NHS
Alder Hey Children's
NHS Foundation Trust

**BOARD OF DIRECTORS PUBLIC MEETING**
**Thursday 25th March 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 |
|---|---|---|---|---|---|---|---|
| **STAFF STORY (9:00am-9:30am)** | | | | | | | |
| **1.** | **20/21/268** | **9:30 (1 min)** | **Apologies.** | Chair | To note apologies. | **N** | For noting |
| **2.** | **20/21/269** | **9:31 (1 min)** | **Declarations of Interest.** | All | Board members to declare an interest in particular agenda items, if appropriate. | **R** | For noting |
| **3.** | **20/21/270** | **9:32 (3 min)** | **Minutes of the Previous Meeting.** | Chair | To consider and approve the minutes of the meeting held on: **Thursday 25th February 2021.** | **D** | Read minutes |
| **4.** | **20/21/271** | **9:35 (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 |
| **COVID-19 Assurance Plan – Alder Hey's Plans for Recovery** | | | | | | | |
| **5.** | **20/21/272** | **9:40 (40 mins)** | • **Update on the 'Brilliant Basics' Programme.**<br>• **Access and Restoration update.**<br>• **Staff/Patient Safety:**<br>- **Covid-19 Vaccine update.**<br>- **Staff Safety Metrics.**<br>• **COVID Risk Register.** | J. Grinnell<br>A. Bateman<br>M. Swindell<br>M. Swindell<br>J. Grinnell | To provide an update on the 'Brilliant Basics' programme.<br>To provide an update on access and restoration of services.<br>To provide an update on the Covid-19 vaccine for staff.<br>To provide an update on staff absences and testing.<br>To discuss the current key risks. | **I**<br>**A**<br>**A**<br>**A**<br>**A** | Presentation<br>Read report<br>Presentation<br>Presentation<br>Read report |
| **Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led** | | | | | | | |

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| **6.** | **20/21/273** | **10:20 (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 |
| **7.** | **20/21/274** | **10:30 (10 mins)** | **Position Statement for PALS and Complaints, Q3.** | N. Askew | To receive the position statement for Q3, 2020/21. | **A** | Read report |
| **8.** | **20/21/275** | **10:40 (10 mins)** | **DIPC Report, Q3.** | B. Larru | To receive the position statement for Q3, 2020/21 | **A** | Presentation |
| **9.** | **20/21/276** | **10:50 (10 mins)** | **Update on the Current Demand and Access to Locality Based Specialist Mental Health Services and Eating Disorder Service.** | L. Cooper | To receive an update. | **A** | Read report |
| **10.** | **20/21/277** | **11:00 (10 mins)** | **Cumulative Corporate Report Metrics - Top Line Indicators:**<br>• **Quality.**<br>• **Safety.** | N. Murdock<br>N. Askew | To receive a report of Trust performance for scrutiny and discussion**,** highlighting any critical issues. | **A** | Read enclosure |
| **The Best People Doing Their Best Work** | | | | | | | |
| **11.** | **20/21/278** | **11:10 (5 mins)** | **Cumulative Corporate Report Metrics – Top Line Indicators:**<br>• **People.** | M. Swindell | To receive a report of Trust performance for scrutiny and discussion**,** highlighting any critical issues. | **A** | *Refer to item 10* |
| **12.** | **20/21/279** | **11:15 (10 mins)** | **Alder Hey People Plan Update:**<br>• **Staff Recovery and Reward Plan.**<br>• **NHS Staff Survey 2020/21 Results.** | M. Swindell<br>M. Swindell | For information and discussion.<br>To present the Staff Survey Results for 2020/21. | **A**<br>**A** | Read report<br>Verbal |

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| **13.** | **20/21/280** | **11:25 (10 mins)** | **EDI Task Force Group Report.** | C. Dove | To receive the final report from the EDI Task Force Group. | **A** | Presentation |
| **14.** | **20/21/281** | **11:35 (10 mins)** | **Freedom to Speak Up.** | K. Turner | To receive an update on the current position. | **A** | Read report |
| **Game Changing Research and Innovation** | | | | | | | |
| **15.** | **20/21/282** | **11:45 (10 mins)** | **Position Statement – Research and Innovation.** | J. Blair/ C. Liddy | To note the current position. | **A** | Presentation |
| **Strategic Update** | | | | | | | |
| **16.** | **20/21/283** | **11:55 (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 |
| **Lunch (12:05pm-12:30pm)** | | | | | | | |
| **Strong Foundations (Board Assurance)** | | | | | | | |
| **17.** | **20/21/284** | **12:30 (10 mins)** | **Financial Update:**<br>• **2021/22 Interim Financial Plan.**<br>• **Position for M11.** | J. Grinnell | To provide an update on the 2020/21 forecast year end position and to seek approval on the interim 2021/22 financial plan for the organisation.<br>To provide an overview of the position for Month 11. | **D**<br><br>**A** | Read report<br><br>Presentation |
| **18.** | **20/21/285** | **12:40 (10 mins)** | **Draft Risk Appetite Statement.** | J. Grinnell/ E. Saunders | For discussion. | **A** | Read report |
| **19.** | **20/21/286** | **12:50 (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 |
| **20.** | **20/21/287** | **12:55 (15 mins)** | **Board Assurance Committees; report by exception:**<br>• **Resources and Business Development Committee:**<br>- **Chair's verbal update from the meeting held** | I Quinlan | To escalate any key risks, receive updates and note approved minutes. | **A** | Verbal/ read approved minutes |

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| | | | **on the 22.3.21.**<br>- **Approved minutes from the meeting held on the 25.1.21 and the 22.2.21.**<br>• **Safety & Quality Assurance Committee:**<br>- **Chair's verbal update from the meeting held on the 24.3.21.**<br>- **Approved minutes from the meeting held on the 17.2.21.**<br>• **People and Wellbeing Committee:**<br>- **Chair's verbal update from the meeting held on the 23.3.21.**<br>- **Approved minutes from the meeting held on the 25.1.21.** | F. Beveridge<br><br>C. Dove | | | |
| **Items for information** | | | | | | | |
| **21.** | **20/21/288** | **13:10 (4 mins)** | **Any Other Business.** | All | To discuss any further business before the close of the meeting. | **N** | Verbal |
| **22.** | **20/21/289** | **13:14 (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, 29th April 2021, 9:00am-1:00pm, via Microsoft Teams.** | | | | | | | |

| REGISTER OF TRUST SEAL |
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| The Trust Seal was not used in March 2021 |

| SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION | |
| --- | --- |
| Corporate Report | Executive Leads |
| CQC Action Plan | E. Saunders |
| DIPC Monthly Exception Report | Dr. B. Larru |
| NHS Staff Survey 2020/21 Results | M Swindell |
| Financial Metrics, M11 | J. Grinnell |
| Cheshire and Merseyside Cancer Alliance Performance Report | A. Bateman |

