscape.

- ***Financial Environment (JG)***
  Risk reviewed and rating reduced to 16 to reflect reduced risk of 2020/21 due financial plan being accepted and confirmation of additional funding. Longer term financial risk remains due to uncertainty within the framework.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Risk reviewed prior to Feb Board.

- ***Digital Strategic Development and Delivery (KW)***
  Risk reviewed, all actions on track. Cyber Essentials Accreditation achieved.

- ***Workforce Sustainability and Development (MS)***
  Actions reviewed and on track against plan.

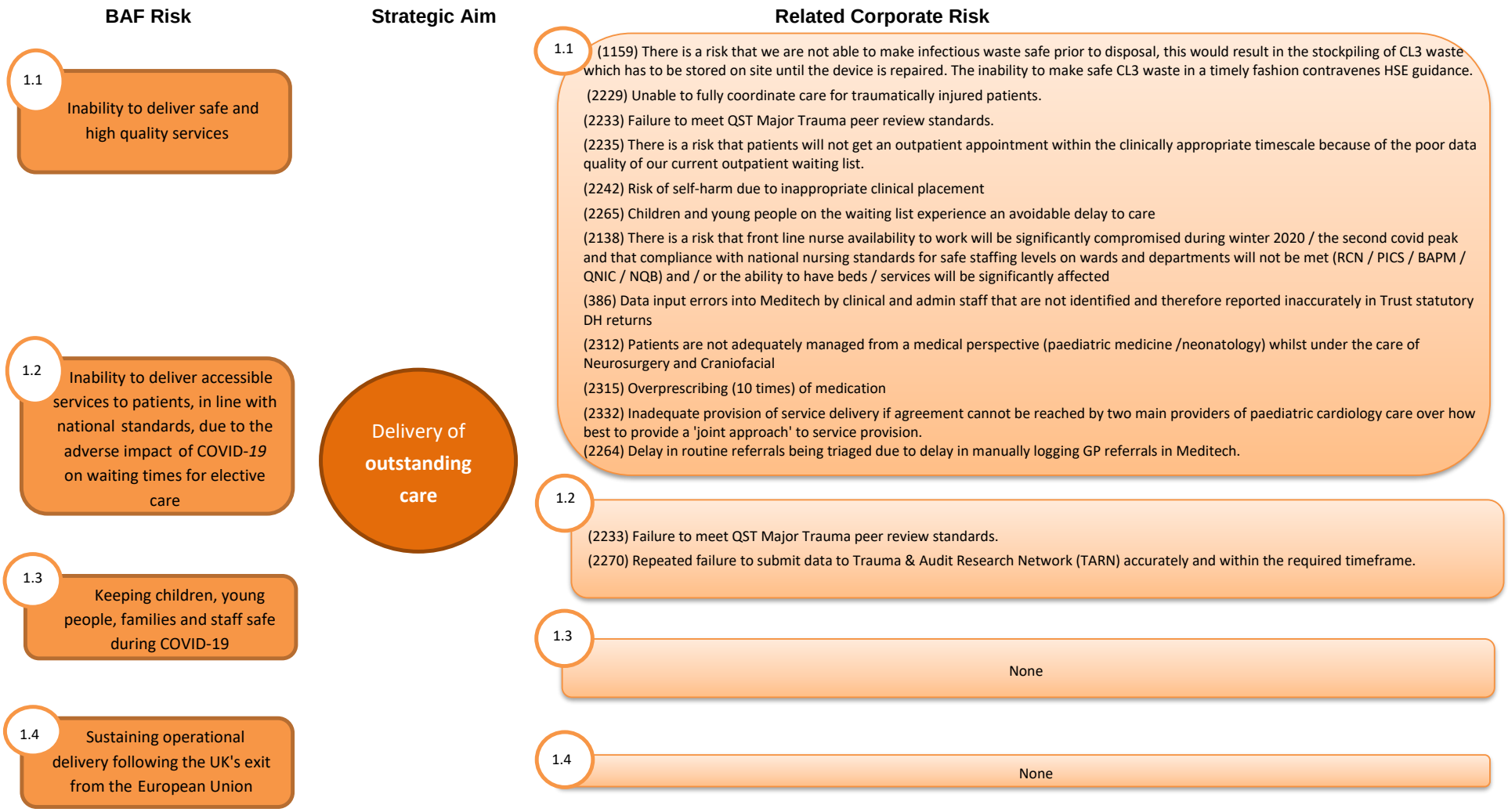
- ***Employee Wellbeing (MS)***
  Risk reviewed - no change to score in-month. Progress against two actions.

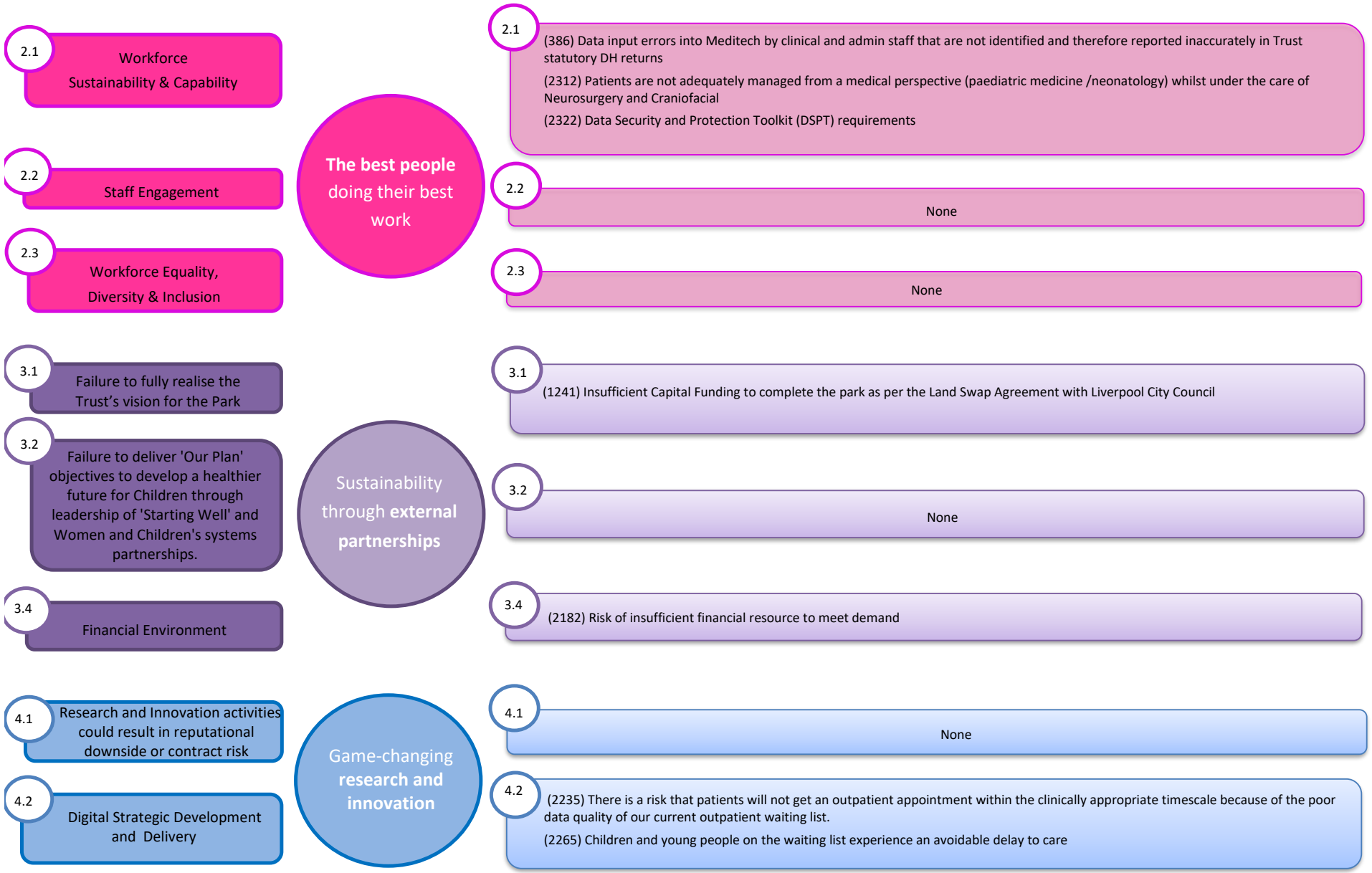
- ***Research and Innovation activities could result in reputational downside or contract risk (CL)***
  Risk comprehensively reviewed and updated in month. No change to score.

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 2nd February 2021




2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
2.1
(386) Data input errors into Meditech by clinical and admin staff that are not identified and therefore reported inaccurately in Trust statutory DH returns
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
(2322) Data Security and Protection Toolkit (DSPT) requirements
2.2
None
2.3
None
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.
3.4
Financial Environment
Sustainability through external partnerships
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
None
3.4
(2182) Risk of insufficient financial resource to meet demand
4.1
Research and Innovation activities could result in reputational downside or contract risk
4.2
Digital Strategic Development and Delivery
Game-changing research and innovation
4.1
None
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2235, 2242, 2265, 2233, 386, 2312, 2315, 1159, 2332, 2264		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

Not having sufficiently robust, clear systems, processes and people in place to respond to competing demands presented by the current health and social landscape.

Existing Control Measures	Assurance Evidence (attach on system)
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I). Change programme assurance reports monthly - change programme currently on hold during Covid pandemic response and resetting	Annual QIA assurance report and change programme assurance report
Risk registers including corporate register inform Board assurance.	Risk assessments etc. and associated risks monitored via the Integrated Governance Committee. Trust Board informed vis IGC minutes. Divisional Integrated Governance Committee Minutes.
Quality section of Corporate Report including incidents, complaints, infection control including sepsis, friends and family test, best in acute care, best in surgical care, performance managed at Clinical Quality Assurance Committee and Trust Board.	Clinical Quality Assurance Committee, Trust Board and Divisional Quality Board minutes
Division and Corporate Quality & Safety Dashboards in place and monitored consistently via performance framework. This includes safety thermometer i.e. infections, falls, pressure ulcers, medication, workforce 'Hard Truths', sickness, appraisals, etc.	Corporate Report - quality section, Trust Board and Divisional Quality Board minutes
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	Minutes from trust Board, CQAC, Weekly Patient Safety Group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA Audit Report
Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).	Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees
Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes
Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	Board and sub-board committee minutes and associated reports
Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework	Minutes from NHSI Quarterly engagement meetings, CQC engagement meetings, Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Patient survey reports and associated action plans
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes.
Internal Nursing pool established and funded	Nursing Workforce report and associated Board minutes.
Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.	Trust Board (Nursing Workforce Report)
Annual Patient Survey reports and associated action plans	Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes.
Trust policies underpinning expected standards	Trust audit committee reports and minutes
CQC regulation compliance	CQC Action Plan monitoring via Board and sub-committees
CQC Regulation Inspection	Evidence accrued to support inspection process. Policies and pathways updated

Gaps in Controls / Assurance

1. Increasing demand system-wide
2. Workforce supply and skill mix

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alignment of workforce plans across the system	31/03/2021	Recruitment schedule continues with a low number of vacancies. Challenges continue re 3rd wave community infections and impact on staffing re sickness and shielding/self isolation etc. All Indian

		nurse have passed OSCEs in December and should receive NMC PINs in January

Executive Leads Assessment
February 2021 - Nathan Askew This risk has been reviewed in the context of the wave three pandemic. The current mitigations in place are effective at this time. This risk is planned to be presented to March board following a full review in light of a changed health and social care landscape
January 2021 - Nathan Askew The risk has been reviewed in the context of the increasing national pandemic. increase in COVID transmission has led to an increase in short term sickness and isolation due to exposure. The Trust are utilising the covid emergency response plan to mitigate this. This risk will review a full review as we end this wave of the pandemic
December 2020 - Nathan Askew Risk reviewed and current controls appropriate. There is a need to review the risk and articulate this in the context of the changes in the health and social care economy. There is a plan to fully review this strategic risk during Q4 and to work with the board and appropriate sub committee to review and approve.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2270, 2233		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

Failure to meet targets and internal performance metrics due to a lack of capacity relative to demand; a loss of capacity during COVID-19 has made access to care extremely challenging. Challenges with data quality could lead to sub-optimal waiting list management and delays to care.

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	- Daily reports to NHS England - Daily performance summary - Monthly performance report to Operational Delivery Group - Performance reports to RABD Board Sub-Committee - Bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	- Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee - Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	- Significant decrease in waiting times for Sefton SALT - Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	- Monthly performance report to Operational Delivery Group - Corporate report and Divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	- Monthly oversight of project delivery at Programme Board - Bi-monthly transformation project update to CQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - Operational Delivery Board as a forum to collectively address challenged areas and to submit cases for investment where access to care is challenged
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance

1. addressing data quality and waiting list reporting issues through the actions contained in the 'Safe Waiting-list Management' programme: enhanced training programme; accurate waiting list and reports; validation of records affected by data quality issues; enhanced awareness through a communication and cultural piece on safe waiting list management.
2. 12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce
3. Transformational projects in outpatients and theatres deliver increase in productivity to improve capacity, access to care and reduce waiting times

4. Provide additional capacity by sourcing capacity from the independent sector

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Theatres transformation project supports surgical specialties to increase restoration to > 110%	07/12/2020	
Assessing incentivised models to support an increase in restoration activity levels	28/02/2021	finalising contractual agreements with LLP/Independent sector
Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training.	18/06/2021	
Outpatient transformation project supports surgical specialties to increase restoration to > 100%	01/03/2021	
12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce	07/12/2020	

Executive Leads Assessment

0 - No Reviewer Entered

February 2021 - Adam Bateman
The number of children and young people waiting over 52 weeks in January is 224. The root cause of the increase in patients with a long waiting time is 1) review of records through safe waiting list management identify data quality adjustments in some cases 2) contraction in inpatient capacity caused by COVID-19 Wave 3 3) acute access pressures in ENT and spinal surgery.
We are taking actions as follows:
1) increase in OPD sessions in ENT and patients seen per session
2) We are expecting to increase capacity through procurement of an LLP service in spinal and orthopaedic service in late February
3) use of the independent sector in March.
4) additional internal capacity in OPD

Our key controls include: * weekly tracking to review chronological booking is leading to a reduction number of patients with a very long waiting time * Safe waiting list management review * clinical review of long wait patients

Overall we expect the the actions will deliver a small reduction in the total number of patients waiting over 52 weeks at the end of February. In ENT we are forecasting to go from > 60 patients waiting 52 weeks for an OP appointment to less than 5.

January 2021 - Adam Bateman
The increase in the number of reportable patients waiting over 52 weeks has two causes. Firstly, the completion of an inpatient RTT assurance review which identified a data quality adjustment that should be made. Secondly, there is a concentrated challenge in timely access to surgical care in ENT, chronic pain, dentistry and spinal surgery. In response we are progressing additional actions to create capacity including the use of the independent sector and a new model for procuring in-house capacity. The third wave of the pandemic is a threat to access to care as theatre capacity is adjusted to support a pivot towards responding to the regional pressures from COVID-19. Our key controls include place: * weekly tracking to review chronological booking is leading to a reduction number of patients with a very long waiting time * Safe waiting list management review * clinical review of long wait patients * strong restoration progress, with the number of patients treated in outpatients and for elective care at 95% of pre-COVID levels for December 2020.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Keeping children, young people, families and staff safe during the COVID-19 pandemic		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring		Link to Corporate risk/s: 2170		
Exec Lead: John Grinnell	Type: External,	Current IxL: 5x3	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Trust Board

Risk Description

There are risks to the physical and psychology safety and wellbeing of children and young people, and staff as a result of the effects of COVID-19.

Existing Control Measures	Assurance Evidence (attach on system)
Formal strategic and tactical command arrangements in place	agendas & minutes
Detailed COVID-19/ Winter Plan agreed and being deployed	
Work programme on keeping our staff safe enacted	
Plan to establish adult invasive capacity progressed	
COVID Specific Scorecard in place	Scorecard to Strategic Meetings
Work Programme established looking at keeping Children & Young People safe	Agendas / Minutes / Actions
Access to Care Group re-established to monitor waiting lists	
24/7 CAMHS crisis line in-situ	Staff rota
Access to emergency and urgent operating theatres	Weekly capacity plan
Clinical review of waiting lists to identify clinically urgent patients requiring assessment and/ or intervention	Electronic patient record
Urgent face-to-face outpatient appointments maintained and digital outpatient consultations established	Outpatient schedule
All vulnerable patient cohorts across specialities (Medical and Surgical) identified	
Specialities have populated vulnerable patient template to outline risk, considerations that may affect current pathway and identify alternative	
Continued to update vulnerable shielding patients with guidance and support as per government advice	
Face masks introduced for staff and visitors	
New environment designed in the hospital and community setting to sustain social distancing and achieve high standards of IPC	
PPE suppliers and innovations strategy to ensure adequate supply	PPE predictor 4 week forward look
Operational plan to increase restoration of capacity	Tracked weekly though Communication Cell Metric Report in Operational Delivery Board
Covid-19 testing service	
Covid-19 test and trace policy	
Cheshire & Mersey Gold Command has been recently strengthened	Notes of meeting shared weekly
Vaccine deployment programme ready and for deployment	
Enhanced staff welfare programme	

Gaps in Controls / Assurance

Due to high infection rates in the community staff availability to meet capacity plans through the winter

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increase awareness and vigilance around keeping staff safe from Covid-19 by maintaining social distancing.	30/04/2021	New manager support pack to help oversee PPE, social distancing and hygiene compliance issued with ongoing monitoring in place.
Ensure actions that have been identified through COVID-secure risk assessments take place	31/12/2020	Work continues regarding the installation of protective screening
Oversight Group initiated focussing on redeployment, temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment	31/03/2021	

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

Vaccine roll-out	30/04/2021	80% of staff vaccinated with first dose as at 21st Jan 2021. Remaining staff still have access to LHCH/Clatterbridge vaccination hub. Plans for second dose in place.