Alder Hey Children's NHS
NHS Foundation Trust

# PUBLIC MEETING OF THE BOARD OF DIRECTORS

**Confirmed** Minutes of the meeting held on **Thursday 25th February 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) |
| | 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 Services | (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. 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) |
| **Patient Story** | Ms. C. Owens | Patient's parent | (CO) |
| | Ms. L. Stubbs | Physiotherapist | (LS) |
| | Ms. V. Furfie | Clinical Information Officer | (VF) |
| **Observing** | Ms. Liz Richards | NHS Professionals | (LR) |
| | Mr. Chris Murphy | NHS Professionals | (CM) |
| **Apologies:** | Prof. M. Beresford | Assoc. Director of the Board | (PMB) |
| | Mrs. C. Dove | Non-Executive Director | (CD) |
| | Mrs. C. Liddy | Director of Innovation | (CL) |
| **Item 20/21/249** | Dr. B. Larru | Director of Infection Prevention Control | (BL) |

**Patient Story**

The Chair welcomed Oliver's mum, Carissa, who was invited to February's Trust Board to share her son's journey with Alder Hey. The Chair also welcomed Lowri Stubbs, Oliver's physiotherapist, and the Trust's Clinical Information Officer for the Community and Mental Health Division, Vicky Furfie, who was supporting Carissa from an IT perspective.

The Board was advised that Oliver has a diagnosis of Spastic Diplegic Cerebral Palsy and underwent surgery in February 2020. Oliver's story explains how well he has done post-surgery especially considering that he had to complete his rehab during the initial stages of the Covid-19 pandemic.

Carissa informed the Board that Oliver spent the first six weeks of his life on ICU and she was advised that there was no cure for Oliver and that he wasn't a good candidate at that time for an operation that would help him to walk. As Oliver got older, he told his mum that all he wanted to do was to be able to walk to the shops. Following a successful operation last year, Oliver is now able to walk, run and dance. Mum pointed out that the operation was an amazing success and that she could see the benefits in such a short period of time. Carissa advised that Oliver received wonderful support from the Trust's Physiotherapy Team throughout the whole process.

Lowri Stubbs provided an overview of the physiotherapy support that Oliver received; as part of Oliver's management he was seen by two highly qualified physiotherapists, his parents received a physio programme and equipment was provided by the Trust's Charity. Lowri pointed out that Oliver surpassed post-operative expectations within a seven to nine month period and is now able to participate in a range of activities. Lowri reflected upon the reasons that Oliver has done so well and felt that having the support of two qualified physiotherapists in the initial stage of Oliver's journey contributed to his success, he was also seen at home where it was more comfortable and the service was flexible and reactive to Oliver's needs post-surgery which also helped.

Carissa informed the Board that she felt very nervous about Oliver having the operation but advised that there wasn't anybody to speak to about the expected outcome of this type of surgery. Carissa made contact with other parents whose children had had the same treatment and managed to get some feedback via this route. Carissa felt that parent's concerns would be alleviated if there was a case study to review or a professional available to offer advice. As it was, Carissa had a whole year worrying about Oliver's surgery. It was reported that Oliver was quite nervous too on the run up to his operation and accessed the Play Service which helped reduce his anxiety. Mum advised that the service was marvellous and helped a great deal.

Carissa informed the Board that she gained a lot of confidence following discussions with Alfie Bass. The Board was advised by Alfie Bass that the outcome of post-surgery has improved immensely following engagement with the Trust's physiotherapists who are based in the community and without their support the outcomes wouldn't be as good as they are. The Chair queried as to whether it is possible to establish a parents' support group. It was reported that a number of families have volunteered to take this idea forward.

On behalf of the Board, the Chair thanked Carissa and Oliver for attending February's Trust Board in order to share their story.

**20/21/243 Welcome and Apologies**

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

**20/21/244 Declarations of Interest**

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

**20/21/245 Minutes of the previous meetings held on Thursday 28th January 2021**
**Resolved:**
The minutes from the meeting held on the 28.1.21 were agreed as an accurate record, pending the following amendment:

- Agenda item 20/21/281, last paragraph, sixth line – The sentence should read: 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.

**20/21/246 Matters Arising and Action Log**

There were no matters arising to discuss, and the actions relating to February have been addressed.

**20/21/247 Update on the Future of Integrated Care Systems (ICSs), Commissioning and Provider Collaboratives**

Louise Shepherd provided an overview of the journey that the NHS has been on since the '5 Year Forward View' was issued in 2014 by Simon Stevens, which set out the vision for bringing services together in a much more meaningful way than had been the case for a long time.

The publication of the current White Paper is the latest significant moment for the NHS. The proposals will formally enshrine into legislation some significant changes about how the heath service will work, in particular the changes to the commissioning landscape. The paper sets out the direction of travel with the integration of social care and local authorities and the expectation that ICSs will work closely with social care. There is no financial structure in place at the present time or detail of how things will work on the ground, though there is an expectation that local areas will address the detail in their own system.

The Board was advised that there is no mention of children's services in the White Paper but there is an expectation that it will provide a significant opportunity in the North West and across Cheshire and Merseyside to create a Children and Young People's Board and a collaborative that will bring together all of the partners who are interested and passionate about children's services to create something new. Attention was drawn to the importance of taking this opportunity. It was pointed out that future funding will flow into programmes as activity based budgets will eventually cease.

The Trust has been working really hard behind the scenes to engage with partners in respect to children's services and get them involved with this area of work. Part of the challenge is that there is a lack of detail at the present time in respect to children and young people, but it is imperative that the Trust provides support and plays an active part in the healthcare partnership in Cheshire and Merseyside, which will formally become an ICS in April 2022. Alder Hey also needs to be prepared for the forthcoming changes in order to support children and young people and the services that the Trust is planning to develop and progress.

It was pointed out that there are going to be a lot of opportunities as well as a year of change and challenges, but it was felt that the opportunities that arise must be taken in order to do something meaningful for children and young people.

The Board received an update on the future of Integrated Care and the Cheshire and Merseyside system. A number of slides were shared with the Board which provided information on the following areas:

- *Context:*
  - Analysis of ICS Legislative proposals and impact on Alder Hey was submitted to the Trust Board in December 2020.
  - Alder Hey submitted three Alliance responses, as per Trust Board agreement in January 2021.
  - NHSE/I White Paper – 'Legislating for Integrated Care Systems' – Five recommendations to be submitted to Government and Parliament by February 2021.