Executive Leads Assessment
February 2021 - John Grinnell Wave 3 response signed off by Board and implementation going well. Adult critical care facility now in situ and responding to system needs. As predicted, hospital occupancy dropped across the system focus shifting to improving access to services for children & young people.
January 2021 - John Grinnell Gold Command continues to oversee Covid response and recovery. Recovery progressing well and vaccination programme launched for all staff in priority order. Increased risk of transmission through wave 3. Focus on staff availability, recovery, our role in supporting the wider system and completing the vaccination roll-out.
December 2020 - John Grinnell Covid response and restoration has been well managed and the Trust is in a relatively strong position at this point both in terms of restoration and managing risk of infection. Key next phases include vaccination roll out, maintaining capacity through winter and remaining vigilant for a third phase.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.4	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Sustaining operational delivery following the UK's exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive			Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: External,		Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Trust Board

Risk Description

Risk of disruption to the provision of products to the NHS

Existing Control Measures	Assurance Evidence (attach on system)
National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	all previous plans held in abeyance for the moment. Project team are still present and able to mobilise as required. Work stream leads identified; previous risk assessments undertaken.
Following webinar requirement now to stand up plans	recommencement of EU Exit team and re-establish roadmap and operational plans
Bi-weekly EU Exit meetings to monitor any developing issues	Minutes from meetings K drive On Call managers management pack

Gaps in Controls / Assurance

There maybe some very limited supply issues when we move from transition at the end of December 2020 but there is no immediate risk to supply other than business as usual fluctuations which would be considered as normal within the current risk profile. As we are in the midst of the pandemic we are unable to forecast future shortages or challenges with this. Group has now formally recommenced. SME's in place to review their respective areas and feedback potential shortages and mitigations required.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alder Hey Brexit group formally recommenced and will now review Road Map and Operational Plans. Meeting bi-weekly.	30/04/2021	Actions complete - now in monitoring phase. Escalation protocols established but not required. Webinars ongoing hosted by NHSE.
each lead aware of the above requirement To feedback formally to the group To develop plans where required	30/04/2021	Previous actions complete. SMEs continue to support the Group. Horizon scanning ongoing with Specialty Groups and areas of focus; feeding back on any areas of particular concern.

Executive Leads Assessment

February 2021 - Lachlan Stark
Risk Reviewed. EU Exit Group continues to meet to monitor the ongoing situation. No major issues have been identified that require escalation.

January 2021 - Lachlan Stark
Now that we have formally left the EU with a "deal" we now need to continue to monitor supply chain as there may be disruption to Alder Hey supply chain.

December 2020 - Lachlan Stark
A series of checklists have been received from NHSE. We are currently in the process of benchmarking AH against these.
Our roadmap plans and risk assessments are progressing well and due to be finalised for 7th Dec.
Our intranet page and FAQ's have been updated and Trustwide comms are to be launched to update staff on progress.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 386, 2312, 2322		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to deliver consistent, high quality patient centred services due to
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time.
2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

Existing Control Measures	Assurance Evidence (attach on system)
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report and KPI Report to WOD
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR	-Monthly reporting to the Board via the Corporate Report -Reporting at ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
Permanent nurse staffing pool to support nurse staffing numbers	Large-scale nurse recruitment event 4 times per year
HR Workforce Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to WOD and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to WOD and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation	People Strategy report monthly to Board
International Nurse Recruitment	75 skilled nurses to join the organisation across 2020/21
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to WOD OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to WOD
Recruitment and Apprenticeship strategy currently in development	progress to be reported to BAME task force and People and Wellbeing Committee

Gaps in Controls / Assurance

1. Not meeting compliance target in relation to some mandatory training topics
2. Sickness Absence levels higher than target.
3. Lack of standard methodology to workforce planning across the organisation
4. Talent and succession planning
5. Lack of a robust Trust wide Recruitment Strategy

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	28/02/2021	There has been a drop in mandatory training compliance , as a result of the covid pandemic. All e-learning training has continued throughout. L&D are focusing on a recovery plan to bring the compliance position back to 90%.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	31/03/2021	to be reviewed in line with divisional workforce planning process
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	31/03/2021	The inaugural meeting of the Recruitment and Apprenticeship task and finish group met in Nov 2020, with a clear and Robust action plan to address diversity and inclusion in Recruitment, Selection and Retention.
2. HR/Managers/SALS and Wellbeing officers are working together to wrap around and effectively support all	31/01/2021	HR/Managers/SALS and Wellbeing officers are working together to wrap around and effectively support all absences. Deputy HR

absences. Deputy HR director is meeting monthly with all HR team to ensure that there are appropriate action plans in place for all staff on long term sickness.		director is meeting monthly with all HR team to ensure that there are appropriate action plans in place for all staff on long term sickness.

Executive Leads Assessment
February 2021 - Sharon Owen Actions reviewed and on track against plan
January 2021 - Sharon Owen Actions reviewed and on track against plan
December 2020 - Melissa Swindell Risk reviewed in month, current score decreased and actions reviewed.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.2	Strategic Objective: The Best People Doing Their Best Work		Risk Title: Employee Wellbeing		
Related CQC Themes: Effective, Well Led			Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known		Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to support employee health and wellbeing and address mental health which can impact upon operational performance and achievement of strategic aims.

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Strategy. Wellbeing Steering Group ToRs
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
Staff Temperature Check Reports to Board (quarterly)	Board reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2019 Staff Survey Report
Reward and Recognition Group schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.	Reward and Recognition Meetings established; reports to Wellbeing Steering Group
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Time to Change implementation	Time to Change implementation
Staff advice and Liaison Service (SALS) - staff support service	
Care first - online Employees Assistance programme	
Counselling and Psychological support - Alder Centre	
Trust Briefs - keeping staff informed	
Spiritual Care Support	
Trust Wellbeing Team	Wellbeing Action Plan
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region	
Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group	Minutes presented to PAWC

Gaps in Controls / Assurance

1. Need to secure permanent resource to support the SALS service
2. need to develop pathways for support

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to determine future service development and delivery that meets demand and is integrated with internal and external counselling provision.	31/03/2021	
Liaise with Regional Resilience Hub as it develops and ensure Alder Hey staff can access the screening tools and support can be offered	01/04/2021	
Fixed term part time psychology post to be made permanent	05/02/2021	Job now advertised internally and interview date set for 5th February.

Action plan developed by SALS and ICU Psychology to support work addressing emotional needs of ICU and redeployed staff in particular	29/01/2021	

Executive Leads Assessment
January 2021 - Jo Potier Risk reviewed - no change to score in-month. Thorough review of risk undertaken to amalgamate risk 2181 in order to manage all actions at Executive Level.
December 2020 - Melissa Swindell Risk reviewed in month. Score reduced and additional actions identified.
November 2020 - Melissa Swindell Risk and associated actions reviewed. good progress in development of SALS and wider MH support

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 4x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to have a diverse and inclusive workforce which represents the local population.
Failure to take steps to become an inclusive and anti-racist work place where all staff feel their contribution as an individual is recognised and valued.
Failure to provide equal opportunities for career development and growth.

Existing Control Measures	Assurance Evidence (attach on system)
WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	- Bi-monthly reporting to Board via WOD on diversity and inclusion issues - Monthly Corporate Report (including workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through WOD
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through WOD
HR Workforce Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
BME Network established, sponsored by Director of HR & OD	BME Network minutes
Disability Network established, sponsored by Director of HR & OD	Disability Network minutes
Actions taken in response to the WRES	-Monthly recruitment reports provided by HR to divisions -Workforce Race Equality Standards - Bi-monthly report to WOD
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
LGBTQIA+ Network established, sponsored by Director of HR & OD	LGBTQIA+ Network Minutes
Time to Change Plan	Time to Change Plan
Actions taken in response to WDES	- Monthly recruitment reports provided by HR to divisions - Workforce Disability Equality Standards - Bi-monthly report to WOD
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
BAME Risk assessments during COVID19. Evidence suggests that our BAME staff are potentially at greater risk if they contract covid 19- enhanced risk assessments have been conducted to date with 90% of BAME STAFF. Outstanding risk assessments are currently being addressed with departmental leads and managers.	90% completion of BAME risk assessments to date

Gaps in Controls / Assurance

1. Need to establish a robust action plan through the work of the BAME Inclusion Taskforce
2. Need to review the resource available to support the EDI agenda

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	31/12/2020	action closed as all actions being refreshed in line with new taskforce and approach to EDI
1. Work with Community Engagement expert to develop actions to work with local community	31/12/2020	action closed to be replaced by revised set of actions as a result of the taskforce and new approach to EDI
BAME Taskforce established, Claire Dove NED is leading. Taskforce is working to identify the main areas of focus for us to increase representation, improve experience, remove racism	31/03/2021	BAME taskforce have now met three times. action plan and ideas progressing/ Board update to be ready for December 2020
Specialist Trusts discussion to explore implementing an EDI team across all four Trusts.	28/02/2021	discussions nearly complete. three trusts are in agreement. just needs final sign off by respective CEO's.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

Executive Leads Assessment
February 2021 - Sharon Owen Actions reviewed and progressing.
January 2021 - Sharon Owen Actions reviewed and progressing against plan.
December 2020 - Melissa Swindell Risk reviewed in month. All actions updated

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led		Link to Corporate risk/s: 1241		
Exec Lead: David Powell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

The Alder Hey long term vision for the Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale or budget and in partnership with the local community and other key stakeholders as a legacy for future generations

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Capacity Lab have been engaged for a period of 3 months to complete a piece of work/proposal for setting up a Community Interest Company as well as supporting the Trust to bring partners on board with the development and providing some financial contributions	
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision, awaiting written confirmation.
Weekly review of status in respect of Covid 19 impact	Meeting record
The impact of Covid-19 is both on physical progress on site and from an inability to engage with community stakeholders however the team continue to pursue works liaising with the appointed contractor.	The Trust is in contact with the City Council to discharge pre-commencement conditions so that once demolition is completed the Phase 1 park reinstatement works can commence in late summer.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
The Trust has appointed Capacity Lab for an 18 month period, they are responsible for working with the local community, planning activities in the park, supporting the local community to form an Enterprise/Community Interest Company. Whilst completing this work they will be engaging with Liverpool City council and local councillors. The work has already begun and feedback from the community is positive	Minutes of meetings SLA
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group

Gaps in Controls / Assurance

1. Fully reconciled budget with Plan.
2. Risk quantification around the development projects.
3. Absence of final Stakeholder plan
4. COVID 19 is impacting on the project milestones

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete cost plan	31/01/2021	Turkington martin who provided the overall plan/vision for the park have been approached and a meting diarised to start to further develop the plan which can then go to tender, some estimation of cost will be achieved through working the plan up with Turkington Martin (Landscaping architects)
2. Agree Park management approach with LCC	01/04/2021	Discussions with LCC continue and most recently positive feedback on an agreement to lease additional car park space off site at Thomas lane sports field/car park. This is to be be agreed within the next month and lease put into place. A whole internal process on management of this is currently under discussion
Prepare Action Plan for NE plot development	03/05/2021	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust
Complete Eaton Road Masterplan	01/03/2021	

Establish Executive Design Group	31/12/2020	
Create action plan for NE plot	03/05/2021	
Review model for corporate office activity	05/04/2021	
Executive Leads Assessment		
February 2021 - David Powell Prior to Feb Board		
January 2021 - David Powell Prior to January Board		
December 2020 - David Powell Prior to Dec Board		

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.2	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Dani Jones	Type: External, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Risk of failure to:
- Deliver care close to home, in partnerships
- Develop our excellent services to their optimum and grow our services sustainably
- Contribute to the public Health and economic prosperity of Liverpool

Existing Control Measures	Assurance Evidence (attach on system)
Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver	Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached)
Compliance with All Age ACHD Standard	ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey
Capacity Plan identifies beds and theatres required to deliver BD plan	Daily activity tracker and forecast monitoring performance for all activity.
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Internal review of service specification as part of Specialist Commissioning review	Compliance with final national specifications
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly)
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Gap / risk analysis against all draft national service specification undertaken and action plans developed	Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance
Involvement of Trust Executives in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed.	
C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan	C&M C&YP Recovery Plan Narrative
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities.
C&M Children's Transformation Programme - AH leadership agreed and new programme for 2021+ under establishment	

Gaps in Controls / Assurance

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	31/05/2021	Likely continuation of pause due to Covid Wave 3: delivery date reset for May 21 initially but will keep under monthly review pending Covid impact
1. Strengthening the paediatric workforce	31/05/2021	Covid Wave 3 likely to create fresh requirements for mutual aid; updated target date to May 21 but will remain under monthly review pending Covid impact.

Executive Leads Assessment

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

February 2021 - Dani Jones Risk reviewed; no change to rating in month. Wave 3 continues to delay local system transformation partnerships, but making progress across the developing C&M CYP Programme and NW Paediatric Partnership.
January 2021 - Dani Jones Risk reviewed; progress with system working supporting delivery of Our Plan during Dec includes progresion of AH led C&M CYP programme - however Wave 3 of Covid impacting currently so likelihood of some system delays top progress. Rating remains static but under monthly review.
December 2020 - Dani Jones Risk reviewed; no change to score in month. Covid impact remains significant but progress in system working, for example HCP C&YP developments. Recommend risk review & update in Q1 2021 in line with Trust Board post-covid strategy update.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2182		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x3	Trend: IMPROVED

Assurance Committee: Resource And Business Development Committee

Risk Description

Failure to deliver Trust control total and affordability of Trust Capital requirements.

Existing Control Measures	Assurance Evidence (attach on system)
Organisation-wide financial plan.	Monitored through Corporate Report
NHSi financial regime and Use of Resources risk rating.	Specific Reports (i.e. NHSI Plan Review by RABD)
Financial systems, budgetary control and financial reporting processes.	- Daily activity tracker to support divisional performance management of activity delivery - Full electronic access to budgets & specialty performance results - Financial in-month and forecast position reported through SDG, Exec Team, RABD Ops Board and Trust Board - Financial recovery plans reported through SDG and RABD - Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	5 Year capital plan ratified by Trust Board
Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	Monthly Performance Management Reporting with '3 at the Top'
Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	Monitored through Exec Comm Cell and Exec Team
Weekly Sustainability Delivery Group overseeing efficiency programme	Weekly Financial Sustainability delivery meeting papers
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD
RABD deep dive into key financial risk areas at every meeting	RABD Agendas, Reports & Minutes
Weekly COVID financial update to Strategic Command	Agenda and Presentations

Gaps in Controls / Assurance

1. New COVID Financial Framework creates greater uncertainty
2. Affordability of Capital Plans
3. Cost of Winter escalating
4. Long Term Plan shows £3-5m shortfall against breakeven
5. Long Term tariff arrangements for complex children
6. Potential COVID Capital costs not covered centrally

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. RABD to oversee productivity and waste reduction programme	31/03/2021	
5. Childrens Complexity tariff changes	31/03/2021	Work concluded and joint agreement on the underlying issue with peadiatric funding. Continuted dialogue with NHSI regional and strategic finance team on an interim solution for 21/22.
4. Long Term Financial Plan	31/03/2021	21/22 framework and guidance not yet released, Work is ongoing to update AH underlying positon and will be completed subject to updated planning guidance. Plan to take update to February RABD meeting.
2. Five Year capital plan	31/03/2021	5 year capital programme continiously monitored and tracked through finance reports and top 5 risks reported at RABD.

Executive Leads Assessment

February 2021 - Rachel Lea
Risk reviewed and risk rating reduced to 16 to reflect reduced risk of 20/21 due financial plan being accepted and confirmation of additional funding. Longer term financial risk remains due to uncertainty within the framework.

January 2021 - Rachel Lea
The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction. An updated revised forecast plan has been submitted showing an improvement. The ongoing pressure from the pandemic will be tracked and any changes to this plan will be raised.

The framework beyond this year is not yet confirmed and remains uncertain. Planning is underway and a 5 year financial model is in progress, to be

completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.
December 2020 - Rachel Lea The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction. The framework beyond this year remains uncertain, expected guidance is due to be released mid December. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.
November 2020 - Rachel Lea Financial regime in NHS remains uncertain due to the ongoing pandemic. The position for 20/21 is more known and mitigations are in place to ensure financial balance is achieved; however the longer term next 5 years is still a significant risk.
September 2020 - Rachel Lea Extension of current framework and arrangements for COVID reimbursement and top up has been confirmed to end of September. Awaiting guidance from NHSI on Phase 3 expected September.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation		Risk Title: Research and Innovation activities could result in reputational downside or contract risk		
Related CQC Themes: Well Led			Link to Corporate risk/s: No Risks Linked		
Exec Lead: Claire Liddy	Type: Internal, Known		Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

R&I activities will include a range of contracts and other partnerships with academia, large corporates, SMEs and investors that need to be in line with the correct Trust governance and frameworks that ensure correct diligence to protect the Trust.
R&I activities will inevitably generate intellectual property which much be detected and exploited in line with Trust Board's decision.