- *White Paper - 5 Recommendations:*
  - Government should set out at the earliest opportunity how to progress the NHS proposals for legislative change.
  - ICSs should be put on a clear statutory footing with minimal national prescription and maximum local operational flexibility.
  - ICSs should be underpinned by an NHS statutory body and a wider statutory Health and Care Partnership.
  - Maximum local flexibility for how partnership is constituted – Chair and CEO, reps from NHS Trusts, GPs and Local Authority (NHSE/I to approve ICS constitutions).
  - Provision should enable transfer/delegation of services to ICS and include appropriate specialised services. NHSE/I should retain ability to specify national standards/requirements for these to ICS's.
- *What this means for Alder Hey:* Future directions/Alder Hey actions.
- *Next steps:*
  - **National:** Consultation on draft proposals for Legislative Reform - response to be submitted by the 7th of April.
  - **Cheshire and Merseyside (C&M):** HCP MOU – notification of intention re approval is required by the 12th of March 2021 – it is recommended that the Trust Board supports the direction of the C&M MOU.
  - **Trust Board:** Strategy Session scheduled for the 29th of April to consider the impact of the changes on strategic direction/priorities.

Fiona Beveridge asked as to how the public health 'Prevention and Promotion' agenda will fit in with the forthcoming changes. It was reported that public health is subject to a number of changes that flow from the White Paper. Public health is at the core of all the place work that the Trust is doing, and Alder Hey is working really hard to make sure that it is well integrated both at place level and Cheshire and Merseyside level, whilst working closely with public health. Anita Marsland offered to link in with Dani Jones to provide an update on the overall transition of the public health pitch.

It was pointed out that there is a lack of clarity in respect to which specialist services will be appropriate for delegation to ICS's and therefore there is a need to continue to shape the role of the Specialist Trust Alliance in an ICS context. Louise Shepherd advised that proposals were put forward as part of the Specialist Trust Alliance, the Children's Hospital Alliance and the local system but it was pointed out that there is a group of specialist trusts that need to continue to develop the offer into the system. Over the next couple of months there is a necessity to come together as a group in order to decide upon the stance that is to be taken to support the Cheshire and Merseyside ICS in the most effective way. Suggestions have been made in respect to bringing clinical people together to discuss the leadership role that the Alliance can play across the system and why specialist services are important. Louise Shepherd advised the Board that the Alliance has a responsibility to address this area of work and felt that linking research with the clinical offer would make it more coherent and compelling.

Nicki Murdock advised of the challenges that are being experienced in respect to bringing leads from the various specialist trusts together due to the impact of the pandemic taking focus elsewhere. The Chair felt that it would be beneficial to include this item on the agenda of the next specialist trusts' CEOs' and Chairs' meeting.

**20/21/247.1 Action: LS**

The Chair commented that the session was really useful and provided a comprehensive overview on the future of ICS's and the recommendations in the White Paper. The Chair thanked Dani Jones and all those involved for the hard work that has taken place and for laying the foundations to enable Alder Hey to move in the right direction. Attention was drawn to the work that Adrian Hughes has been conducting is association with District General Hospitals in the region. Louise Shepherd advised of her support for this work which will play a significant part in forthcoming changes and pointed out that it has been handled really well. It was reported that the Board will return to the future of ICS's during a strategy session that has been scheduled to take place on the 29.4.21.

**20/21/248 Alder Hey in the Park Campus Development**

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

- *Park Reinstatement Phase 1* - The Board was advised that the Trust is on track to meet the extended deadline for completion of Phase 1 of the park reinstatement. It was confirmed that a handover meeting for Phase 1 is due to take place with Liverpool City Council (LCC) w/c 1.3.21. The next stage of the process is to complete Phase 2 which is in the process of going out to tender.
- *Park Reinstatement Phase 2 and 3* - The Board was advised of the issues being experienced from a budget/specification perspective in respect to the reinstatement of Phase 2/3 of the park. An exercise on costing is currently in progress and when concluded will be submitted to the Resources and Business Development Committee for review.

  Capacity Lab has been working with the community on the idea of a Community Benefits Society. The Board was advised that there has been a lot of interest in this idea therefore discussions are going to take place with LCC to see if this idea can be adopted and established.
- *New Neonatal Unit* – The Neonatal Unit project is currently at stage 3 of the design element and will be ready to tender at the conclusion of this stage.
- *Infrastructure Works and Commissioning* – The Trust has been looking at agreeing a district heating system that utilises the water system that runs under the Campus. It was reported that the Trust has received a grant from the Government in order to engage in the survey work for this project. If the survey work has a positive outcome it will enable direct ground source heating to be installed and flow through all of the hospital buildings. Attention was drawn to the importance of this project in respect to the organisation's Green and Sustainability agenda. It was confirmed that Alder Hey has been given permission to progress the survey.
- *North East Plot Development* - Step Places have submitted their plans to the Planning Committee and expect an outcome late spring/early summer. The Trust continues to work on options to ensure the development can support Alder Hey.
- *Relocations* – Options have been explored in respect to the requirement of additional office accommodation. A value for money exercise has been conducted and a recommendation to purchase an offsite building is to be submitted to Resources and Business Development Committee (RABD) for approval.

The Chair pointed out that there will be some critical decisions made over the next few months but felt that it is really positive to see that Phase 1 of the park is on track to meet the extended deadline for completion.

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

**20/21/249 Covid-19 Assurance Plan – Alder Hey's Response to the Third Wave**

*Progress on the Trust's response to the Third Wave*

The Board received an update on the Trust's response to the 3rd wave of the pandemic. Information on the following areas was shared:

- *Wave 3 priorities:*
  - Full paediatric critical care capacity was maintained, however this was not required.
  - 82% of planned care capacity was maintained.
  - Adult pod opened on ICU.
  - Paediatric capacity for Cheshire and Merseyside was maintained, however this was not required.
  - Five staff volunteers supported the Nightingale Hospital.
  - 84% of staff have received their first dose of the Covid-19 vaccine and mutual aid was offered to Liverpool Heart and Chest Hospital (LHCH).
- *Context:*
  - Referrals are 26% down on the same point as last year
  - Infection rates are dropping rapidly.
  - Hospital admissions have seen a sharp decrease.
  - Covid hospital occupancy levels are dropping more slowly and some hospitals are still very tight on critical care capacity.
- *Alder Hey's key highlights:*
  - 9 adults were treated in critical care.
  - 84% of staff have been vaccinated and second dose plans are in place.
  - Staff can access vaccinations from LHCH and CCC
  - Absence dropped from plus 10% to now c7%.
  - 86% of outpatients were maintained.
  - 82% of planned theatres were maintained.
  - Low nosocomial infection rates among children, young people and staff.
  - Targeted welfare programme in place.
  - Governance 'lite' in operation.
- *Next Phase – Immediate priorities:*
  - Test and trace.
  - Vaccination.
  - Welfare/resilience.
  - Restoration.
  - Recovery and transformation.
  - Readiness for any future wave.