Existing Control Measures	Assurance Evidence (attach on system)
RABD review of commercial contracts per SFI. Trust Board oversight of shareholding and equity investments.	Reports to RABD / Trust Board and associated minutes
Establishment of Research Management Board	Research Management Board papers.
Innovation Committee	Committee oversight of Innovation strategy with NED expertise
Clear Management Structure and accountability within Innovation Division	
Alder Hey Innovation LTD governance manual established	
Plans for joint research & innovation clinical leadership being explored	
Research - Covid recovery plan operational.	Trust Board papers
Research - monthly focus on research at Care Delivery Board to support strategy deliver.	Care Delivery Board papers
Clear Management Structure and accountability within Innovation Division	
Legal Partner now in contract	
Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.)	

Gaps in Controls / Assurance

1. Availability and incentivisation model for resources to deliver strategy.
2. Capacity for business development and inward investment.
3. External factors such a Covid and Brexit creating delays in expansion plans.
4. Capacity of clinical staff to participate in research/innovation activity.
5. Capacity of clinical services to support research/innovation activity.
6. Availability of space for expansion of commercial research/innovation growth.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Research recovery plan operational	31/03/2021	Participating in 7 Urgent Public Health (UPH) Studies. Reactivated 38.9% of Suspended CRN studies. 19 New Studies opened - 13 Academic & 6 Commercial.
Deployment of ten year Innovation Strategy (2030)	30/04/2021	February Innovation Committee will share and agree Innovation Partnerships Strategy for year 1 2021.

Executive Leads Assessment

February 2021 - Claire Liddy
Risk comprehensively reviewed and updated in month. No change to score.

January 2021 - Claire Liddy
no change to risk. minimal change to status, progress against commercial research noted

December 2020 - Claire Liddy
reviewed no change. Full update to risk to be actioned from January 21

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2235, 2265, 2143		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x1	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Failure to deliver a Digital Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare, failure to provide high quality, resilient digital and Information Technology services to staff.

Existing Control Measures	Assurance Evidence (attach on system)
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy Update Sept: ISD Excellence in Informatics Level 1 accreditation achieved
Formal change control processes in place	Exec agreed change process for IT and Clinical System Changes
Executive level CIO in place	Commenced in post April 2019
Quarterly update to Trust Board on digital developments, Monthly update to RABD	Board agendas, reports and minutes
Digital Oversight Collaborative in place & fully resourced - Chaired by Medical Director	Digital Oversight Collaborative tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Implementation of fortnightly huddle with divisions from April 2019. Divisional CCIOs recruited. Divisional IT Leads in place.
NHSE & NHS Digital external oversight of programme	NHSD tracking of Programme through attendance at Programme Board and bi-monthly assurance reports.
Digital Strategy approved by Board July 2019, mobilisation in place to new governance and implementation arrangements	Digital Futures Strategy
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Monthly digital performance SMT meeting in place	ToRs, performance reports (standard agenda items) KPIs developed
Capital investment plan for IT including operational IT, cyber, IT resilience	Capital Plan

Gaps in Controls / Assurance

Cyber security investment for additional controls approved - dashboards and specialist resource in place
Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs
Approach to training under review

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of cyber actions including managed service and cyber essentials accreditation	31/03/2021	Cyber Essentials Accreditation achieved
Refreshed Digital Training Strategy - ensuring staff have the appropriate skills and training in digital systems	01/06/2021	Draft training strategy developed
Implementation of Alder Care Programme	01/10/2021	Programme progressing well against Plan. Progress monitored through digital reports at RABD

Executive Leads Assessment

February 2021 - Kate Warriner
BAF reviewed, all actions on track. Cyber Essentials Accreditation achieved.

January 2021 - Kate Warriner
BAF reviewed and re-set in line with current position

December 2020 - Kate Warriner
BAF reviewed, risk score at target, future actions on track against plan

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 14th December 2020 at 10:00am, via Teams

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	Claire Dove	Non-Executive Director	(CD)
	John Grinnell	Director of Finance	(JG)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Alison Chew	Associate Director Operational Finance	(AC)
	Mark Flanagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Rachel Lea	Acting Deputy Director of Finance	(RL)
	Claire Liddy	Director of Innovation	(CL)
	Abby Peters	Associate Director of Strategy & Partnerships	(AP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Amanda Graham	Committee Administrator (*minutes*)	(AG)
Apologies:	Shalni Arora	Non-Executive Director	(SA)
	Sue Brown	Associate Development Director	(SB)

20/21/128 **Minutes from the meeting held on 14th October 2020.**
Resolved:
The minutes of the last meeting were approved as an accurate record.

20/21/129 **Matters Arising and Action log**
MS has drafted a letter to Capita and will update at the January meeting.
There will be an update from Surgery on productivity at the January meeting.
Capacity Lab to be invited to join a future meeting.
The Treasury Policy is to be included with the minutes.

20/21/130 **Declarations of Interest**
There were no declarations of interest.

20/21/131 **Finance Report**
Month 8
AC presented the Month 8 Finance Report. A further revised plan has been submitted to NHSI based on £5.2m deficit, which is being reported against for Month 8.

The in-month position is a deficit of £700k, £300k ahead of plan, with capital slippage reduced following spend of £3.9m against planned £2.1m.

Restoration activity targets have been met for elective and day-case activity at 92%, over the 90% set, but not for outpatient activity which was 94% against its 100% target.

Work is ongoing within C&M to bridge the funding gap. Longer term risks are related to cash and the impact of submitting deficit plans in future years which will impact the capital programme and associated revenue costs. A proposal for the Paediatric Tariff issue has been made for 2021/22 and we continue to lobby for this.

A request has been made to bring forward any capital spend from C&M; Finance are currently working with the IT and Medical Equipment teams on this.

CD queried whether any impact framework is being used to realign capital expenditure to revised ways of working; JG responded that there has been quite an amount of rechecking on the whole Estates strategy by evaluating different ways of working, testing of key principles etc and this piece of work will be brought back in the New Year for further tracking. CL added this scope could include the community buildings to be included in the Alder Hey estate.

Resolved:
RABD received and noted the M8 Finance report.
Thanks were recorded for Alison Chew who is leaving the Trust after over 13 years.

20/21/132 **2020/21 Framework**

JG gave an overview of the situation in C&M. Each individual organisation is undergoing a degree of scrutiny of financial forecast and plans. Further updates will be given to future meetings.

RL gave an update on the 2020/21 Financial Framework including the latest forecast plan for 20/21 which has been resubmitted at £5.2m deficit, but with £3.7m lodged as national / regional issues, comprising of the non-clinical income, annual leave accrual and the Welsh activity risk.

With effect from January, the SDG meetings will resume with a focus on both 20/21 and 21/22 as well. A Corporate vacancy panel has now been instigated to review vacancies before advertising. New governance arrangements around COVID spend have also been put in place.

Resolved:
RABD received an update against the 2020/21 Financial Framework.

20/21/133 **2021/22 Planning**

RL gave an update on the 2021/22 financial planning, with an indicative timetable expected with headline assumptions. Technical guidance is expected in late January with submission of draft plans by 11th March and final plans by 29th April. Currently the length of these plans is not known; it is expected that efficiency levels will be required and the block payment will remain.

RL outlined the draft modelling undertaken on 21/22 and how this compares to the previous five year plan submitted in 2019. Reference costs have also recently been submitted at 114, against 107 in 2018/19, so a 7% increase and now 14% higher than average.

CL noted the need for a financial strategy and queried the context across C&M. JG responded that a financial strategy will be developed. Regionally the Trust is comparable with most others.

Resolved:
RABD received an update against the 2021/22 Financial Planning.

20/21/134 **(*Item removed from agenda before meeting)***

20/21/135 **Month 8 Corporate Report**

AB presented the Month 8 corporate Report, noting that staff have been working incredibly hard to restore services, with Outpatients showing a 10-point increase on October to 94% and Elective restoration at 92% which is above the 90% national target. Although there are monthly improvements, some transformational work is being undertaken with the Surgical Division to reduce the number of children waiting over 52 weeks from referral to treatment time to enable more children to be treated within 18 weeks.

Resolved:
RABD noted and received the M8 Corporate report.

20/21/136 **Safe Waiting**

AB gave an overview presentation on the Safe Waiting List Management program, supplementing the paper circulated. The background to the current situation was outlined and the outcome of the externally commissioned assurance review was shared. Information was given of the workstreams, processes and measures put in place alongside the specialised support that has been brought in.

An Executive Oversight group has been convened to provide assurance and the associated risks are being monitored as part of that. The Trust have shared the information with the CCG and will be submitting regular highlight reports to them as part of the assurance process. The CCG were given information around the wider systematic improvement program involving training and cultural components.

Resolved:
RABD received an update

20/21/137 **PFI Report**

IQ queried the revisiting of inspection of corroded pipework; RG advised that this was due to continuing leaks despite samples having been taken so all of the plant rooms are being inspected due to the number of leaks experienced.
IQ noted that the performance of Interserve seems to be improving; JG also noted that there has been a change in Interserve's leadership to Mitie, with certain key personnel remaining in post and close to the hospital. RG suggested that GD be invited to RABD in the New year to give an update. IQ also queried whether it would be an appropriate time to meet with the new leadership team; JG agreed, noting that this change should be beneficial for the Trust as Mitie have a strong technological & digital focus.

Resolved:
RABD received and noted the PFI report.

20/21/138 **Operational Delivery Networks**

DJ gave an overview of the paper detailing delivery networks hosted by the Trust, giving assurance around the fulfilment and discharge of those responsibilities and proposed a 6-monthly reporting cycle for these. Note was made of the development and escalation plan for connecting services which have a relationship with but are

not under those networks and also of the North West Paediatric Partnership Board which holds a governing-body role.

Resolved:
RABD received and noted the Delivery Networks update paper.

20/21/139 **Communications update**
MF noted that a full presentation of the emerging communications strategy would be brought to the next meeting.

Resolved:
RABD to receive a presentation on the emerging Communications Strategy at the next meeting.

20/21/140 **Board Assurance Framework**
ES gave a brief update on the Board Assurance Framework.

Resolved:
RABD received the BAF update.

20/21/141 **Any Other Business**
No other business was received.

20/21/142 **Review of Meeting**
Key points: safe waiting lists..

Date and Times of Next Meeting: Monday 18th January 2021, 10:00, via Teams.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on
Wednesday 16th December 2020
Via Microsoft Teams

Present:	Fiona Beveridge	(Chair) Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director - Community & Mental Health Division	(LC)
	Urmi Das	Interim Divisional Director for Medicine	(UD)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Nicki Murdock	Medical Director	(NM)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Robin Clout (on behalf of KW)	Interim Deputy CIO	(RC)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)
In attendance:			
	Adrian Hughes	Deputy Medical Director	(AH)
	Jill Preece	Governance Manager	(JP)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Phil O'Connor	Deputy Director of Nursing	(POC)

Agenda item:

20/21	**Apologies:**		
	Anita Marsland	Non-Executive Director	(AM)
	Alfie Bass	Divisional Director, Division of Surgery	(AB)
	John Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Jacqui Pointon	Associate Chief Nurse/Safety Lead for Community Division	(JP)
	Melissa Swindell	Director of HR & OD	(MS)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
	Kate Warriner	Chief Digital & Information Officer	(KW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

20/21/68 Declarations of Interest

SQAC noted that there were no items to declare.

20/21/69 Minutes of the previous meeting held on 18th November 2020

KB requested minor amendments to one item within the notes from the previous meeting which would be actioned offline.

Resolved: committee members were content to **APPROVE** the minutes of the meeting held on 18th November, subject to minor offline amendments.

20/21/70 Matters Arising and Action Log
Action Log

19.20.161 CQSG performance indicators. NM confirmed that she was scheduled to meet with NA on 22nd December 2020 in order to finalise the performance indicators, an update would then be provided to the Divisions, with a verbal update to follow at January 2021 SQAC meeting.
Resolved: This item would remain **OPEN** until a further update is received at January 2021 meeting.

20.21.21 Clinical Audit – SQAC noted that the Board/Committee administrator was in the process of diarising a meeting to discuss this action.
Resolved: This item would remain **OPEN** until a further update is received at January 2021 meeting.

20.21.28 Corporate Report Quality Metrics – SQAC noted that UD continues ongoing discussions with colleagues from B'Ham and Bristol with regards to the 'Was not brought rate' and comparable data.
Resolved: This item would remain **OPEN** until a further update is received at January 2021 meeting.

20.21.42 IPC Exception Report – NM advised in BL's absence that discussions with Divisional Directors had commenced on a number of IPC related matters but particularly regarding each of the divisions having an IPC Lead, SQAC noted that this was ongoing.
Resolved: This item would remain **OPEN** until a further update is received at January 2021 SQAC meeting.

20.21.42 Clinical Claims Report - PB provided a comprehensive update on the current position. The Trust's Clinical Legal Services Manager had been in contact with NHS Resolution (NHSR) who have agreed to perform an analysis of the Alder Hey, GOSH and Sheffield score cards (the score cards have 10 years' worth of clinical claims data), however NHSR would need to ensure a sharing agreement is signed off by the three trusts prior to any information being exchanged. In any case this data would not be ready for release until the New Year – potentially February 2021.

In the meantime, the Trust would hold a virtual meeting between the legal teams and Medical Directors of the three trusts with the NHSR safety leads in the early spring. Alder Hey had also agreed to run an event at the Trust with NHSR in the early autumn in order to review the new scorecard which would be released in August 2021, in order to show staff how to get the most out of the data and potentially share some of the data from the analysis of the 3 trusts. This would help to review trends and similarities' and review what could be learnt in order to further improve safety and potentially shared learning across the 3 trusts.

Resolved: FB welcomed the positive update, and the committee endorsed the suggested way forward. SQAC noted that this action could be **CLOSED** and looked forward to receiving an update on future forward activity which would be reflected within the future Clinical Claims updates to SQAC.

20.21.45 BAF - 20.21.55 Top 5 Risks/priorities – NA reported that the Patient Safety Day had taken place on 24th November 2020, following this NM & NA were

meeting on 22nd December 2020 in order to formulate the priorities, reflecting the output from the session. NA stated that it was very likely to be 3 quality priorities, rather than 5 as this was in line with the KPMG Operational Excellence Programme. Divisions would then be asked to focus on 1 or 2 local priorities within their different departments.
Resolved: SQAC **noted** the aim for 3 Trust wide overarching priorities. This item would remain **OPEN** until a further update is received at January 2021 SQAC meeting detailing the 3 overarching priorities and the metrics.

20.21.56 Clinical Audit & NICE update – SQAC noted that SA planned to review resources within the Clinical Audit Team and provide an update to SQAC at the end of quarter 4.
Resolved: update to be provided to April 2021 meeting.

Delivery of Outstanding Care
Safe

20/21/71 CQC Action Plan

ES presented the CQC Action Plan updates to 31st November 2020 which continued to progress at a good pace and remained on track in all areas.

SQAC noted that there was a CQC engagement meeting scheduled on 18th December 2020, the current CQC Action plan, together with the underpinning supporting evidence had been shared with CQC ahead of the discussion.

Resolved: SQAC received and **NOTED** the CQC Action Plan, and noted the completed actions. FB thanked ES for update**.**

20/21/72 Safe Waiting List Management: update from oversight group

AB gave a presentation on Safe Waiting List Management which provided information regarding background to the current position and the outcome of the externally commissioned assurance review of inaccurate reporting of waiting times.

AB advised that there was a comprehensive, Executive led, clinically focussed programme with an oversight group to deliver the recommendations / improvement actions and that external support was in place. This programme had a timescale of 8 months; this would enable a systematic review to take place and sustained improvement to embed.

FB recognised the significant work completed to date with clear governance, systems and processes in place in order to address this issue. FB sought assurance as to whether the Safe Waiting List Management Team was content that the process was well embedded within the Trust, given the increasing waiting lists, and questioned whether this was a sustainable process in the long term.

NA confirmed that he was content with the progress made to date and that those patients who had experienced a 52 week wait had been subject to a thorough clinical review process and that there had been no harms confirmed; and as such felt assured.

KB welcomed the comprehensive update, but questioned whether there were any other potential problem areas in terms of data reporting. AB stated that there were other areas that require a review but that the focus had been made initially on

inpatient waiting lists. A comprehensive review would be undertaken within outpatients during January 2021 with the same rigour applied. AB confirmed that a review would also take place for those patients on planned lists, diagnostics lists, for those patients requiring treatment on a specified date, in order to ensure that the routine times are appropriate.

KB requested a forward plan of upcoming data reviews following the Christmas period/New Year along with a briefing on the role and remit of the data quality team. AB confirmed that there is a comprehensive detailed programme plan which details forward plan for the next 4-6 months and that he was content to share this with SQAC colleagues.
Action: AB to share forward plan with SQAC and update at a future meeting with regards to future/next steps regarding the structure of the data quality team.

CT added that once the data quality issue was addressed, whether there was an action plan with regards to capacity. AB confirmed that the team had been working hard to restore services, in order to make inroads with regards to reducing waiting times. AB stated that 2021 would be extremely challenging, whilst trying to address waiting list challenges and also to restore services, whilst reviewing what additional capacity could be delivered, whilst balancing staff wellbeing. AB advised that there was an offer of independent support, however this does not work for some specialties. The Trust was continuing to explore all possible options in terms of increasing capacity during 2021.

Resolved: SQAC received and **NOTED** the Safe Waiting List Management Update. FB thanked AB and the team for work to date, and for the level of assurance provided to SQAC.

20/21/73 **Progress update regarding CQC Section 64 Actions**

LC provided background detail regarding 2 young people who had presented to the emergency department in mental health crisis and the subsequent acute care pathway provided for safe care and treatment.
She reported that both young people had been admitted to Ward 4C during Summer 2020; both had complex emotional challenging and behavioural issues, and whilst the Trust had successfully managed the transfer to an appropriate location the 2 patients stayed at Alder Hey for a 2/3 week period. During this time each patient had been involved in separate serious incidents. A comprehensive RCA had been undertaken and the team were on trajectory to implement the recommendations

Recently the CQC had requested a suite of data seeking further assurances in relation to these RCAs. LC confirmed that there was a meeting scheduled with CQC on the afternoon of 16th December 2020 following their internal review of the evidence submitted.

SQAC noted that a detailed report and potential action plan would be shared at January SQAC meeting in order to demonstrate actions required in order to address any further queries.

Action: SQAC to receive detailed CQC Section 64 report, together with action plan at January 2021 meeting.

Both KB and FM were keen to understand the Trust's position on such cases going forward given the impact on children & young people's mental health during the

pandemic and the strong likelihood that the organisation would be faced with this situation again in the near future. LC advised that CQC had accepted that these young people should not have been at Alder Hey, however, whilst these young people had been admitted they had sadly sustained 2 serious incidents. CQC are looking to ascertain how these incident occurred, and what had been learned from them.

Resolved: SQAC received and **NOTED** the position in relation to the Section 64 actions.ES advised that an update would be provided at Trust Board on 17th December 2020 and that a further update would be provided at SQAC at January meeting.

20/21/74 **DIPC Exception Report**

NM presented the DIPC Exception Report on BL's behalf, key issues were highlighted as follows:-

- NM referred to 2020/21 targets for each of the metrics, and whether the organisation should be working towards a 10% reduction, or a target of 0. NM advised that following detailed discussion at Patient Safety Day held on 24th November 2020, there was strong feeling from colleagues that the target of 0 would be an unrealistic target and colleagues felt that this was setting people up to fail, and that a higher target was the preferred option. NM advised that that agreement had been made to aim towards 0, however targets would be set for above 0, given consideration from the comments received from clinicians at Patient Safety Day.
- NM advised that there are 14 CLASBI's (ICU only), 8 MSSA, and 3 C.difficile cases, all cases are being followed up with investigations. NM stated that there is a need to improve CLABSI's and that colleagues are working hard to address and improve this.
- Flu Compliance – 87.95% of staff immunised, with the need to reach 90% compliance, NM advised that there is a need to immunise approximately 100 additional staff. FM referred to the number of consented records for flu – 3,340 and the number of completed immunisation staff – 3,351 and stated that the Trust seemed to vaccinate more people than consented for. NM confirmed that the figures included colleagues who had been vaccinated elsewhere, and given that they had been vaccinated elsewhere that the Trust would not have consented for these staff, however the Trust had received notification of consent. FB confirmed that the new graphics within the report are extremely welcomed. FB acknowledged the comments made at Patient Safety day in terms of the preferred target, and suggested that further thought is required in the future regarding the graphics within the report over the longer term.

SQAC received and noted the assurance provided by the DIPC Exception Report.

Well Led

20/21/75 **Board Assurance Framework**

ES presented the Board Assurance Framework detailing updates to the end of November 2020 and reported that both ES & NA had undertaken discussion regarding Risk 1.1. NA advised that since this risk had been agreed 12 months ago it was timely to undertake a thorough review; this risk would be therefore be reframed for the December report. A detailed update would be provided at January SQAC meeting ahead of presenting to Board of Directors.

ES advised that a comprehensive update with regard to waiting list management and had been incorproateed into risk 1.2 and that AB had reflected this in the current risk score increasing it to 20. ES reported that the hospital capacity had been green throughout the last quarter, with continued focus on restoration and addressing the waiting list challenges.
KB requested whether SQAC could receive a presentation update in the New Year on Risks 1.1 and 1.2 from NA and AB. NA confirmed that BAF deep dives had been scheduled into the committee workplan commencing January 2021.

Action: SQAC to receive deep dive update from AB regarding risk 1.2.at the January SQAC meeting.

Resolved: SQAC received and **NOTED** the BAF update. FM thanked ES for update.

20/21/76 **Corporate Report – Quality Metrics Divisional Update**

NA provided a brief overview, SQAC noted that there had been good progress in month, in areas, especially in IPC with trends within tolerance.

- Highlight collection of medication errors, this had been discussed at Patient Safety Day and had been discussed at Patient Safety meetings. NA sated that within the meeting pack, the paper should read '10 times dose calculation errors. NA advised that there is a significant amount of work taking place regarding medication, prescribing, dispensing and administration. NA advised that the suggestion is that Medication safety becomes one of the top priorities for 2021, and to collectively align the workstreams and workgroups to hopefully improve upon safety. There had been a downward trend over the last couple of weeks, however high-risk medication and complex medication – infusions, insulin remain the majority of prescribing errors**.**
- There had been a reduction in PALS and complaints, which would be discussed further at Trust Board on 17th December 2020. NA stated that there are further improvements that are required with regards to processes and performance with regards to complaint and PALS response turnaround times. NA stated that the metrics also required reviewing. NA advised that currently the Complaints report is shared on a quarterly basis, however NA recommended that the Complaints report requires monthly oversight, in order to ensure continued sustained improvement and ensuring oversight.
- Brilliant basics improvement system, - NA advised that he is really pleased to report that the pilot had commenced in Day Surgery and in Ward 4C, the teams are working through the theory and training period currently, with the aim of roll out throughout the rest of the organisation in February/March 2021.
- NA advised that the Sepsis screening in ED remains challenging, with regards to the screening fallowing below 1 hour timeframe for administration of antibiotics, - NA confirmed that there is a dedicated working group who are reviewing this currently, with the aim of seeing some improvement in due course.
- NA confirmed that there had been some improvement in the patient satisfaction survey regarding play and education, there is still further work to do within this area. There had been an encouraging meeting held with the school headmaster, and the Trust is moving in the right direction in terms of working in partnership with educational colleagues.

Division of Community & Mental Health

LC presented the following key issues for the committees attention:

Safe

- Zero incidents recorded of moderate, severe, or fatal harm
- Zero Pressure Ulcers (Category 3 and above)
- Highlight included recruitment of tissue viability nurse, the post is now out to advert and would be recruited to imminently.
- Main challenge remain regarding medication incidents which had been discussed at the last committee meeting, relating to lost or delayed prescriptions, being received, a significant piece of work had taken place to review how prescriptions could be received for children and young people/families, either for collection and the team are working with local community pharmacies in the absence of electronic online transfer. This remains a significant challenge for the Division, LC confirmed that she welcomed NA plan regarding medication safety review in its entity as a whole review in 2021.

Caring

- Reduction in PALS (18) compared to previous month of 33
- 98% positive Family & Friends scores within the Division
- 6 formal compliments received in month, this is as a result of PALS queries that had been received, LC requested that these PALS responses, be managed as a formal complaints process, as they particularly related to ASD and ADHD. With the Division having a significant improvement plan in place for ASD/ADHD.

Effective

- The Division had no children/young people waiting over 52 weeks.

Division of Medicine

UD presented the Quality Metrics Divisional update; key issues as follows:-

Safe

- Zero Never Events
- Zero clinical incidents resulting in severe, moderate or permanent harm
- Cleanliness score of 96%
- Pharmacy outpatient time for complex patients remains at 100%
- No hospital-acquired infections for MRSA and C Difficile
- Challenges remain regarding Sepsis patients in Ward 4B, which had brought the current rate down to 75%, with the team actively reviewing this, with an After action review which had taken place, with appropriate measures in place, in order to address and improve.

Caring

- 7 formal complaints, Complaints are reducing, as are issues relating to neurology incident, with a decrease in second stage complaints also. The team are currently reviewing a complaint relating to communication.
- 29 PALS responses
- Zero 28 days breaches.
- Challenge remains regarding the Was Not Brought rate at 11% which has reduced from 13%

Effective

- ED performance continued to meet the national standard 97.1 %. The Emergency Department continues to be responsive to the challenges of COVID and seeks to continue to improve its reliance for winter. The Division had increased theatre utilisation.

Responsive

- RTT compliance continued to improve, currently at 81% (against 68% in October), with the Divisions intense focus on restoring capacity and expanding access to care.
- There continues to be no patients waiting over 52 weeks for treatment.
- Continued recovery plan of diagnostic targets, 97.7% and has narrowly missed the 99% standard.
- Challenges remained regarding outpatient imaging reporting times, Associate Chief of Operations is reviewing this position.
- Highlight included consistent delivery of national cancer standards, and continued recovery of diagnostic targets.

Well Led

- Mandatory training is slightly below 90% and this is currently being reviewed.

Division of Surgery

CT presented Surgery key issues update; key issues as follows:-

Safe

- Zero clinical incidents resulting severe, moderate or permanent harm
- CT stated that the main issue within the division related to medication errors, and given earlier comments by NA, that hopefully this would be a main Trust priority for 2021 and colleagues would be working on prescribing and administration within the division.
- Zero category 3 or 4 pressure ulcers within the last month, CT advised that there is currently an unstageable pressure ulcer which would be reported in the next update, there is currently an RCA being undertaken.
- Zero never events.
- Challenge for the Division regarding FIT testing compliance as the masks had changed, and for those staff who had been tested early in the pandemic have had to have another test, as they are not compliant across the Division.

Caring

- There had been a decrease in complaints currently 4 complaints from previous month, with a decrease in PALS from previous months. Complaints related to perceived lapses in clinical care, access to care within the anticipated timeframes and communication across specialties and divisions. The Division are looking to try and engage, and to have clinical reviews earlier to respond to complaints sooner in more timely manner. Haven't got complaints and PALS levels to where want to be.

Effective

- Reduction in referrals received
- Was not brought rate currently at 9.8%
- Reduction in cancellation on day of admissions at 6%

- Reduction in cancellations with 6 weeks' notice
- Zero patients waiting over 28 days to be rescheduled
- Theatre utilisation remains consistently 88-90%
- Reduction in cancellations on the day
- Increase in admissions patient's readmission within 48 hours

Responsive

- Highlights, - increase theatre sessions day case running more outpatients over weekend which had helped reduce backlog.
- Waiting list size increasing 8,216 currently
- Slight reduction regarding patients waiting over 52 weeks, still remains a challenge.

Well led

- Increase in staff who have had PDR
- Reduction in long term and short-term sickness
- Challenge regarding maintaining and managing long term sickness currently at 4.8%

FB recognised the challenges regarding current waiting lists. CT confirmed that there had been significant work within the Division in terms of day case, utilisation and Saturday clinics which hopefully would aid the reduction in waiting lists.

FB thanked all Divisions for continued ongoing work in order to address current challenges within the Divisions.

Resolved: SQAC **NOTED** continued work to address issues.

20/21/77 **Neurology Update**

UD presented an update on the investigation into the governance arrangements within the specialty of neurology following identification of clinical practice outside that which would normally be undertaken. She provided the committee with an overview of background detail and findings from the comprehensive RCA level 2 undertaken along with lessons learnt and recommendations.

AH advised that this had been a significant piece of work undertaken, (1037 children) which had been extremely time consuming for the division, and had been stressful for those colleagues involved, with significant demands placed on the clinical team. Weekly meetings had been held with the CCG since June 2020 which had now moved to bi-weekly. Clarity was still awaited regarding the scope of practice and whether it was unacceptable by a paediatric neurologist. AH was hopeful that BPNA would support the Trust in the stance that had been taken.

UD stated that she had recently met with the GMC, and following that meeting the GMC are planning on providing training in 2021 in order to support colleagues with regards to Raising Concerns. UD advised that there is a Task and finish group which had been established.

FB thanked AH & UD for helpful discussion, FB recognised the lengthy process and thanked the team for the continued drive and commitment from colleagues in order to address this ongoing issue. UD stated that individuals are feeling more comfortable in raising concerns.

UD advised that the Trust was working hard to ensure appraisal training is more robust, with the Trust appraisal lead, and RO working closely together. AH stated that it is difficult to identify when and if there is a problem through the appraisal process and advised that there is a need to further improve the culture in order to support staff. FB commented that leadership is extremely important in this regard.

LC referred to learning for the organisation, and stated that it is important to ensure that the Trust have a legal obligation regarding cessation of any service, and as a minimum there would also be a requirement to undertake a Quality Impact Assessment, with significant learning also required, together with reflections required Regarding lessons learned in the future. UD confirmed that she had previously undertaken offline discussions with colleagues regarding this issue. UD fully recognised this.

ES referred to legal implications and stated that two of the parents from this cohort of patients had sent a copy of a letter before claim of judicial review, with Alder Hey named as an interested party, with main parties being NHSE, Secretary of State, and NICE. AH stated that he was aware of the judicial review, which was very much about PANDAS which is a highly controversial condition, which many neurologists believe does not exist, AH stated that this is an extremely complex area, as commissioning did not exist for these patients, as there are huge questions whether this condition exists, with safeguarding issues also. AH advised that the Trust was not commissioned to look after these cohort of patients, and the team at Alder Hey would never have agreed to review this cohort of patients, as they had felt that it is not the correct pathway of care for these patients. This is a unique circumstance.

Committee noted significant safeguarding issues, with extremely controversial issues, with no commissioning arrangements for this cohort of patients or a pathway to support.

Action: SQAC to receive Neurology Action Plan

Resolved: SQAC received and **NOTED** the Neurology Update. FB thanked UD & AH for informative update and looked forward to receiving the Action Plan at the appropriate time in the New Year..

20/21/78 CQSG Key issues report

NA presented the CQSG key issues report and highlighted the large volume of activity that had taken place at the meeting held on 10th November . Issue/s for the committees attention were presented as follows:

- MS teams meeting – increased attendance in some areas, issues regarding quality of the meetings, and colleagues equipment, this issue required scoping over the next few months in order to upgrade kit. NA agreed to escalate any remaining unresolved IT issues regarding equipment to RC for RC/IT team to address.
  Action: NA to provide RC with feedback regarding any outstanding equipment issues, to enable RC to address with IT colleagues.

KB referred to key issues to escalate from CQSG and stated that it would be useful for CQSG to be more explicit, in order for SQAC to know why issues are being escalated i.e. whether a particular issue is an early warning to SQAC, whether

issue is a significant issue which is being dealt with by CQSG, or whether it is an issue, which CQSG are stuggling to address and require assistance/support from SQAC. NA accepted this had not been as clear as it could have been historically and that this would be clear going forward. FB welcomed this approach for further clarity regarding 'escalation' from CQSG and agreed it would be more helpful for CQSG to be more explicit in the future, in order to provide future clarity.

Resolved: SQAC received and **NOTED** CQSG update, and noted formal thanks to PB for chairing CQSG.

20/21/79 **Any other business**

NA referred to the Ockenden Report which had been published on 10th December 2020 detailing the failings regarding maternity services at Shrewsbury and Telford NHS Trust. NA advised that he planned to provide a brief update at December Trust Board outlining the 7 urgent recommendations. None of the recommendations were applicable to Alder Hey as the Trust does not provide maternity services. NA advised that there are 5 recommendations relating to neonatal service provision, the Trust is fully compliant with 4 of these recommendations, the Trust is not compliant with 1 recommendation, as the recommendation is not applicable to Alder Hey due to the way the unit is set up within the report.

Resolved: NA provided assurance that the Trust was compliant with the urgent recommendations within the Ockenden Report, and stated that an update would be provided to the December Board, ahead of a formal Trust response to NHSE/I.

20/21/80 **Review of meeting**

The following items would be included on the key issues report fort he December Board meeting:

- The presentation on Safe Waiting List Management and the associated critical completed work in order to address the data issues.
- The comprehensive neurology update and action Plan expected in 2021.

FB stated that there had been good discussions across a wide range of issues.

20/21/81 **Date and Time of Next meeting**

20th January 2021 at 9.30 via Microsoft Teams

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on
Wednesday 20th January 2021
Via Microsoft Teams

Present:	Fiona Beveridge	(Chair) Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director - Community & Mental Health Division	(LC)
	Urmi Das	Interim Divisional Director for Medicine	(UD)
	John Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Nicki Murdock	Medical Director	(NM)
	Jacqui Pointon	Associate Chief Nurse/Safety Lead for Community	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Robin Clout (on behalf of KW)	Interim Deputy CIO	(RC)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)

In attendance:

	Adrian Hughes	Deputy Medical Director	(AH)
	Jill Preece	Governance Manager	(JP)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)

Agenda item:

20/21 **Apologies:**

Anita Marsland	Non-Executive Director	(AM)
Alfie Bass	Divisional Director, Division of Surgery	(AB)
Phil O'Connor	Deputy Director of Nursing	(POC)
Melissa Swindell	Director of HR & OD	(MS)
Kate Warriner	Chief Digital & Information Officer	(KW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

20/21/82 **Declarations of Interest**
SQAC noted that there were no items to declare.

20/21/83 **Minutes of the previous meeting held on 16th December 2020 –**

Resolved: committee members were content to **APPROVE** the minutes of the meeting held on 16th December 2020.

20/21/84 **Matters Arising and Action Log**

Action Log

The action log was updated accordingly.