The Chair pointed out that the last month has been really challenging for the Trust and asked that thanks be relayed on behalf of the Board to colleagues in PICU and staff members who have helped in that area. The Chair also thanked the Executive Team for their strong leadership during 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 January 2021. The following highlights were shared with the Board:

- It was reported that the Trust has continued to sustain a high-level of planned care, as well as maintaining urgent, emergency and critical care services. In January an adult intensive care unit (AICU) was established which 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 the Trust delivered between 100 and 110 sessions per week relative to the usual schedule of 149 sessions.
- *Outpatients* - The Trust has increased overall activity in outpatients, relative to December, but the proportion of activity restored fell in-month to 86% in January 2021.
- *Elective and Day Case* – Activity has been reduced in these two areas following the provision of mutual aid.
- *Diagnostics* – A high level of activity has been maintained relative to January 2020 and is at 97% as of January 2021.
- It was reported that during January the number of patients waiting over 52 weeks for treatment increased to 222. The Board was advised that in March the organisation will start to develop service plans with all specialities that will set out the high impact action that will improve waiting times in that speciality. There will be a focus on four themes; demand management, productivity, safe waiting list management and expanding capacity.

The Chair thanked Alfie Bass and his team for the work that took place to maintain theatre lists, taking into account the challenges that have been experienced.

Staff/Patient Safety

*Covid-19 vaccine update*

It was reported that 84% of the Trust's workforce has received the first dose of the Pfizer Covid-19 vaccine. A table relating to the breakdown of staff groups who have received the vaccine was shared with the Board which indicated that 79% of BAME colleagues have received their first dose of the vaccine. Work is taking place to ensure that everyone has had the opportunity to take up the offer of the vaccine and guidance from Liverpool Women's Hospital has been received in order to offer information on the queries that have been raised in respect to fertility and having the vaccines.

The Board was advised that the Trust is on track to offer the second dose of vaccine to staff. It was pointed out that staff wanting the Oxford vaccine can access it via Clatterbridge.

*Staff safety metrics*

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

- Overall absence - 6.74%.
- There are 35 members of staff who are symptomatic or have been confirmed as Covid +.
- There are 12 members of staff who are self-isolating.
- There are 22 members of staff who are shielding.

- It was reported that the Trust is seeking national guidance to support re-deployed staff and have an understanding of the long-term plan.

*Infection Prevention and Control Assurance (IPC) including nosocomial infections*

It was reported that NHS Public Health England (PHE) has published a third version of the guidance for IPC recommendations and NHS England (NHSE) has published a new IPC Board Assurance Framework document.

The Board received an update on the IPC Board Assurance Framework. A number of slides were submitted which provided information on the following areas:

- The layers of interventions that have been implemented across the Trust to keep children, young people and staff safe.
- The process that the Trust is following for discussing, agreeing and updating PHE/NHSE guidance within the Trust.
- Examples of domestic decontamination and IPC working together to keep the hospital clean and safe.
- Point of care testing.
- *PPE guidance* – The Trust is trying to produce PPE via innovative ideas in order to simplify equipment and make it more comfortable for the end user.
- *Isolation facilities* – Work is taking place to look at how isolation bays can be used more efficiently, particularly in the surgical units in order to support the re-opening of many theatre lists.
- *Access to laboratory support* – The department constantly looks to bring new technologies to the Trust that are suitable for paediatrics.
- *Occupational Health and needs and obligations of staff in relation to infection* – There is a track and trace team that sits within IPC. The team has been able to support people who have been exposed to Covid-19, educate and have a good overview of any outbreaks of Covid-19 within the Trust.
- *PHE Pilot* - The Trust is participating in a PHE pilot that allows quarantined staff to be tested on a daily basis and enables Alder Hey to review staff absence if the respective staff member is a low risk.
- The Board was advised that the majority of the IPC guidance is designed for adult patients, but it was confirmed that Alder Hey is compliant with all relevant areas of the IPC BAF.

The Chair thanked Beatriz Larru for her leadership and drew attention to the wonderful work that is taking place to keep patients and staff safe, along with the support of new technology.

**Resolved:**
The Board noted the IPC BAF update.

*Safe Waiting List Management Update*

The Board received an update on the progress that has been made since January 2020. The following points were highlighted:

- *Data quality* – 17,953 records have been validated on full unfiltered inpatient and outpatient referral to treatment (RTT) waiting lists. Staff have worked really hard on this data exercise and it was reported that the Trust is looking to complete the validation of a c 44,000 records by the end of April 2021.
- *Safety of patient care* – Validation identified 81 additional patients who needed to be included on the waiting list for patients waiting over 52 weeks for

treatment. It was reported that 54 of these patients have now been treated and there are 16 who have been scheduled to receive treatment within six weeks. The remainder of patients within this group have chosen to delay treatment until after the pandemic. The Board was advised that 79 out of 81clinical reviews have been undertaken to date following the validation exercise and it was confirmed that zero harm was reported.

- *Electronic Patient Pathway Forms (EPPF)* – An E-learning training module is to be made available in March 2021 and an improved EPPF is to go live in March. Staff have been made aware of the forthcoming changes to EPPF via a number of communications over the last seven weeks.
- *National Model for Clinically Prioritising Children (access to theatres*) – It was reported that the Trust is working with other paediatric hospitals to amend the priority code (P code). The Board was advised that there are 58 P2 patients on the waiting list, 42 have a scheduled TCI within the next three weeks all within the P code time frame. It was confirmed that no patients have waited longer than the priority code allocated.

The Chair queried as whether the Trust has had any expressions of concern from parents regarding this matter. It was reported that there have been a number of concerns raised but there have been no formal complaints. Families have been very understanding and have acknowledged the difficulties that the Trust has been experiencing as a result of the pandemic.