Matters Arising

Covid Update

NM provided an update on current Covid 19 position. NM confirmed that it was the Trusts intention to receive and support the care of adult Covid positive patients, in order to support the regional increase in demand for acute adult Covid positive patients requiring intensive care support and facilitating up to 10 intensive care beds.

NM confirmed that supporting documentation would be circulated to SQAC following the meeting, which would provide colleagues with an overview/summary paper, overarching governance arrangements, and a report regarding Critical Care pandemic staff and how patients are to be received and managed. NM sought urgent scrutiny by SQAC of these documents to enable offline approval via email and requested any comments to be shared by no later than 5.00pm on 22.1.2021 in order for approval at Board of Directors meeting scheduled on 28.1.2021. NM advised that the Trust currently had 1 adult Covid patient and assured the Committee of the strict criteria regarding the admission of Covid patients.

Action: SQAC to promptly **review/scrutinise and provide any comments** with regards to the documentation to be circulated on the afternoon of 20.1.21, ahead of approval at Trust Board on 28.1.21.

20/21/85 **Update on BAF Risk 1.2**

AB provided an update on Risk 1.2, key issues as follows:- SQAC received a comprehensive update which detailed risk overview, details on key controls in place, next steps and governance arrangements.

The risk score was currently set at at 20; in November 2020 a judgement had been made to increase the risk score to account for two key factors in terms of the impact of Covid 19 on elective waiting times and issues with data quality affecting the accurate reporting and tracking patients on the waiting list. The score did not relate to any patient harm episodes, as there had been no confirmed cases of harm.

Challenges related to the number of patients waiting over 52 weeks, which currently equates to 201, with upward trend in the last couple of months which had been driven by data quality work over the last few months.
The Trust was progressing additional actions to create more capacity including the use of independent sector and a new model for procuring in-house capacity with regards to timely access to surgical care in ENT, chronic pain, dentistry and spinal surgery.
AB reported that the third wave of pandemic was posing a threat to access to care as adjustments to theatre capacity are made to support a response to the regional pressures from Covid.
AB confirmed that next steps focussed on gaps in control, data quality, waiting list reporting, access to planned care and additional capacity to address.

Safe waiting list update - AB stated that significant work had progressed over the latter few weeks regarding validation. New inpatient RTT had been constructed in conjunction with MBI which would go live 21st January 2021. The Safe Waiting List Review Team were due to continue to review records by March 2021.
Clinical reviews had commenced: with 87% completed there had been no confirmed cases of harm identified. Briefings were being held for staff over the next 2-week period.

FB queried the impact on the 'No child unaccounted for' metric. AB stated that the electronic patient pathway form was completed, presently 1 in 12 children do not get this completed on the day, or in a timely way. This issue is being elevated, a new patient pathway form had been created which is more user friendly, and would ensure enhanced tracking, this will be disseminated to colleagues within the organisation.

KB stated that the presentation of BAF risk was extremely useful in order to provide SQAC with assurance.
FB thanked AB for comprehensive presentation.

SQAC received and **NOTED** update on BAF Risk 1.2 and safe waiting list update.

20/21/86 Corporate Risk Register Report

JG presented the Corporate Risk Register Report and advised that there was a rapid review underway of key risks, in particular COVID risks, and therefore colleagues would see a slightly different version of the Corporate Risk Register Report at the Trust Board meeting on 28.1.21.

CU reported that there were currently 19 risks on the Corporate Risk Register, within 5 key themes and was pleased to confirmed that all risks were in date, and had been fully reviewed, with risks continuing to be well managed, with good shared learning across the organisation.

FB welcomed the report and stated that SQAC would continue to keep risks under close review.
KB referred to Risk 386 regarding Data input errors, and queried whether there were any wider risks regarding patient pathways. AB stated that this related to the Safe Waiting List Management programme, and referred to the Safe Waiting List provided within BAF 1.2 update.

FB stated that there are a number of risks that had remained static, and queried the requirement for a review, and whether colleagues needed to consider a different approach in terms of these risks.
JG stated that these risks would be reviewed at Audit and Risk Committee to review any mitigations and any actions and advised that given the nature of a number of the risks, it was expected that they would remain static. KB confirmed that there was an update report on the upcoming Audit and Risk Committee which contained fewer long standing risks than previously and that a significant amount of work had taken place to mitigate current risks.

FB referred to the Surgery Risk regarding Neurosurgery which had been added to the Corporate Risk Register in November 2020 regarding patients not being adequately managed from a medical perspective whilst under the care of neurosurgery and craniofacial specialties and sought further background information on how this risk materialised and queried how effective the controls

in place are. UD confirmed that this risk related to a longstanding issue with regards to General Paediatric cover for patients attending the Trust for Surgery. A thorough review was underway. A meeting scheduled for week commencing 11.1.21had to be cancelled due to COVID pressures but progress is ongoing to address this issue.

20/21/87 Update on Quality Priorities

NA provided an update on 3 agreed Quality Priorities for 2021-22 and reported that, following the Patient Safety discussion held in 2020 and also feedback and data received, the proposal for the Trust is to have 3 overarching priorities:-

- Medication safety, (covers prescribing, dispensing administration, technology and high-risk medication)
- Deteriorating patient (covers unplanned admission to PICU, Parental concerns and sepsis)
- Mental health, (covers suicide prevention, ASD and emotional/physical health)

NA confirmed that the next steps were for the quality hub to work with ward-based staff and divisions to articulate the metrics and opportunities within each of the domains to shape the patient journey over the coming 6 weeks.

Action: SQAC to receive a **further update** at March 2021 meeting, prior to sharing at Board.

NM emphasised mental health expertise and broadening expertise of staff regarding mental health for young people, to ensure that this is embedded within the Trust as part of a holistic approach.

FB queried whether any support was required from SQAC with regards to 'live real time data' – NA advised that there was ongoing commitment from the BI team and commitment had been received from KW in terms of resources. With ongoing work to maximise innovation in terms of data capture and converting date to information.

Delivery of Outstanding Care - Safe

20/21/88 CQC Action Plan

ES presented the CQC Action Plan update to 31st December 2020 which continued to progress at a good pace and remained on track in all areas. All actions due for completion in December had been completed. ES commended the Surgical Division for continued efforts regarding relating to the consent action and reference the huge plethora of work that had been undertaken to date including a full rewrite of the Consent Policy in line with new GMC guidance.

Monthly meetings were being held to progress actions relating to consent including:

- Development of an 'Educational package' to include mandatory training module in order to highlight consent within the Trust
- Development of a new audit template, with 6 monthly audits taking place within surgical division.
- 'E Consent' - divisions now starting to use E-consent more widely

ES referred to ongoing 'maintenance tasks' and advised that these would continue to receive monthly updates until the action plan was closed off by CQC and then remitted to Trust internal governance processes for ongoing monitoring.

Resolved: SQAC received and **NOTED** the CQC Action Plan and **NOTED** the completed actions and February deadlines. FB thanked ES for update**.**

20/21/89 Review of Investigation Process into Incidents 43057 and Incident 43669

PB presented comprehensive report and action plan, which detailed background findings regarding comprehensive Review of Investigation Process into incident 43057 and Incident 43669. PB confirmed that some low-level recommendations had been made.

PB confirmed that there had been significant progress made in terms of the Action Plan, all actions had short deadlines. In light of this, JG requested whether PB could further review the deadline dates in order to fully assure the committee that these deadlines could be met.

Action: PB & NM to review and agree deadline dates within the Action Plan.

KB alluded to escalation when working with 3rd parties who may not be contributing as appropriate, and asked whether all staff are clear on who to escalate such issues to in order to ensure timely responses. PB confirmed that health to health agencies are bound by frameworks, and that for other agencies discussion would usually be escalated through to 'Director to Director' level and using Safeguarding escalation process.

Resolved: SQAC received and **NOTED** the Review of Investigation Process into Incidents 43057 and Incident 43669.

SQAC **APPROVED** the action plan and recommendations, subject to review of deadline dates within Action plan.

FB thanked PB and the team for continued work to date, and for the level of assurance provided to SQAC.

20/21/90 Progress update regarding CQC Section 31 Actions

NA provided an update on key issues and advised that work was ongoing with regards to previous concerns raised by the CQC. The Trust had been issued with Section 31 Conditions of Practice onto the Trust License on 18.12.20. NA confirmed that the Action plan had been completed and signed off and sent to various bodies including CQC with associated supporting evidence, with the request to review at management review meetings, the aim in the next 2/3 weeks was to have these conditions removed from the license as soon as possible.

NA would provide further update at February 2021 meeting.

Action: SQAC to receive update at February 2021 meeting.

Resolved: SQAC received and **NOTED** the position in relation to the Section 31 actions

FB thanked NA for update.

20/21/91 Findings from external Children in Care (CiC) Service Review

LC presented SQAC with an update report from the external CiC review, which

was commissioned by LC and undertaken by Designated Nurses for Children in Care in Liverpool and Sefton CCGs. The report provided background detail, key findings actions, governance and monitoring arrangements. LC reported that some key actions were owned by CCG.
The Report and Action Plan would be monitored through the Community Divisional Governance Group. KB queried whether there are any other areas within the Trust where this external review approach may be useful.. LC confirmed that the Division of Community and Mental Health had plans to review this, with oversight through Community Divisional Board, and monitored on a quarterly basis through the quality and contract meeting with CCG. LC advised that the action plan included in the meeting pack is a draft plan: LC had met with CCG on 15.1.21 to strengthen and add additional actions.

Action: LC agreed to circulate the amended action plan

Resolved: SQAC received and **NOTED** the Children in Care Services Review.

FB thanked LC for update and looked forward to reviewing progress update regarding the Action Plan at the next planned update.

20/21/92 DIPC Exception Report

BL presented the DIPC Exception Report, key issues were highlighted as follows:-

- The Trust had seen an increase in MRSA and C Dificile cases which had been reported in many other Trusts also. BL confirmed that the CLABSI Working Group had been reinstated across the Trust.
- Flu vaccine – 87% uptake compared to 50% in other Trusts
- NM confirmed that delivery of Covid Vaccine was currently at 80% for the Trust, and that the Trust was continuing to work well in terms of administering the vaccine
- Track and trace team had been in place since August 2020, available 7 days in order to monitor contacts

FB commended the approach taken with regards to the reinstated CLABSI working group to address CLABSI's.

FB thanked BL for update.

Resolved: SQAC received and **NOTED** the assurance provided by the DIPC Exception Report.

Effective

20/21/93 CQSG Key Issues Report

NA provided a brief verbal update, and confirmed a change to the structure for CQSG, to enable rotation of discussion regarding experience, safety and effectiveness.
Future CQSG reports would be streamlined and would be reviewed by the Medical Director and Chief Nurse, with the aim for exception reports against the Quality Metrics to be raised at CQSG, and any appropriate escalation to SQAC if required. SQAC colleagues were supportive of this planned approach.

Resolved: SQAC **NOTED** and were supportive of CQSG update.

FB thanked NA for CQSG update.

20/21/94 **NICE Guidance (NG10) Violence and Aggression**

LC presented NICE Guidance (NG10) Violence and Aggression and reported that the Trust had been assessed in 2015/16 specifically in relation to the Trust's Tier 4 Specialist Inpatient Unit for Children. In January 2020 therefore, a detailed assessment of the Trust's current compliance with NICE guideline 10 was undertaken.

The assessment concluded compliance with the recommendations included in NICE guideline 10 in relation to the services provided by its Community Mental Health Services and Tier 4 Specialist Inpatient Unit for children.
Partial compliance was highlighted for the acute hospital site.

LC went on to draw attention to the findings and recommendations and subsequent actions required by the Trust and confirmed that an action plan had not been created as all items had been included within the CQC s31 action plan and the RCA action plan.

In response to a query from FB regarding involvement of C&YP in decision making and recording LC advised that the Community & Mental Health Division continually document as appropriate regarding the voice of the child. However, culturally this could be strengthened across the organisation. It was envisaged that this would be addressed within the quality workstreams.

FB thanked LC for NICE Guidance update, FB stated that SQAC would assume this would reach compliance within weeks, in terms of recommendations made.

SQAC received and **NOTED** the NICE Guidance (NG10) Violence and Aggression Update

Well Led

20/21/95 **Board Assurance Framework**

ES presented the Board Assurance Framework detailing updates to the end of December 2020 and reported that both ES & NA had undertaken discussion regarding Risk 1.1 ES advised that this risk would be subject to a comprehensive review over the upcoming period.

Risk 1.2 had been dealt with under agenda item 20/21/85 in the update provided by the Chief Operating Officer.

ES drew particular attention to risk 1.4 'Sustaining operational delivery following the UK's exit from the European Union', in terms of the potential impact on the supply chain and any potential ramifications on patient safety. FB stated that this risk was being closely monitored though several channels and confirmed that SQAC would continue to monitor patient safety risks. NM confirmed that the Trust does have a longer level of stock in place currently.

Resolved: SQAC received and **NOTED** the BAF update. FM thanked ES for update.

20/21/96 Divisional Reports by exception

Division of Community & Mental Health

LC presented the following key issues for the committee's attention:

Safe

- Reduction in Medication Errors to 16 in December 2020, compared to 33 in the previous month, in relation to ongoing work regarding lost prescriptions, particularly regarding ADHD medication and ongoing work with the Royal Mail.
- 1 incident reported regarding restrictive intervention for a patient on Tier 4 Unit, review had been undertaken.

Caring

- Reduction in PALS from 17, to currently 15 in December 2020.
- Reduction in complaints, 2 complaints received in December, compared to 6 received in November 2020
- Received 100% positive scores for both Community and Mental Health Services, positive Family & Friends scores within the Division, as the virtual feedback is now included.

Effective

- The Crisis Care Team continue to provide 24/7 service, during December 2020 the service had received 278% increase in calls, compared to December 2019, Ongoing work required regarding ongoing investment required from CCG and internally in order to support crisis care support team.

Responsive

- Significant reduction regarding C&YP waiting over 40 weeks, in Community Paediatrics - 149 in October 2020, and 5 in December 2020.
- RTT - 32% in July 2020, with 65% in December.
- Pre April 2020 cohort of ASD and ADHD patients are reducing in line with predicted trajectory.

Well Led

- Division had received funding from National Lottery to launch Covid support team in mental health services for a 12-month period for an online support programme.

Division of Medicine

UD presented the Quality Metrics Divisional update; key issues as follows:-

Safe

- Zero Never Events
- Zero clinical incidents resulting in severe, moderate or permanent harm
- Cleanliness score of 96%
- No hospital-acquired infections for MRSA and C Difficile
- Challenges remain regarding Sepsis – 73.68%, with the team actively reviewing this, on review 19 high risk patients in December, with 14 patients treated less than 60 minutes, 5 patients had difficult IV access and 3 patients required multiple lumbar pictures which contributed to the delay.
- Ongoing challenges regarding medication errors

Caring

- 6 formal complaints, challenges remain regarding complex complaints regarding tics and tourette's patients

Effective

- ED performance continued to meet the national standard 98.6%. Continued sustained improved in comparison to 85.6% previous year.
- Challenges remain regarding the 'was not brought rate' - 13.7%, with an increase in cancellation less than 6 weeks, attributed to short term isolation given that clinicians are not able to undertake clinics.

Responsive

- RTT compliance continued to improve, currently at 85%, reduction relating to patients at 40 weeks – reduction from previous 63 to currently 24 patients.
- Ongoing challenges regarding capacity.

Well Led

- Division are underspend by 30K
- Highlights - safer staffing levels
- PDRs had increased from 69% to 74% within the Division
- Challenges relating to sickness over 4%
- Mandatory training is slightly below 90%, as Basic Life Support face to face training cannot take place at the present time

Division of Surgery

CT presented Surgery key issues update; key issues as follows:-

Safe

- Zero clinical incidents resulting severe, moderate or permanent harm
- CT stated that there had been a significant reduction in medication errors.
- Challenges – the Division had a Category 3 pressure ulcer, RCA panel not yet met, however division had identified early learning from this incident, pathway for use of devices is currently being reviewed

.

Caring

- There had been a decrease in formal complaints, challenges regarding providing access in a timely manner for elective patients.

Effective

- Was not brought rate had increased to over 11%
- There had been several operations cancelled, with 3 patients waiting over 28 days to be rescheduled for elective procedures.
- Reduction in patient's readmission to PICU within 48 hours

Responsive

- Highlights – Division continue to increase theatre sessions day case running more outpatients over weekend which had helped reduce backlog.
- Waiting list – approximately just under 8,000 patients currently
- 183 patients waiting over 52 weeks, this remains a challenge.

Well led

- Increase in staff who have had PDR
- Long term and short-term sickness remain a challenge.

- CT advised that the Division now have 2 quality safety leads within the division, which will aid further improvements in terms of governance and safety.

FB thanked all Divisions for continued ongoing work in order to address current challenges within the Divisions.

Resolved: SQAC received and **NOTED** Divisional Updated and **NOTED** continued work to address current challenges.

20/21/93 Any other business
None

20/21/94 Review of meeting

- SQAC agreed to promptly scrutinise documentation being circulated via email on 20.1.21 regarding governance arrangements relating to the Trust caring for adult Covid positive patients, ahead of discussion at Trust Board on 28.1.21
- FB welcomed continued progress on both BAF Risk 1.2 and safe waiting list management
- SQAC supportive of the Quality priorities emerging, and the significant ongoing work in order to shape the metrics, and would receive update in March, ahead of presenting to Trust Board.
- SQAC welcomed future CQC update.
- FB commend the comprehensive report regarding investigation process
- SQAC supportive of the NICE guidance NG10 update
- SQAC agreed that good quality discussion had taken place and FB fully understood the pressures that colleagues are currently facing. FB stated that safe and quality remain a priority for the organisation.

FB thanked all for good discussions across a wide range of issues.

20/21/95 Date and Time of Next meeting
18th February 2021 at 9.30 via Microsoft Teams

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on Tuesday 17th November 2020
Via Microsoft Teams

Present:	Claire Dove	Non-Executive Dorector (Chair)
	Melissa Swindell	Director of HR & OD
	Fiona Beveridge	Non-ExecutiveDirector
	Mark Flannagan	Director of Communications & Marketing
	Adam Bateman	Chief Operating Officer
	Pauline Brown	Acting Chief Nurse
	Rachel Greer	Associate COO – Community
	Adrian Hughes	Deputy Medical Director
	Erica Saunders	Director of Corporate Affairs
	Ramman Chhokar	Associate COO - Medicine
In attendance:		
	Sharon Owen	Deputy Director of HR&OD
	Elvina White	Care Pathways, Policies & Guidance (Part Attendance)
	Jo Potier	Associate Director of Organisational Dev
	Tony Johnson	Staff Side Chair
	Darren Shaw	Head of Learning & Development
	Cath Wardell	Associate Chief Nurse – Medicine
	Dot Brannigan	Public Governor (Observing – Part Attendance)
	Jackie Friday	Executive Assistant (Minutes)
Agenda Item:		
20/54	Aimee Godsman	Health & Safety (Weightmans)
	Laren Steele	Non Clinical Claims Rep (Weightmans)
Apologies:	Ian Quinlan	Non-Executive Director
	Nathan Askew	Chief Nurse (NA)
	Nicki Murdock	Medical Director
	Andy McColl	Associate COO – Surgery
	Jacqui Pointon	Associate Chief Nurse – Community
	Amanda Kinsella	Health & Safety Manager
	Helen Blackburn	Medical Education & Revalidation Manager

20/40 **Declarations of Interest**

None.

20/41 **Minutes of the previous meeting held on 14th September 2020**

Resolved: The minutes of the last meeting were approved as an accurate record.

20/42 **Matters Arising and Action Log**
Action Log

20/29 – Procurement – Diversity & Inclusion – CD advised she will present at a future Board meeting the Governments Framework for Social Value (part of the Government covid recovery plan – to be rolled out January 2021). CD to raise with CEO & Chair.

Action: Procurement – Diversity & Inclusion - CD to liaise with CEO & Chair re presenting at a future Board the Government Framework for Social Value.

20/30 – Governance & Terms of Reference/Workplan (streamlined agenda and workplan) – MKS advised she worked with ES and the Governance Manager to standardise the format of agenda and minutes so they are in line with other Trust Board Committees. The agenda has been streamlined – removed some of the regular reports, the required information is included in the People Report to make less operational and more relevant. ES suggested we work through a couple of cycles with the new format then take some feedback from the Chair & other Non-Execs to guage how it's working. The agreement of top 5 risks (agenda item) will help focus things.

Action: PAWC to receive feedback from Chair & Non-Execs re standardised/streamlined minutes/agenda/workplan - at a future meeting.

20/34 – HEE NW Annual Assessment Visit 2015-19 – Prepare assurance report for CQC. – ES advised this will be part of the Engagement agenda on 18th December. Local inspectors are interested to find out why we continue to be listed as high risk. Need to ensure we are ready to respond.

Action: PAWC to receive update at January 2021 meeting.

17/21 – Programme Assurance/progress update – Feedback on outcomes of Change Programme Framework – MKS advised the Change Programme has changed in light of the piece of work taking place with KPMG. The way in which we are reporting on objectives is coming through the people plan objectives. ES concurred that this has been superceded. The governance of these workstreams will be embedded/integrated into the governance committees over the next period. **Action is closed.**

19/51 – Modern Slavery – CD reflected on the significant consequences of modern slavery, particularly in relation to Procurement at the Trust and will provide more information to the Committee to assist and understand the ramifications.

19/73 Mandatory Training & CQC – ongoing and updates now included in the People Plan – **Action is closed**.

19/69 – Nurse Associate Recruitment – Develop a wider plan to be reviewed – CD advised that this is something we are looking at the BAME task force. Action to invite Nurse Education leadership to the next BAME Inclusion Taskforce.

Assurance on Key Risks

20/43 **To agree top 5 Risks**

MKS advised that each Committee reporting into the Trust Board has been asked to agree the top 5 Risks. MKS opened up the discussion to agree the top 5 risks for people and workforce – the risks agreed will become an area of focus in terms of monitoring and making sure that appropriate mitigations are in place. A number of risk/observations were raised:

- Sickness absence & wellbeing and the impact on the organisation – covers a number of elements – general and covid sickness absence, asymptomatic testing, longer term mental health, phsycological safety (feel safe). Staff working full out, pressures, ensuring we have a robust package to support staff.
- Recruitment/Strategy – covers a number of elements – diversity and inclusion approach particularly in the recruitment of nurses. PB advised that in terms of funding the Trust has been successful in a national bid and this has been pledged to increase the student nursing capacity and placement offer and is inclusive of reaching out to would be colleagues in the BAME community.
- The quality of education as a whole – operational challenges to ensure staff can perform their role as effectively as possible. HEE inspection - support for self assessment – as this determines how much money we get from HEE and determines our status as a teaching hospital. Uni's – changing curriculums pose real challenges, provide different types of training for medical education. Mandatory training safeguarding, information governance & resusitation etc.
- Longer Term Workforce Planning – to face challenges in the future, ensure we have enough staff and with the right skills to support future services. Adjustment to change – technology dependencies – support members through change.
- Risks to change possibly – due to staff survey results – reframe of risks – in relation to feedback this year due to Covid in February or March when we have a clearer idea on staff feedback.

CD advised that we need to ensure that the ownership of the top 5 is clear to ensure we see progress. MKS thanked the Committee for feedback. MKS to review risks outside of this Committee and share with CD. CD reflected on businesses prior to Covid in relation to the support and wellbeing of staff (chill space/physical space) and suggested it would be interesting as to how staff feel following Covid. JP advised that a proposal/bid had gone to the charity for space for wellbeing purposes.

Action: PAWC to receive an update of Top 5 Risks for approval – January 2021.

PAWC discussed and noted the Top 5 Risks.

Trust People Plan 2019-2024

20/44 **People Plan (Board November 2020)**

Taken as read, the report is presented each month at Board. MKS referred to the reviewed agenda and advised of the inclusion of more information in relation to KPI's and the key points of activity over the previous month. MKS highlighted that daily reports on staff availability are produced and are issued to management across the organisation outlining the sickness absence position. Total absence (including Covid/ self isolating and regular absence etc.) is hovering around 7.5%, one of the lowest in Cheshire & North Mersey and Greater Manchester, so we are doing pretty well in comparison. But overall sickness remains high at 5.5%. Covid quite low, monitoring on a daily basis by HR. A report goes to the Executive Committee monthly. A deep dive on long term sickness took place this month. JP and the SALS team team are working through what their approach will be to support staff who have long-term sickness with stress and any sort of anxiety/mental health issues.

CD referred to the adult hospitals and the expectance of higher Covid sickness levels. CD asked for comparisons to Manchester Childrens hospital. MKS acknowledged that general trends had been looked at and will liaise with counterparts in Manchester to get a sense of what their data is, along with Sheffield and Birmingham. Although the challenge we have even though we are like for like for the same service, we are not like for like in terms of compositon. The majority of organisations outsource their services (i.e. Facilities/Hotel Services, areas that traditionally have higher rates of sickness), we don't so our stats tend to look a bit higher than others.

Action: MKS to compare AH's sickness rates with other Childrens Hospitals (Manchester/Sheffield/Birmingham).

20/45 **Staff survey** – MKS stated that the survey closed 27th November, 44% response rate received, not hopeful of reaching same as last year (62%), due to the current climate and a lot of the success last year was based on the effort of 'floor walking' by some of the team (i.e. reminding staff), not been able to do that this year, hoping for 50-55%. Preliminary data too be received before Xmas. The main results will be issued in February. Will be brought back to the next Committee.

Action: Update on the Staff Survey at the next Committee

CW referred to the opportunity last year of receiving paper copies of the Staff Survey, to enable staff to sit down with a coffee and complete. MKS advised that requirement for either paper or online versions are requested to be sent out at the onset of the survey and unfortunately cant be changed. MKS advised that the survey is also compatiable with your mobile (smart phone), so staff do not need to stand at a computer to complete it. (i.e. forward email to your Hotmail account/gmail account). CW to promote this with staff.

20/46 **Flexible working** – MKS stated that we have a significant amount of staff working from home. Staff working from home received the latest letter from the CEO recently advising on the likely return to work (possibly Spring, next year). Measures have been put in place to make sure that people are safe and supported at home (i.e. Risk Assessments, ensuring staff have the right IT kit, can access tax breaks that the government offered). A further short survey has also been received by staff working from home to get a sense of how staff are feeling and what they think about flexible working (i.e. what the future looks like for them and the way they work with teams etc.). This will be fed into a review of the estates strategy. MKS advised of a workshop about to take place to review what that strategy will look like (i.e. short term things to fix – to facilitate staff back on site as space is a challenge).

CD queried when frontline workers may expect to receive the Covid vaccination? MKS advised in terms of the vaccine and the NHS, we have been asked to make preparations and get ready to receive the vaccine rollout from 1st December 2020. No specifics have been received yet about who will receive it first.

CA noted that we have been trying to put in place flexible working because of the issue of space and recognised it's a longer term strategy not just as a response to Covid (in response to the organisation and how it needs to operate in the future). MKS concurred and advised that it is about how we use the whole campus and the space we have, along with how we will support staff to work flexibly going forward. MKS advised that staff have fed back that that they really like working from home, so its finding a balance which gives some flexibility as an organisation with space but also meets staff needs for a better work life balance. Short term actions that need addressing for the Spring – the Institute is one of them – there is not enough room, particularly as the Trust wants to expand activity there (what it was originally designed for) around research education and innovation. JP brought attention to the impact/risk on wellbeing and research from other Countries, the evidence is saying initially people like working from home (referred to the point when our staff were surveyed). The data has started to change – peoples wellbeing actually declines – people start to get fed up. JP suggested that we need to keep measuring the surveys and responses from staff.

CD acknowledged it's the wider affects of the current situation that is effecting our staff (not seeing family/friends, shopping etc. a whole holistic approach), the whole picture needs to be taken into account. FB suggested on the chat that it is also harder for new members of staff to integrate with Teams just now. MKS advised that the Head of Learning and Development has been working with colleagues around how we make sure we support the Trust Induction Corporately, but also locally for new people who join the Trust to ensure they feel supported too. The Committee further reflected on individual experiences and acknowledged that its about ensuring staff have the right support and feel there is light at the end of the tunnel in the future, whilst being creative with the space we have to allow that flexibility, particularly corporate who have mostly been working from home.

20/47 **E-roster** – MKS stated that the contract has been awarded to Allocate, who provide most e-roster systems across NHS England. The process of implementing the system has commenced and looking to start the build of some pilot areas by the end of the month. Phase 1 will be getting the Medics onto the systems, for leave and study leave. Phase 2 will be 4A and 3C as implementation areas. Wards currently work on a paper based roter system, we are one of a handful of hospitals that don't have an e-system. E-roster will be accessible via an App on your smart phone and enable staff to manage shifts in advance and to build flexibility into their shift patterns. An E-roster Manager has joined the Trust and has vast experience of working with the leaders across the organisation to make sure that the people are brought into it and they understand it. The Committee will be kept sited on this. The Trust has been mandated to introduce this system by NHSEi and have received funding to deploy this sytem.

CD asked will it be evaluated over the first year and adjustments made. MKS confirmed that will happen.

PAWC **received and noted** the content of the People Plan.

20/48 **People Plan – Action Plan**

MKS advised that along with the People plan is a detailed Action Plan issued to the Committee for noting - Flexible Working, Health & Wellbeing and Equality Divesity and Inclusion. There are also a number of actions that have come out of national people

plan that employers are required to do. These have been pulled together in one place as it was thought to be important for the Committee to see how we are monitoring and measuring progress against activity against the national request for action, but also the things that we have agreed are our 3 top priorities.

CD requested that this will be brought back to subsequent Committees if there are any requirements for further information.

PAWC **received and noted** the content of the People Plan Action Plan.

20/49 **Non AFC Pay Update**

The paper is noted as read – MKS acknowledged the importance of this paper and advised we receive this proposal each year and that it actually only affects a small number of staff who do not sit on the national agenda for change pay scales. As they don't sit on the national agenda for change pay scales, they do not automamatically receive a cost of living increase as would agenda for change staff. This proposal is brought to PAWC for approval in support of the recommendations to enable staff affected to receive a similar level of increase.

PAWC **approved** the proposal for Non AFC Pay Update.

20/50 **Internal Communications Update**

The Committee received an internal communications update for information, noted as read. MF shared some of the highlights and related information:

- Progress has been made on stakeholder engagement and pure public relations in relation to the park and campus.
- Deputy Director of Communications has supported the Chair with coverage of Black History month, with lessons learned in relation to how we may support/recognise other similar points in time (i.e. Devalli, Ead and Christian festivals).
- Media hits – mostly driven by social media coverage, that leads to broadcast coverage, eg. Recent article in Daily Mail – (known for good health coverage) named the Charity in relation to a grant given for a piece of equipment.
- Working with KPMG – using Brilliant Basics as a lever to embed the internal communications process and support the devolution of divisions/departments to develop their communicating skills. Future updates will be brought back to the the Committee.
- Covid – ongoing weekly communication process in place – currently sharing information about testing & vaccination, Team performing well in this area, but learning all the time.
- Christmas is happening at the Trust - normally businesses would be approached to support the Trust, but because of Covid and uncertainties this has not been possible. The Tree will be launched on about 3rd December, with virtual tree lighting and Santa visits etc. Its as much about staff morale and children and young people, its important that staff feel part of Christmas. The Christmas Committee is always open to any new ideas or offers of help as things like present giving and selection boxes will need to be managed very carefully (i.e. quarantined and distributed properly).

- Research and Innovation – looking forward will be meeting Director of Innovation and then the Charity to talk about how we properly resource - public relations and positioning the brand.
- The Marketing & Communications Team are up for an award 'Covid Comms in House Team award, up against 7 or 8 other companies (inc. Liverpool Museums and Marks and Spencer). Just to be nominated is an honour.

CD recognised that the Staff Awards Ceremony is a morale booster for staff and asked what will happen with next years Staff Awards Ceremony, as normally the Trust would be planning for this just now. MF advised that he is conscious it may have to be different next year, if it has to be done virtually we could look at a Celebration Day/Week or more hopefully a physical summer event possibly inclusive of all Staff. Talking to other Trusts as to how they have put this in place, some are on hold, some are virtual. MF advised this is on hold just now and will be reviewed next year. MF informed the Committee that a virtual weekly star award has been taking place during Covid at the weekly broadcast.

CD drew attention to staff health & wellbeing, particularly in relation to the possible isolation of staff working from home/flexible working and asked how is the Trust reaching those staff. MF advised that there are daily updates emailed to staff along with the broadcasts to keep abreast of what is happening. MF emphasised that it isn't all about centralised news letters etc. MF highlighted the importance of all divisions/departments having a good communication structure in place (e.g. Finance & IT have good communications structure in place). Following on from the work with KPMG, this will be progressed by the Marketing & Communications Dept to embed good ways of communicating and helping divisions/departments to do it well.

FB referred to engagement and people working from home - is there a Trust wide call to staff on the build up to Christmas relating to any opportunities around volunteering/activities, that people could join in whilst working from home. MF thought this was a good idea and he will put it to the Team.

Resolved:
PAWC **received and noted** the content of the Internal Communications Update

Leadership Development & Talent Management

20/51 None to report.

Resolved:
PAWC **noted** there were no updates to receive.

Health & Wellbeing

20/52 **SALS Update**

The Committee received a report (noted as read) outlining the development and implementation of a Staff Advice & Liaison Service (SALS) for all staff to access to the services and outlining next steps. JP shared the highlights since an update was last formally brought to the Committee.

- Like so many things since Covid the service has changed/accelerated. SALS has been successful in recruiting a full time SALS Manager and also on a fixed term a psychologist to support the work of the team, which has seen an increased

demand. Since April this year 500 contacts have been made to the service. Suspect this figure is underestimated as you can often support staff anywhere, not just formal sit down sessions with individuals (i.e. – brief responsive support given to individuals when approached in the Atrium). There are two arms - some staff do not know what they need and part of the value is just helping people understand what is going on. Also early intervention is crucial, organisation wide events to get more information of scale out to staff. Microsoft Teams has been great in supporting live events (i.e. event aimed at Leaders and Managers – psychological first aid – what we can all do to support each other). The Team are keen to develop more of that, but its balancing that with ensuring we respond quickly to people and remain responsive (the same day or next day). Currently the service is available 7 days a week.