*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. The following points were highlighted:

- The Board was advised that there have been a number of risks on the register that have either been downgraded or closed and it was felt that the themes are still consistent with the current environment. Attention was drawn to the risk relating to access to services that is one of the key risks for the Trust.
- *Risk ref: 1560 (Risk of patients breaching 18 weeks referral to treatment - CAMHS)* – It was reported that there has been a 20% increase in referrals since the start of the pandemic, along with an increase in the complexity of children and young people presenting with mental health issues since the last lockdown. The Board was advised that all children on the waiting list are telephoned on a regular basis, psychiatry leads are in post and work is taking place to bring clarity around choice and partnership appointments. It was confirmed that there are no patients waiting over 52 weeks, but the Trust is continuing to monitor this area of work.
- *Risk 2285 (Risk to Operational Delivery Network function as pandemic impacts on the ability of providers with the North West All Age Congenital Heart Disease Partnership (ACHD Partnership) to continue to provide normal services)* – The Board was advised that the main issue relating to this risk is the bringing together of two services to deliver equity of access across the North West. It was reported that Manchester University NHS Foundation Trust had transferred their cardiology RTT waiting lists to the joint service but at a later date found a list that included a significant number of patients waiting for treatment that they were unaware of. It was confirmed that this list is being reviewed independently to see if any harm has come to these patients and whether the wait has had an effect on any patients who have died that were on the waiting list. It was reported that joint meetings are held on a six monthly basis, but Alder Hey has suggested that meetings need to

take place more frequently. The Chair queried the timeline of the independent review. Nicki Murdock agreed to look into this and provide confirmation of the date.

**20/21/249.1** **Action: NM**

Fiona Beveridge queried as to whether this issue is having an effect on Alder Hey's waiting lists. It was confirmed that it is not.

Louise Shepherd highlighted the importance of bringing this matter to the Board's attention as the Board is holding a lot of risk that it isn't sighted on and therefore has a responsibility to review this issue. It was pointed out that the partnership with LHCH and MFT is key for Alder Hey, but attention was drawn to the importance of having confidence in respect to the governance arrangements that are in place when developing partnerships. The Chair highlighted the importance of understanding the lines of accountability and governance arrangements to enable the Board to be clear on the risks that that it is managing. Nicki Murdock agreed to provide an update on this issue during April's Trust Board.

**20/21/249.2** **Action: NM**

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

**20/21/250 Division of Surgery: Governance and Safety Rates Update**

The Board received a presentation on improving safety and governance in the Surgical division. The following points were highlighted:

- Safety and Governance Improvement Strategy:
  - Clear leadership and structure to the governance team.
  - Integrated medical governance with ward and theatre governance to ensure engagement of medics in the division.
  - Key headlines and issues to feed into DIG by exception.
  - Sharing of learning from RCA's and cultural work.
  - Divisional governance meeting to feed into CQSG.
- New 72-hour review panel process has been implemented to review any moderate or above harm incidents in surgery.
- Strategic themes and specific objectives have been identified with a timeline for completion:
  - Establish Divisional Governance Group with Divisional Director, CAN, Medical Governance Lead and two Quality Officers – Completed January 2021.
  - Departmental Governance Leads (0.5 PAs in Job Plan) – Completed August 2020.
  - Standardise documentation for departmental governance meetings, covering full breadth of governance agenda – Completed January 2021.
  - Ward Challenge Boards – To commence in March 2021.
  - M&M module incorporated into Ulysses – Pilot completed in December 2020.
  - Twice weekly 72-hour harm meeting – Established in February 2021.
  - Clean-up of Ulysses – Feasibility established.
  - Training package for governance leads – Being developed.
  - Focus on shared learning; monthly safety bulletin, annual Safety Day – Planned for August 2021.

- The Safer Teams at Alder Hey Theatres (STAT) cultural programme was rolled out in February 2021. Feedback was really positive from staff members who participated in the pilot that was completed towards the end of 2020. It was pointed out that the key to this programme is the establishment of a team programme that involves group training as a whole for anaesthetists, consultant surgeons, ODAs and theatre staff. Day 1 of the training consists of a classroom based human factors session and Day 2 is spent in the operating theatre in order to conduct simulations based around the steps to safer surgery, etiquette and interaction. A follow-up takes place six weeks later in the form of a theatre coaching session which is based on an observational tool. It was confirmed that the Trust plans to roll this programme out to all surgical teams.
- The Association for Perioperative Practice (AfPP) have been commissioned to conduct a thematic review into Never Events. This will involve an inspection in May/June 2021 following the uplift of Covid-19 restrictions. The first phase of the review took place in September 2020 via focus groups which will inform some of the aspects of their two-day inspection. The initial lessons from the Never Event review were:
    1. The Trust to review its Never Event action plan.
    2. Discuss job planning for surgeons more widely and look at how a surgeon's NHS commitments fit in with external NHS work.
    3. Standard Operating Procedures (SOP) are required for surgical assistance.
    4. Review and expand the education team.
    5. Review and update Band 6 competencies and job descriptions.

Shalni Arora queried as to whether the Trust requested the AfPP to conduct a review of Never Events. It was reported that the Trust was going to request a review but NHSE and Liverpool CCG assisted as part of their oversight of the Never Events that the Trust produces and arranged for a review to take place.

The Chair thanked Alfie Bass and all those involved for the remarkable progress that is being made to transform theatres at Alder Hey.

**20/21/251 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 1.1.21 and the 31.1.21. The following points were highlighted:

- It was reported that there are eight ongoing incidents currently under review, two new incidents were opened during this reporting period and two investigations were closed last month.
- *StEIS Reference 2021/1919:* This investigation relates to a patient under the care of Bangor, who contacted the Neurology Team at Alder Hey for telephone advice. The patient was treated according to the advice that was provided. The patient suffered a raised intracranial pressure requiring a shunt. There were queries around treatment pathway and advice was provided. This is a joint investigation that is on-going.
- *StEIS Reference 2021/1899: Unexpected death of a patient in HDU -* This investigation relates to the unexpected death of an eight day old baby on HDU. A 72-hour review was conducted but didn't demonstrate any route causes initially. The Trust is awaiting the post-mortem report for clarification on the underlying cause of death. The Board was asked to note that the resuscitation of the patient when it occurred was highly commended.

- It was reported that the last four entries on table 3 (*open ongoing investigations)* are over the sixty-day timeframe. It was pointed out that these investigations are highly complex and include multiple organisations. Extension dates have been agreed with Liverpool CCG and families have been updated accordingly.

Kerry Byrne referred to StEIS reference number 2021/1899 and queried as to whether the narrative in the corporate report was appropriate. The Board was advised that any incident that results in the death of a patient has to be captured in the corporate report. It was pointed out that the patient was unwell upon arrival at Alder Hey and deteriorated very rapidly - within the space of an hour - but during their stay received the right treatment. This was an unexpected death for the family and the Trust, but it was confirmed that the post-mortem will determine the cause of this patient's demise.