- Some struggles is the availability of other services behind SALS (i.e. Alder Centre waiting lists are increasing, which is to be predicted and the poor availability nationally for adult mental heath services is a challenge).
- JP advised she is part of a new Task & Finish Group being set up to support regional resilience – specifically targeting frontline health and social care staff who present with symptoms of trauma. In its first phase but that will offer some capacity around actually offering people treatment. Will involve large scale screening. Looking to improve how we measure what we are doing, but we are not alone as this is a national issue of how you measure well – sickness absence alone is not very reliable indicator as it doesn't tell us about the impact of mental health (i.e. staff could be present in work but having emotional/financial issues/stress problems). Trying to gather a lot of qualitative data, case studies, videos of people of what the service has made to them. Also going to work with regional and national groups about how we measure this nationally, what are the important things to look at.
- The SALS manager is part of the National wellbeing working group developing health and wellbeing conversations – and has taken part in developing the paperwork. Invites to this group has come about due to them hearing about the SALS work that takes place at the Trust. In turn we have been asked by regional and national groups to supply presentations about our service.

CD asked when was the service introduced. JP confirmed January 2020. CD acknowledge the great work of SALS and recognised the requirement, particulary since the pandemic. CD reflected on measurements and the work produced at Blackburne House to support Wellbeing of Staff (sickness absence/emotional wellbeing). MF advised the SALS team have been shortlisted for a HSJ award (embargoed until tomorrow) and acknowledged the importance of this team in looking after us. CD finished by added that this is one of the most important pieces of work at the Trust and will work in the Trust favour in supporting our staff.

Resolved:
PAWC received and noted the SALS update.

The Academy

20/53 None to report.

Resolved:
PAWC noted there were no updates to receive.

Health & Safety

20/54 **Annual Non-clinical Claims report**

Before handing over to Aimee Godsman and Lauren Steele MKS shared the context behind this report (following an MIAA audit that took place recently). For clarity MKS confirmed that this is not an MIAA report, but a Trust report relating to non-clinical claims activity (incorrectly identified as non-clinical claims MIAA report on the agenda). This is the first time this report has come to the Committee. A non-clinical claim audit through the Audit Committee schedule had been undertaken. The report received moderate assurance through the Audit Committee with a number of recommendations. Health & Safety is MKS's remit and non-clinical claims sits under Health & Safety, managed by the manager of Health & Safety and covers sharps, slips and falls. MKS advised that annually SQAC receive clinical claims and thought it would be helpful similarly for PAWC to see annually the kind of activity/costings of the non-clinical claims and also more importantly to see what we can learn to ensure they do not happen again. MKS added that both AG and LS are from Weightmans and an agreement/contractual arrangement has been put in place to manage our non clinical claims (as specific resource not available in the Trust). They have done a fantastic job to get a good outcome for the audit and have also compiled a report. With the H&S manager being on leave they have stepped in to present the findings. Report taken as read. AG/LS picked out the salient points for the Committee.

- The report outlines the ongoing and new non-clinical claims for the last year, the claims come in under the Liability to Third Parties Scheme (LTPS).
- Non-clinical claims – the report shows some trends that can incur lots of costs/damages. There are a couple in the report.
- The last year we have received 8 new non-clinical claims – not a lot in compared to other larger acute non paediatric Trusts (outlined in Benchmark table included in document)
- Since Covid there has been a reduction in claims, two closed claims and 10 ongoing.
- From investigations undertook by AG there is an ongoing issue weight of doors, although we can aniticipat H&S will be able to mitigate the risk and improve doors. The other type of claim is needle stick disposal injuries.
- LS referred to a table in the report and advised that a system has been developed by Weightmans called Tableau, that allows them to analyse the information that the Trust has (in place of NHS resolutions score cards currently used by the Trust). This enables the data to drill down to a greater extent into some of the issues to enable to benchmark the data more accurately and look at trends. This is a secure portal available on-line (i.e. review needle stick claims on a particular ward in a particular period). The offer is there for the Trust at no cost, used at other Trusts.
- Suggestions for the Trust – review the policy for the management and prevention of sharps injuries, or also some training given to staff in the disposal of sharps, infection prevention and also the use and management of them. Along with reviewing the benchmarking data.

MKS acknowledged we have been without resosurce for a time and thanked LS and AG for their support in getting to grip with non-clinical claims and comparisions with

other Trusts. MKS drew attention to the possibility that there may be a cultural side of claims (not unfamiliar with making a claim) with repeat offenders and would be interested to learn from incidents and to see if we are managing processes effectively and the opportunity of closing any loopholes found. Further discussion took place about a the 'claims culture' in some large organisations/companies and it was acknowledged that with a needle stick injury there is no defense as the needle shouldn't be there so it's strict liability, other scenarios were discussed. LS referred to measures in place with NHS Resolution and Weightmans processes for repeat offenders with specialist teams to deal with this that is clear and robust. LS added with that in mind there is some training (a few training slides)that could be shared with the H&S Team to give them some insite of what to look for when dealing with incidents (fundamental honesty).

CW referred to incidents on a particular ward with challenging patients that culliminated in a significant amount of claims and enquired whether they had had an impact on the high figures outlined in the report over the last couple of years? LS advised that they do make up a proportion of the ongoing claims for 2018. Further discussion ensued about special patient restraint training not given to staff in this area. Happy to provide more information. LS asked CW to inform AG of any RCA general outcomes information available in relation to Claims.

CD referred to the costs in the report over the last 10 years particularly for trips/falls and needle stick injury categories and acknowledged that ongoing specific training should support this area especially areas of biggest concentration of incidents. MKS concurred and thought it important this Committee received a similar report as SQAC particularly around lessons learned and what we do as a result of these incidents. CD thanked AG & LS for the report.

Resolved:
PAWC **received and noted** the content of the Annual Non-clinical Claims report.

Equality, Diversity & Inclusion

20/55 BAME Task Force (Action Plan)

The Committee received the action and it is noted as read. CD gave a brief overview and acknowledged the following:

- When the Task Force first got together to map out the areas to review, there was a sizeable list that the Task Force needed to look at.
- The most important one was the Listening Events, a number of these have taken place, with some being very challenging and sad as to some of the issues raised, particularly around progression with people feeling they have not had the same opportunities as their counterparts. A report will be written up.
- Apprenticeships have been looked at and a presentation received at the Task Force. Ongoing work continues behind that.
- Black History Month has gone down exceptionally well – I think people have really learned from that and enjoyed what has been put on. The Deputy Director of Marketing and Communications has done an excellent job. A film was shown, put together by a colleague from Blackburn House, Daughters of the Windrush and the question and answer session was really good, some of the questions were excellent. A great deal of interest.

- Gowing forward we will be looking at a Campaign 'a face like mine' did they see anyone that looks like them, reviewing that campaign just now. Communications will continue via blogs to keep the momentum going.
- Looking to review with the Task Force the first interim report at Xmas to see where we are up to and agree next steps for the year ahead. Really pleased with the progressed made. Also I would like to applaud the BAME staff following 250 letters issued, those that came forward and participated in the Listening Events which apsolutely gave us a rich stream of information that we can act on.

MKS added the feedback was great and it feels like there is some real commitment there to make some real change. MKS thanked CD for leading it.

Resolved:
PAWC **received and noted** the content of the Action Plan

Governance

20/56 **Corporate Report Metrics – October 2020**

MKS advised that similar to other committee's, who receive their section of the actual corporate report, we will now do the same for workforce. The paper is noted as read and includes an overview of workforce KPI's and divisional comparisons. MKS to share a snapshot of the Trust. Mandatory Training dropped a little to just under 90%, acknowledged that is related to Covid as not as much face to face training, but still trying to ensuring there is focus on that and people are still receiving reports and receiving the information that they need. Still pushing PDR's, paperwork revised and simplified to aid conversations, questions added about health & wellbeing, overall 67%, still asking staff to schedule as best they can. Medical PDRs are on track with - doing well. The Committee acknowledged that representatives from the divisions have left the Committee and it was noted that it would be helpful at the next Committee to have their input for people metrics for their respective Divisions. MKS shared (page 69) PDR's Community 73%, a bit more work to be done in Surgery and Medicine, hovering around 57-60%. Sickness – Community 4%, Surgeries risen to just under 7%, so again some focussed work happening with the divisional team in sickness.

CD acknowledge we are a bit late and suggested putting Corporate Report metrics further up the agenda, to enable people to report – then leave if needed.

Action: Move this section to earlier time slot on the agenda.

Resolved:
The Committee received and noted and update on the content of the Corporate Report.

20/57 **Board Assurance Framework – October 2020**

The Committee received a full report, the report is noted as read. ES gave a brief update and referred to the top 5 risks discussed earlier. ES highlighted that there is quite a bit of work going on around the risk framework at the moment. Brought about by the demise of the IGC, the Committee reset and the springing to life of the Care Delivery Board which is very focussed on operational risks. Taking a risk based approach. ES advised for the purposes of people risks, perhaps a bit of attention should be paid to areas like the current gaps in assurance and the actions and making sure that things are bang up to date. ES advised that she will work together with MKS on that. In particular Wellbeing needs attention as it still talks about SALS not being implemented. The other comment is we are working on a 'risk appetite

statement' at the moment, in common with many NHS organisations just now – due to the extraordinary situation that we find ourselves in. Once drafted the Committee will have to have a discussion around where the tolerance of people based risk lies, this can be quantified and also there will be the qualitative work that happens around that too. This will take place over the next couple of Committee cycles with a view to taking to the Board for finalisation and adopted by the board as our risk appetite statement quite formally, ahead of the new financial year.

CD asked for an update on nurse succession planning/age profile. PB advised been quite active in this area, particularly with ward managers and specialist nurses, which is where predominantly our nurses who could retire are working. One thing majored on, previously they were all of a higher banding, so quite difficult to attain. Increasingly now there are teams in place that can progress through the skills and competencies even from a band 5 level into those much more senior roles. Much more robust now for succession planning.

Resolved:
PAWC received and noted the latest position of the Board Assurance Framework.

20/58 **CQC Action Plan**

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. The report outlines the action required and the progress made for two recommendations. ES advised the recommendations are:

- Mandatory Training - specific to ED, discussion has commenced with CW re processes being embedded, just making sure the measures are in place that is a sustainable position for that staffing group, this is on track.
- Appraisal rates – specific to ED – this has now been closed, there are decent levels of assurance and tracking in a timely way. ES thanked everyone concerned for the work on that.

Resolved:
PAWC **received and noted** the content of the CQC Action Plan

20/59 **HEE NW Annual Assessment Visit 2015-2019**

The Committee received a report prepared by the Medical Education Manager. The purpose of the paper was to update the Committee following the Trust's Annual Assessment visit in 2019 and further developments and plans put in place to provide assurance on the progress made.

MKS shared the background information of an Executive summary and for clarity. The quality framework was devised back in 2016/17, HEE developed a whole heap of questionnaires for organisations to complete for HEE to monitor the level of support, training and resource available to staff and students on placement. The version in existence now came into being in 2018. There is the main report which has a number of responses that we need to give around the quality domains (see page 105). Then there is some specific individual reports we need to submit around ED, libraries, incidents, specialists doctors on anything relating to patient safety and human factors. This has been coordinated and led by the Director of Medical Education with input from all of the individual leads who need to respond, (i.e. practice education and medical education). With regards to the submission, all the requirements were met for medical nursing and AHP students and those placements. However there were some gaps within dental and pharmacy training, that we didn't feel met all of the framework requirements. Both of those departments have

developed action plans to make sure we will be compliant and action plans monitored by Department leads. The leads for education will make sure those action plans are tabled at the Education Governance Committee, so we can monitor them as well. This has been submitted now to HEE and we await feedback, they may come back with more questions for clarity.

CD asked if we grade these areas, MKS advised for these particular areas we don't.

Resolved:
The Committee received and noted the content .

20/60 **Policies**

The Committee received the following policies and Equality Assessments for formal ratification/approval. The Deputy Director of HR outlined high level changes and advised all policies had previously been approved at either the Policy Review Group or LNC with the support of Staff Side colleagues. MKS advised of apologies for late papers received and asked if members had had a chance to review in order to ratify.

- **Special Leave**
  MKS advised that there were no significant changes. FB confirmed she had reviewed the policy and appreciated there were minor changes to bring into line. FB advised that the Equality Impact Assessment was a little bit short in terms of the importance of having different kinds of leave. The importance from a gender equality point of view is that we get the balance right between making sure people are available for work/teams can function, but we also can accommodate different kinds of requests for leave that people have. It is gendered. Having it very transparent and even across the different kinds of leave, is an important part of how this is managed. The equality impact assessment should really tease things like that out rather more fully. It really just implied that there were no equality issues. FB added that she didn't think that is the correct approach to take. MKS said this will be taken on board and the Team will have another look at the EIA and thanked FB for her input.

  Action: Special leave ratified subject to an updated Equality Analysis to emphasise the importance of the policy from a gender equality perspective (female dominated workforce) – more specifics required to outline the key points of the potential impact is of not having the policy in place.

- **Supervision of Medical Staff in Training**
  EW advised that a few organisational updated. So no significant update.

Resolved:
The Committee **ratified the policies** and the equality analysis for the above were approved.

20/61 **Board of Directors Summary**

Assurance - Key risks at todays Committee to be noted:

- CD - Sickness to RABD due to financial implications.
- ES - H&S of internal claims,cost implications, safety and welfare of staff. ES suggested that an overarching report of non-clinical claims discussed today and clinical claims (presented at SQAC) may merit being taken to Audit & Risk

Committee – ES to take off line with relevant colleagues and pick up with the Chair of that Committee, next meets in January.

- CD Quality of the Self Assessment HEE, to SQAC, in a quality perspective
- FB – Mandatory Training to CQC.

Resolved:
The Committee agreed the progression of key risks.

Sub Committee/ Working Groups reporting to Committee

20/62 The Committee received the minutes for the following for information.

- LNC – 10.08.20
- JCNC – 24.08.20 & 29.09.20
- Health & Safety – 31.01.20 & 22.04.20
- BAME Task Force – 1.10.20

Resolved:
The Committee **noted** the content of LNC, JCNC, Health & Safety & BAME Task Force.

20/63 **Any other business**
None.

20/64 **Review of Meeting**

CD reviewed the meeting and noted that significant strides forward had been made with Erostering. SALS – amazing work had taken place and acknowledged the issue is the space where they can take people. Staff Questionnaire, need to make the Board aware that we will not be having the same results as last year, no doubt the same as other Trusts. CD advised it was a great meeting and thanked all involved.

20/65 **Date and Time of Next meeting**
19th January 2021, 10am-12noon, via Teams

Minute Reference	Action	Who	When	Status
Assurance on Key Risks				
20/43	• Top 5 Risks – receive an update for approval	MKS	January 2021	
Trust People Plan 2019-24				
20/44	• Sickness rate comparisons with other Children's Hospitals (Manchester/Sheffield/Birmingham)	MKS	January 2021	
Leadership Development & Talent Management				
20/27	• SALS update – review of usage	JP	November 2020	Complete
Health & Wellbeing				
20/28	Sickness Absence/Shielding/Agile Working • Working from home – update on review • Winter plan update – workforce monitoring	 MKS MKS	 November 2020 November 2020	
Equality, Diversity & Inclusion				
20/29 20/42	EDS2 & Workforce EDI Annual Report • Share Procurement strategic government guidelines for sourcing suppliers/services with ES/MKS • Revisit Procurement statement to get a sense of what further action is required. • Share highlights of EDS2 & Workforce EDI Annual Report to BAME Task Force • Present at future Board the Government Framework for Social Value (as part of the Government covid recovery plan to be rolled out in January 2021). Raise with CEO & Chair of Board.	 CD ES/MKS SO CD	 November 2020 November 2020 November 2020 2021	
Governance				
20/30	Terms of Reference / Workplan • Streamline agenda and workplan • Work through a couple of cycles with the new streamlined agenda and workplan – take feedback from Chair/NEDs to guage how its working.	 ES/MKS ES/MKS	 November 2020 2021	 Complete
20/34	HEE NW Annual Assessment Visit 2015-19 • Prepare assurance report for CQC	 ES/MKS	 January 2021	
20/52	Corporate Report Metrics	MKS	January 2021	

	• Move this section on agenda to earlier to support attendance at Committee of Divisions			
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Noted on 19/09/2019 that DMO support is in place for this ongoing action.	ND MKS	November 2020 November 2020	Complete Complete
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed.	MKS/CD	Ongoing	Ongoing
	Engagement			
15/08 16/02	• Develop Values in Procurement, values-based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Ongoing	Ongoing
Equality & Diversity				
20/20 17/13 19/68	• Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	MKS/CD SM	TBC 1/4ly Update 6 monthly Review	 Ongoing Ongoing
Education Governance Update				
18/38	• To be a regular item on the Committee Agenda.	HB	Agreed May 2019	Ongoing
19/91	• Update on HEE action plan	HB	April 2020	Ongoing
Nurse Associate Recruitment				
19/69	Develop a wider plan – to be reviewed	Vikki Hughes	April 2020	
Mandatory Training & CQC				
19/73	To be standard agenda items going forward	MKS/JF	November 2020	Complete

Alder Hey Children's NHS
NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 7th December 2020 at 1:00pm** via Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mrs. C Liddy	Director of Innovation	(CL)
	Dr. F Marston	Non-Executive Director	(FM)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. K. Warriner	Chief Information Officer	(KW)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
In Attendance:	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. J. Hague	External Advisor.	(JH)
	Mrs. E. Hughes	Assoc. Chief Innovation Officer	(EH)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Ms. R. Lea	Acting Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr. D. Powell	Development Director	(DP)
Observing	Ms. F. Ashcroft	CEO of Alder Hey Charity	(FA)
	Mr. S. Jacobs	Public Governor, Wider North West	(SJ)
Item 20/21/48	Mr. J. Taylor	Acting ACOO, Clinical Research Division	(JT)
Apologies:	Ms. J. Blair (JB)	Acting Director of Research	(JB)
	Prof. I. Buchan	Appointed Governor (External Advisor)	(IB)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. J. Grinnell	Director of Finance	(JG)
	Mr. R. Guerrero	Clinical Director of Innovation and Consultant Congenital Cardiac Surgeon	(RG)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)

20/21/42 Apologies

The Chair noted the apologies that were received.