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

**20/21/252 Mortality Report, Q2**

The Board received the Mortality Report for quarter 2, 2020/21. The following points were highlighted:

- The Board was advised of the national changes to the child death mortality process. The most significant change for mortality reviews is the introduction of the Medical Examiner system. The system introduces a new level of scrutiny whereby all deaths will be subject to a Medical Examiner's review if not reported to a Coroner. It was reported that Alder Hey already follows this action as part of its mortality process.

  Louise Shepherd raised a query about Alder Hey's compliance in the event that the national system differs from the Trust's due to the changes in guidance. It was confirmed that the Trust will be compliant, but discussions are taking place with David Levy to agree that Alder Hey can continue to use the system that it has in place as it is far more advanced than what is being introduced nationally. Attention was drawn to the importance of ensuring that Alder Hey doesn't take a step backwards as a result of having to comply with national requirements. Following discussion, it was agreed to acquire written confirmation, acknowledging that the Trust's system is fully compliant and in line with the new guidance.

**20/21/252.1 Action: NM**

- It was reported that there has been no increase in the inpatient mortality rate at this time due to the impact of pandemic.
- *Bereavement Suite* - The Board was advised of the feedback that has been received from families in respect to the impact that the limited visiting is having upon them and the staff involved, as a result of the pandemic. It was reported that the Trust is following national guidelines and has benchmarked itself against other children's trusts. Discussions are on-going to see how this matter can be improved in a safe manner, whilst awaiting national guidance.
- *Adult Covid deaths* – A review of three adult deaths has been conducted with the support of a physician from Aintree Hospital who has familiarity with reviewing adult mortality cases. Following discussion, it was agreed to conduct a deep dive into all six adult deaths at Alder Hey during the pandemic and submit a report on the overall outcome in April/May 2021.

**20/21/252.2 Action: NM**

- *External Benchmarking (Standard Paediatric Mortality Index)* – Alder Hey has a performance of 63 deaths against 50.2 expected deaths, which is in line with Birmingham and Manchester mortality levels. This provides assurance that Alder Hey does not have any mortality rate issues.

**Resolved:**
The Board received and noted the Mortality Report for Q2.

**20/21/253 Digital Update**

The Board received an update on the Digital and Information Technology programmes including performance on operational IT delivery. The following points were highlighted:

- It was reported that good progress has been made against a number of key areas:
  - Go live with 111 First via Meditech and becoming the first trust in the North West to deliver this virtually.
  - 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.
  - Achievement of Cyber Essentials accreditation.
  - High levels of adoption of video consultations nationally and regionally.
- It was reported that the Digital Team has been shortlisted for an HSJ award. The presentation is scheduled to take place on the 26.2.21 and focuses on the work that the Trust conducted in respect to the GDE programme and HIMSS.
- The Trust is continuing to work towards HIMSS Level 7. This has been slightly delayed due to the pressures experienced as a result of the pandemic, but internal work is now being progressed and a specific piece of work is taking place with PICU.
- The Trust has achieved Cyber Essentials accreditation which was one of the key areas that the Trust was progressing as well as being a key area of assurance from a BAF/data protection and security toolkit perspective. The Trust has conducted some testing of its resilience links with the new infrastructure that is in place. It was reported that this has been very successful.
- The digital partnership with 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. It was confirmed that there will be a further proposal submitted to the Trust Board in March in respect to previous conversations that have taken place with regards to Alder Hey and Liverpool Heart and Chest Hospital.
- Attention was drawn to the work that has taken place on staff development and engagement in the Digital Services department. It was pointed out that the service has gone through a significant cultural change over the last two years in terms of staff engagement and are moving towards a real customer service approach, which has been reflected in the report.

Shalni Arora asked as to how Alder Hey's Digital Strategy compares with other trusts. It was reported the Alder Hey is far in advance of other trusts. The development that has taken place over the last two years enabled Alder Hey to move forward during the pandemic, whereas other trusts struggled from a digital/IT perspective. It was pointed out that Alder Hey has continued its pace and development throughout the pandemic and has received good feedback from staff in respect to their experience.

**Resolved:**
The Board received and noted the Digital and Information Technology update.

**20/21/254 Cumulative Corporate Report – Top Line Indicators**

*Quality and Safety:*

- There have been five medication incidents resulting in harm. A review of these incidents has taken place, but it was pointed out that there were no common themes. This will form part of the quality priority work around high-risk medication and processes. It was confirmed that work is currently taking place at ward level and by the pharmacy team in respect to these incidents.
- It was reported that performance has improved with regard to patients being treated for sepsis, both within ED and inpatients. It was reported that ED exceeded its sepsis target and inpatients were very close to their target.
- The Board was advised that education has exceeded its target and play has improved, narrowly missing the target.

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

**20/21/255 Cumulative Corporate Report – Top Line Indicators**

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

**20/21/256 Alder Hey People Plan Update**

The Board was provided with a strategic update on the Alder Hey People Plan and the response to the requirements of the national NHS People Promise. The following points were highlighted:

- It was reported that the Trust has been shortlisted for an HSJ award and a presentation took place on the 24.2.21 in respect to the work of the Staff Advice Liaison Service (SALS), leadership, 'Ground Truths' and 'Team Time'. The Board was advised that all members are welcome to attend the HSJ Awards event and the invite/link for the event will be circulated accordingly.
- *BAME Inclusion Task Force* - The next BAME Inclusion Task Force meeting is scheduled to take place on the 26.2.21 and will continue to progress all outstanding actions.
- *Flexible Working* - The Trust is moving towards phase 2 of the flexible working project and will be focussing on the Estates Strategy, office space, people needs and optimising space. A survey was conducted to acquire the views of staff members in respect to what it has been like working from home and how they would like to work going forward. The feedback received following the survey indicates that staff want the flexibility of being able to work from home as well as on site and some staff members would like to see some radical changes. A focus on this work will commence in the coming weeks through to June in order to create a great environment for staff to work in.
- *Staff Survey* - The results of the National Staff Survey have been released but are under embargo at the present moment. The Board was advised that

the outcome of the survey is really positive for the Trust and there is a plan to share the results with staff over the coming weeks.

It was reported that the Trust has been compared against all acute trusts and all acute and community trusts. The Board received an overview of the 'theme results', which indicated that Alder Hey has among the best results nationally.

The Board compared this year's results against the 2019 survey results, and it was found that there were significant improvements in all bar three themes, which remained the same. 78% of staff said that they would recommend Alder Hey as a place to work, this is an increase of 8% since last year, and 91.7% said that they would recommend Alder Hey as a place for treatment, this puts the Trust at the top of the table for this category.

It was reported that each team will receive data that is specific to them by mid-March so that local conversations can commence to see how the Trust can improve upon the improvements that have already made.

The Chair felt that the results of the Staff Survey were remarkable, especially when the Trust is in the midst of a pandemic. Melissa Swindell pointed out that the success was due to a whole Trust effort.

**Resolved:**
The Board received and noted the Alder Hey People Plan update and the outcome of the National Staff Survey results.

**20/21/257 Financial Update**

In Month 10 the Trust reported a £0.8m deficit, £0.2m ahead of base plan, in line with a revised plan of £4.5m. The actual YTD is £3.2m deficit, in line with the latest plan.

It was reported that the Trust has received confirmation that it will be receiving £2.1m cash funding for the shortfall in non-clinical income levels, subject to audit evidence. There is to be some cash funding for annual leave accrual, but the Trust hasn't received confirmation of the amount to date. Any further requirement will be an allowable overspend. The remaining gap of £1.2m deficit relates to slippage on capital charges due to delays in capital spend c £1m and changes in non-block income c £0.2m, but it was felt that the Trust is in a good position to achieve a breakeven by the end of the financial year.

It was reported that the Trust is still awaiting further detail on 2021/22 financial envelopes, which are due imminently. The timetable for 2021/22 planning is as follows:

- *Early April* - Operational guidance for Q2 to Q4 to be issued.
- *April* - 2021/22 capital plans are to be submitted.
- *End of June* - Q2 and Q4 operation plans submitted and commissioner plans agreed.

The Board was advised that the Trust is still pushing for an interim solution for the Paediatric Tariff from April and adjustment to block. An update on progress will be provided during Month 11 of the financial update. It was reported that the national funding for Mental Health and activity restoration is yet to be confirmed, but it was pointed out that there is to be a focus on more material investments for services.

Attention was drawn to the pressure that the whole system is under to spend Capital allocations during 2020/21. It was confirmed that the Trust is doing as much as possible to achieve its target spend by the end of the financial year.

The Chair thanked John Grinnell for the update and pointed out that whilst there is some good news there are still some uncertainties.

**Resolved:**
The Board received and noted the financial update for Month 10.

**20/21/258 Board Assurance Framework**

The Trust Board received a summary of the monthly updates to the 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. The following points were highlighted:

- The Board was advised of a significant level of scrutiny of their respective risks by the Assurance Committees, including receipt of substantive reports or deep dives.
- Attention was drawn to the following risks on the BAF:
  - Risk 1.1: CQC regulatory compliance – It was reported that the CQC Section 31 conditions were removed on the 15.2.21 and a new registration certificate has been reinstated.
  - Risk 1.1: The Chief Nurse will be reframing the entire risk to reflect the current approach to quality and safety – this will be reported at the March Board.
  - Risk 4.1: A significant piece of work has been conducted on the risk relating to innovation and it now fully reflects the Innovation Strategy that the Innovation Committee has been focussing on.
- The Trust is entering into the year-end assurance process of which MIAA will provide independent assurance on the Trust's approach throughout 2020/21.

The Chair felt that the level of scrutiny that has been undertaken by the Committees provides real assurance and highlights the ownership of risks.

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

**20/21/259 Board Assurance Committees**

*RABD* – The approved minutes from the meeting that took place on the 14.12.20 were submitted to the Board for information and assurance purposes.

It was reported that during the meeting on the 22.2.21 the Committee received a report on the purchase of Puma Court, and the Limited Liability Partnership (LLP) proposal. The Chair of RABD advised that the LLP proposal was approved by the Committee on the 22.2.21 to enable the Trust to enter into a contract with a newly formed Limited Liability Partnership company to increase clinical capacity within the hospital and support restoration of activity, a model that is already in place across many NHS organisations.

Attention was drawn to the large amount of work that took place prior to submitting the proposal to the Board. It was felt that the proposal will give the Trust downside

protection and will minimise Alder Hey's reputational risk. The Board was advised that a pause will take place after a six-month period in order to review the service once it has become embedded.

The Board received a number of slides that provided a summary of the LLP proposal. The following information was shared:

- The LLP that has been formed is called Liverpool Children's Surgical Group LLP (LCSG) and is made up of 18 members, all Alder Hey Consultants (14 surgeons and 4 anaesthetists).
- The LLP agreement has been built on a principle that would facilitate improvements in access to care and that this could be linked to an incentive model.
- Due diligence has been undertaken with legal, VAT and employment advice.
- Key principles within the LLP contract.
- Benefits from the agreement.

Fiona Marston queried as to whether there will be an increase in cost for these services from LLP more so than if the Trust had the same service during a different time of the normal working week. It was reported that one of the key principles was to make sure that the LLP service offered value for money. The gross cost to the Trust per session for additional activity will be the same for the LLP as it is for waiting list initiatives, the term 'additional activity' is used to describe weekend work or extra clinics conducted by staff members, therefore, the Trust has negotiated the gross cost to be the same per session based on an overtime rate.

**Resolved**:
Following the recommendation by RABD, the Trust Board approved the LLP proposal.

*SQAC* – The approved minutes from the meeting that took place on the 16.12.20 and the 20.1.21 were submitted to the Board for information and assurance purposes.

It was reported that during the meeting on the 17.2.21 a number of in-depth discussions took place around 1. Clinical Audit: how the Committee can become more strategic across the Trust in terms of deciding where audits will be most useful, following-up on the closure of action plans and having a long-term process for reviewing key issues that have been dealt with. 2. CYP with complex, challenging behaviours: the identification and appropriate mental health pathways for children and young who are being admitted to Alder Hey via ED and the joined up working that needs to take place in respect to mental health across the Trust to increase awareness and focus on pathway outcomes for children and young people. It was pointed out that a number of actions were agreed which Lisa Cooper will progress as the SRO for the programme of work under Operational Excellence.

*People and Wellbeing Committee* – It was reported that during the meeting on the 19.1.21 the Committee agreed its top five risks/priorities and received an update on wellbeing, SALS and junior doctors' education. The approved minutes from the meeting that took place on the 17.11.20 were submitted to the Board for information and assurance purposes.

*Innovation Committee* – It was reported that during the meeting on the 8.2.21 the Committee received a presentation on the 'Mental Health as One' project for children and young people. The Board was advised of the input that the Committee has received from external advisors in respect to the Trust's Innovation Strategy.

The Committee had a good discussion on the updated BAF risk, and it was confirmed that the governance of the Acorn Partnership will become the remit of RABD. The approved minutes from the meeting that took place on the 7.12.20 were submitted to the Board for information and assurance purposes.

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

**20/21/260 Any Other Business**

There was none to discuss.

**20/21/261 Review of the Meeting**

The Chair felt that the last few weeks have been remarkable in terms of the progress that has been made across the Trust and the positive way in which Alder Hey has responded to the third wave of the pandemic. It was felt that the Trust is in a good position as it heads towards the end of the year and will be able to look back on a number of positive outcomes that took place during 2020/21.