20/21/43 Declarations of Interest

The Innovation Committee noted the declaration received from Fiona Marston in relation to her association with the Liverpool Tropical School of Medicine.

20/21/44 Minutes of the previous meeting held on 22nd of October 2020
Resolved:
The minutes from the meeting held on the 22nd of October were agreed as an accurate record of the meeting.

20/21/45 Matters Arising and Action log

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Action 20/21/26.2: *Board Assurance Framework (Policies for managing innovation risks - Share the policies with the Committee for managing innovation risks, as agreed on the 6.7.20)* – It was agreed to arrange a Teams meeting between

Jonathan Hague, Claire Liddy and Erica Saunders to look at Unilever's policies for managing innovation risks.
Action: KMC

Action 20/21/33.1: *Innovation Strategy Media Campaign (Liaise with Mark Flannagan to discuss Comms support for this area of work)* – An update has been included in the performance report.

Action 20/21/37.1: *Health Tech Seed Fund Proposal (Provide a more detailed report on the Health Tech Seed Fund to enable a decision to be made about progressing the proposal)* – This item has been deferred February as the proposal is still being progressed

20/21/46 Innovation Strategy Discussion Update

The Committee was advised that the strategy has progressed since the last meeting and is heading towards the publication phase. Claire Liddy thanked everyone who participated in the strategy creation session as it was a helpful and beneficial exercise.

The Committee received a presentation on 'Making the Innovation Strategy happen' and was provided with an overview of on the ground and live projects that the Trust is looking to progress, that will hopefully deliver this financial year. Information on the following areas was shared:

- The Trust's elevator pitch – Our Innovation Dream 'Today's Child…tomorrows healthier adult'.
- The project that the Trust is going to be taking forward as part of the strategy - Alderhey@nywhere.
- Two main initiatives of the strategy; Advancings@fety and AccessToC@re.
- Technologies to be included in the strategy; Artificial Intelligence, Meditech RPC, sensors/wearables, immersive and DFD.
- The focus of the Discovery Programmes.
- Spotlight on Artificial Intelligence HQ.
- The next steps:
  - Dare to Innovate Strategy on the brink of being finalised; graphic designed, internal and external stakeholder engagement in January 2021.
  - Brand Agency appointment.
  - Discovery Programmes progressed with deliverables by March 2021.

The Committee was asked to provide feedback on the strategy's elevator pitch and approve the themes that the strategy will take forward. Jonathan Hague and Fiona Marston made a number of suggestions in respect to ensuring that the strategy is kept as simple as possible, includes health outcomes for children and young people along with numbers and metrics to measure impact. It was also felt that depending on how commercially focussed the Trust wishes to be, hard commercial metrics will also need to be incorporated in the strategy. It was suggested that the strapline 'Daring to Innovate' is not aligned to the mission and does not differentiate the Trust.

Fiona Marston raised a query around the budget that would be required if the Trust progressed all of the work described in the strategy and felt that a focus is needed in order to prioritise the themes that the Trust will eventually take forward.

A discussion took place around the importance of focussing on the positioning of the Alder Hey brand and taking the time in which to do this. It was pointed out that innovation needs to be included in the overall Comms Marketing Strategy to establish a synergy. The Committee was advised that Claire Liddy has agreed to take responsibility for appointing a Branding Agency.

Louise Shepherd pointed out that the strategy doesn't refer to partners, the community or the Trust's links with the city, and felt that it is imperative not to diminish the Liverpool story or lose the connection as Alder Hey is a key part of this. Attention was also drawn to the importance of including the health outcomes for children and young people in the strategy.

Amanda Lamb felt that the strategy has progressed immensely and aligns with the work that is being addressed across the city by Health Innovation Liverpool (HIL). It was felt that it is important to make sure that the programmes the Trust is wanting to develop are marketable and that there is also a market to progress them.

The Committee was asked to support the initiatives around 'Advancing Safety' and 'Access to Care' taking into account the comments received during the meeting. Following discussion, it was agreed that the McKinsey diagram in the strategy should be amended to include a reference to health outcomes for children and young people before the themes of the strategy can be approved.

Claire Liddy thanked everyone for their feedback, acknowledged the comments made by members of the Committee and agreed to take note of them when refining the strategy. It was pointed out that the main focus of today's discussion was the two initiatives, which are a subset of the strategy, and it was confirmed that the city region has a dedicated section in the strategy. It is recognised that Alder Hey will have to work with corporate partners and academia to bring in solutions and technical expertise to help deliver the strategy. It was agreed that the strategy needs to focus down even more on the challenges that the hospital faces and wants to solve and the healthcare outcomes the Trust wants to deliver. It was agreed to update the strategy, taking into account the reference to health outcomes for children and young people and re-circulate it to Committee members in advance of February's meeting.

20/21/46.1 **Action: CL**

Resolved:
The Innovation Committee noted the Innovation Strategy update.

20/21/47 **Innovation Performance Report**

The Committee received an update on innovation performance. A number of slides were presented, and information was shared on the following areas.

- Impact to Care: Handover App

  Problem - It was reported that the handover of patients between shifts and within teams pre Covid-19 was all paper based, with multiple sheets printed and carried around the hospital by staff each day.

Solution - Power Apps within the integrated Office 365 infrastructure was used to create a cloud-based digital list that can be securely accessed and edited from any device.

Outcome - The process of patient tracking and handover has been completely digitised, significantly improving the accuracy of handovers and reducing dependence of paper and pen, with safety, environmental and infection control benefits.

- Virtual visiting in NICU.
- NHS X CYPMH.
- Clear Mask Prototype.
- *Chatbot* – It was reported that this area of work is being rolled out on a site in Warrington.
- *Click Audiology Trial* – Hand hygiene solution trial has been completed in the Pathology and feedback has been provided by the Research Department.
- *Brand and Reputation:* (Giant Health Event) – It was reported that a half day virtual international conference took place where the Trust showcased 33 Alder Hey talks about the Trust's achievements and how it has been done, which were delivered by innovative staff and clinicians. It was confirmed that this event has increased the Trust's profile, Twitter followers and contacts.
- Discussions have taken place with three companies in respect to brand and reputation and it was pointed out that further work regarding this matter will take place over the next month. Mark Flannagan highlighted the importance of compiling a plan for the brand and the Branding Agency to ensure clarity around profile and other activity versus brand positioning.

Resolved:
The Innovation Committee noted the update on performance.

20/21/48 Joint Research Projects

The Committee received a presentation on the joint Innovation and Research strategic partnership work that is taking place at the present time. A number of slides were shared with the Committee which provided information on the following areas:

- *Ambitions of the Research Division:* To share research knowledge, experience and infrastructure to explore and test new ideas and innovations.
- Support and guidance for the Click project is being offered via;
  - Protocol development.
  - Advise on regulatory requirements.
  - Sign posting to statistics support.
  - Guidance on recruitment strategy.
  - Research delivery, staff and training.
- *On-going project for measuring hormones in saliva* – This illustrates how a research and innovation project can weave through public and private funding.
- *Key enablers* – **1**. Critical relationships with academic colleagues who have the expertise to strengthen resources for writing grants, protocols and publications in respect to getting our NHS colleagues to have the appropriate support to develop the right skills. **2.** Tangible outputs that speak to academic partners

Claire Liddy advised of the recent discussions that have been taking place around Artificial Intelligence and pointed out that the Trust will have to expand its

capabilities in order to become a global leader in this space. Taking this into account, there is a possibility that there will be opportunities for joint appointments with academic partners. It was confirmed that a further discussion regarding this matter will take place during February's Innovation Committee meeting.

20/21/48.1 **Action: CL**

Resolved:
The Committee received and noted the presentation on the joint Innovation and Research projects that are taking place at the present time.

20/21/49 **Health Innovation Liverpool Update**

The Programme Director for Health Innovation Liverpool (HIL), Amanda Lamb, introduced herself to the Committee and provided an overview of the group of organisations who are taking on the initial financial risk of the creation of HIL; University of Liverpool, Liverpool City Council, Combined Authority and KQ Liverpool.

It was reported that the overarching aim of HIL is to translate knowledge from Research and Development (R&D) into a capability that will escalate and grow the health and life science sector competence across the footprint of the city region.

The Committee was advised that the HIL strategy has three main overarching strategic objectives; **1.** Enable opportunities for productive and healthier lives. **2.** Facilitate a research fuelled pipeline that allows growth across health, lifestyle and digital. **3.** Accelerate global health innovation.

The Committee was informed of a number of areas that HIL is presently developing:

- Next Generation Health Campus.
- Public and private investors.
- R&D collaborations.
- Civic Data Co-operative Programme.
- First patent with a focus on viral particle capture.
- Alder Hey collaboration, with a view that the Trust will become a key delivery stakeholder/partner in the work of HIL.
- Bids.
- Larger strategic programme; asthma child friendly learning health system.

Louise Shepherd thanked Amanda Lamb for the update. It was agreed that Alder Hey's strategy touches on all of the strategic objectives outlined in the HIL strategy, but a question was raised about what can be done to ensure Alder Hey has a definite strategic link with HIL.

Amanda Lamb advised the Committee that the intention was to have achieved a more systemised approach earlier on in the year, but due the pressures of the pandemic progress has been delayed. It was confirmed that resources are now in place to enable recruitment to commence. The first appointment is to be that of a Delivery and Risk Manager who will capture the programmes and introduce some structure. This will alleviate some of the burden so that the respective personnel can continue to co-develop the strategy. Amanda Lamb agreed to meet with Alder Hey in order to provide regular updates, look at how Alder Hey can support development whilst ensuring it is synergistic. Attention was drawn to the importance of ensuring that HIL and Alder Hey are mutually supportive of each other.

20/21/49.1 **Action: CL**

It was reported that Liverpool Health Partnership has currently activated a piece of work that will continue until March 2021with a focus on innovation across Liverpool Health Partners. It was felt that HIL and Alder Hey need to link that thread to reinforce the work that is underway. Amanda Lamb suggested having more visibility in order to strengthen the triangulation of meetings and reduce the risk of gaps.

Resolved:
The Committee noted the update on Health Innovation Liverpool.

20/21/50 Business Development/Partnerships

The Committee received a number of slides that provided an update on the development of partnerships with a number of companies, from an opportunities and status perspective.

It was reported that the Trust would like to work with industry partners that have a global reach and access to technologies/platforms in order to fast track Alder Hey's innovation ambitions. Over the last month, the Trust has been liaising with a number of corporate organisations around the new strategy areas which seem to have resonated with companies. Consequently, there are a number of discussions taking place and contact has been made by partners who wish to further their work with Alder Hey.

Fiona Marston queried the benefits that the Trust has gained from its longstanding partners. It was pointed out that there hasn't been a monetary focus on this area of work during the last five years but the Trust is now in a position to co-create with partners and bring something of value to the table that will provide Alder Hey with revenue, cash in kind, resources/platforms and access to R&D capabilities.

Fiona Marston drew attention to the importance of having a strategy prior to meeting with large corporate organisations to ensure that the Trust achieves its objectives and doesn't share too much information. Fiona Marston offered to support Claire Liddy and Emma Hughes when preparing for these types of meetings.

The Chair queried as to whether there are agreements in place with the companies being discussed, that covers intellectual property (IP). It was reported that following engagement meetings with the respective organisations Alder Hey is going to review the overall relationship in terms of collaboration, agreements, IP, funding and resources. Following discussion, it was agreed to submit a 'Corporate Partnership Schedule' to the Committee in February, April and June that includes an update column identifying as to whether agreements are in place, a brief overview of the Heads of Terms so that the committee can be assured that agreements are being signed off and that Alder Hey is only sharing specified information.

20/21/50.1 Action: EH

Jon Corner drew attention to the data that will spin out of these corporate relationships that will provide Alder Hey with leverage, and raised a question about the Trust's Data Strategy in terms of what it is and how it will utilize its data as a future platform for innovations that are being developed. Jonathan Hague pointed out that Alder Hey has got the data that these organisations covert and felt that the Trust should enter into an alliance framework agreement when partnering with a company, in order to protect Alder Hey's IP rights. The Chair asked that an alliance framework agreement be incorporated as part of the Trust's standard documentation.

20/21/50.2 Action: EH

Amanda Lamb advised that the director who has been appointed by HIL to lead on CDC has experience of dealing with three of the organisations that the Trust is liaising with and offered his support as meetings progress with these partners. Jonathan Hague felt that it would also be beneficial to keep Peter Gallaher involved in this area of work too from an advice and support perspective.

A discussion took place around the governance element of the sign-off arrangements for agreements and it was queried as to whether Committee approval is required at the present time. It was confirmed that approval isn't required at this stage and it was pointed out that the purpose of the update was to provide an overview of how the Trust is applying the strategy in terms of the companies that it is liaising with. Fiona Marston felt that it would be beneficial for the Committee to receive a brief overview of the Heads of Terms for respective partnership agreements to enable Committee feedback prior to sign-off.

20/21/50.3 **Action: EH**

A discussion took place on the benefits and importance of having a Data Strategy. It was reported that Tektology are experts in data, AI and strategy space and have been commissioned to do a piece of work for the Trust on its Data Strategy. Claire Liddy invited Jon Corner and Jonathan Hague to participate in the interviews that are being scheduled with Tektology in order to share their experiences with small and global companies from a data perspective.

Resolved:
The Committee noted the update on business developments and partnerships.

20/21/51 **Inward Investment Pipeline**

The Committee received a number of slides that provided an update on submitted bids and grants that the Trust has applied for, including those that have been successful. It was reported that the Trust has submitted a number of proposals for local initiatives and programmes. The Committee was advised of the status of these proposals and the next steps required to progress them.

Resolved:
The Committee received and noted the Investment Pipeline update.

20/21/52 **Innovation Committee Terms of Reference**
Resolved:
The Committee received and approved the revised Innovation Committee Terms of Reference.

20/21/53 **Innovations Limited Update**

The Committee was provided with an update on the governance and structure of all companies that Alder Hey have an equity interest in. The following points were raised:

AH Living Hospital – An agreement was made in February 2020 that the Charity would exit the Joint Venture (*Alder Hey Living Hospital*) and would gift its 50% shareholding to the Trust. This was transacted in March 2020 and the appropriate paperwork was completed on Companies House to remove the charity directors and transfer the share ownership to the Trust. The company is now a 100% wholly owned subsidiary with Alder Hey as the only shareholder. It was confirmed that all filings for the company are up to date.

The Committee was advised that the Trust is currently in dialogue in terms of the future of this company and a recommendation will be submitted following the conclusion of discussions.

Acorn Spin Out Companies – Alder Hey has issued notice to 'We Are Nova' advising of the companies that are to be formally closed as they are no longer active. This matter has been ongoing for a number of months and the Trust has still not received confirmation that these companies have been closed. The secretarial remit for these companies is the responsibility of 'We Are Nova'. The Trust has contacted this partner on numerous occasions all to no avail therefore the next step will be to seek legal advice.

Acorn Limited – The recommendation is still for Alder Hey to exit this agreement and company; however this will happen once the Trust receives confirmation that the spin out companies have been closed and the appropriate company structures are in place for the two remaining companies, Hygiene Ltd and Audiology Solutions Limited. It was confirmed that the Trust will also be seeking legal advice on this matter too.

Hand Hygiene Solutions – The product development is ongoing. Trial units for the product have been installed in the Trust and are undergoing some technical troubleshooting. It is expected that the trial will commence mid-December and the outcome of this trial will determine the next steps. The company has a Chief Executive in place who is progressing this work. There is funding in place to continue with the trial and once the outcome has been concluded, the next stages of funding can be determined.

Audiology Metrics Limited (Click) – There is no funding currently within the company to allow next steps to progress; the company is applying for grants to continue operations. The next step is a clinical trial which Alder Hey Research and Audiology teams are keen to support. Alder Hey has requested sweat equity in return for trial resource and this is under consideration by all shareholders.

The committee was asked to note the contents of the report and the following actions that are to be progressed:

- Confirm a company secretary to be responsible for the administration, running and governance of all companies on behalf of Alder Hey.
- Proposal to be submitted to the Committee on the 8.2.21 on the on-going future of Alder Hey Living Hospital Limited confirming as to whether it should be closed down or continue as wholly owned subsidiary.

20/21/53.1 **Action: RL**

- Legal advice to be sought on escalating the closure of the Acorn Spin Out companies.

Resolved:
The Committee received and noted the Innovation Limited update and the actions to be progressed.

20/21/54 **Board Assurance Framework**

It was confirmed that a revised version of the Board Assurance Framework will be submitted to the Committee in February.

Resolved:
The Committee received and noted the Board Assurance Framework for October 2020/21.

20/21/55 Any Other Business

There was none to discuss.

20/21/56 Review of the Meeting

It was felt that the Committee addressed all key areas during the meeting.

Date and Time of next meeting: Monday the 8th of February 2021 at 1:00pm, via Microsoft Teams.