**Date and Time of Next Meeting:** Thursday the 25th March 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 March 2021** | | | | | | | |
| 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 | Closed | **19.3.21** - The draft Risk Appetite Statement is being submitted to the Board on the 25.3.21. |
| 25.2.21 | 20/21/247.1 | Update on the Future of Integrated Care Systems, Commissioning and Provider Collaboratives | Arrange for an item to be included on the next agenda of the specialist trusts' CEO's and Chair's meeting, in order to discuss the challenges that are being experienced in respect to bringing leads from the various specialist trusts together to prepare for the forthcoming changes as highlighted in the White Paper. | Louise Shepherd | 25.3.21 | Closed | **19.3.21** - The Specialist Trust CEOs and Chairs have discussed this over the last few weeks and have agreed that Janet Rosser from The Walton Centre and Louise Shepherd will represent the Specialist Trusts on the Partnership Board this year. A prospectus setting out the key issues for the group in relation to C&M is in development by all 4 trusts and will form the basis of our work together and with the Partnership over the next year. **ACTION CLOSED** |
| 25.2.21 | 20/21/249.1 | Covid-19 Assurance Plan – Alder Hey's Response to the Third Wave | *Covid-19 Risk Register* - Advise of the timeline of the independent review that is taking place into Manchester University NHS Foundation Trust's Cardiology RTT waiting list that was overlooked. | Nicki Murdock | 25.3.21 | On Track | **19.3.21** - A verbal update will be provided on the 25.3.21. |
| 25.2.21 | 20/21/252.1 | Mortality Report, Q2 | *National Changes to the Child Death Mortality Process* - Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance | Nicki Murdock | 25.3.21 | On Track | **19.3.21** - A verbal update will be provided on the 25.3.21. |
| **Actions for the 25th of April 2021** | | | | | | | |
| 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 | Overdue | 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 | 29.4.21 | 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.<br>**19.3.21** - A report will be submitted to the Board on the 29.4.21. |

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

Alder Hey Children's NHS
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 |
| 26.11.20 | 20/21/188.1 | Board Assurance Framework | Submit the Risk Management Strategy to the Board for ratification in January. | Erica Saunders | 29.4.21 | On Track | 23.1.21 The Risk Management Strategy is to be submitted for ratification in March 2021. 19.3.21 - The Risk Management Strategy has been deferred until April 2021 - |
| 25.2.21 | 20/21/249.2 | Covid-19 Assurance Plan – Alder Hey's Response to the Third Wave | *Covid-19 Risk Register* - Submit a report on the lines of accountability and governance arrangements in place for the RMCH/Alder Hey partnership in order to provide clarity on the risks that the Trust Board is | Nicki Murdock | 29.4.21 | | |
| 25.2.21 | 20/21/252.2 | Mortality Report, Q2 | *Adult Covid Deaths* - Conduct a deep dive into the six Covid-19 adult deaths that took place at Alder Hey during the pandemic and submit a report to the Board on the overall outcome, in April/May 2021. | Nicki Murdock | 29.4.21 | | |

| **Status** | |
|---|---|
| Overdue | |
| On Track | |
| Closed | |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

## Thursday 25th March 2021

| | |
|---|---|
| **Paper Title:** | **Access and Restoration** |
| **Report of:** | **Adam Bateman**<br>**Chief Operating Officer** |
| **Paper Prepared by:** | Lachlan Stark, Associate Chief Operating Officer<br>Planning & Compliance |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ■<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Impact:** | We have invested in additional capacity for planned care at weekends. |

## 1. Introduction

In February we continued to provide mutual aid to acute adult hospitals in Cheshire & Merseyside to support the creation of additional critical care capacity in response to the third wave of COVID-19 cases. This mutual aid was formally ended on Monday 8th March 2021.

The establishment of an adult critical care unit on the Alder Hey site led to a contraction in the number of planned operating sessions; the revised theatre schedule provided 100 theatre sessions compared to the pre-COVID-19 level of 139 elective planned sessions. Sustaining 100 theatre sessions was impressive and testament to the planning and hard work of our teams.

There is a correlation between the contraction in theatre capacity and an increase in waiting times for patients awaiting admitted care. In order to address the backlog we have developed a recovery plan which will quickly restore access to services in March and seek to increase capacity and productivity in 2021-22 with a view to clearing the backlog over a 12-month period.

## 2. Summary of progress in restoring services

In **outpatients** our overall activity has improved as a percentage of last year's total. In **elective and daycase** services our level of restoration remains below 85% due to the continuation of mutual aid. In **diagnostics** we have maintained a high proportion of activity.

| Service | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 |
|---|---|---|---|---|---|---|---|
| **Outpatients** | 13,108 | 16,581 | 16,656 | 17,441 | 14,988 | 16,179 | 16,005 |
| **Daycase** | 1464 | 1532 | 1675 | 1780 | 1726 | 1522 | 1609 |
| **Elective** | 370 | 378 | 422 | 423 | 400 | 353 | 361 |
| **IP/DC** | 1,834 | 1,910 | 2,097 | 2,203 | 2126 | 1875 | 1970 |
| **Diagnostics** | 1,413 | 1,608 | 1,554 | 1,552 | 1589 | 1556 | 1586 |

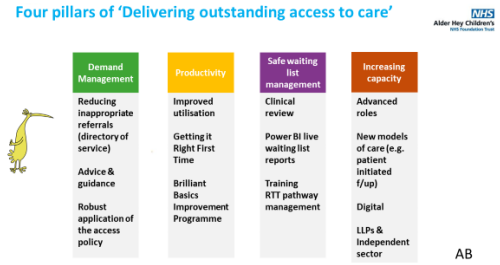
| Service | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 |
|---|---|---|---|---|---|---|---|
| **Outpatients** | 86% | 87% | 84% | 95% | 95% | 89% | 92% |
| **Daycase** | 83% | 74% | 85% | 92% | 94% | 81% | 83% |
| **Elective** | 86% | 88% | 98% | 92% | 102% | 87% | 88% |
| **IP/DC** | 84% | 76% | 87% | 92% | 95% | 82% | 84% |
| **Diagnostics** | 92% | 90% | 86% | 90% | 105% | 97% | 98% |

# 3. Recovery plan

## 3.1 Overview of recovery plan

Our recovery plan is centered on the following workstreams:

- Use of LLP and independent sector, increasing capacity at weekends
- OPD transformation including referral management and advice and guidance
- Day case transformation
- Specialty recovery plans captured through annual planning
- Access to care for children and young people in Cheshire & Merseyside: an approach built on equality and partnerships



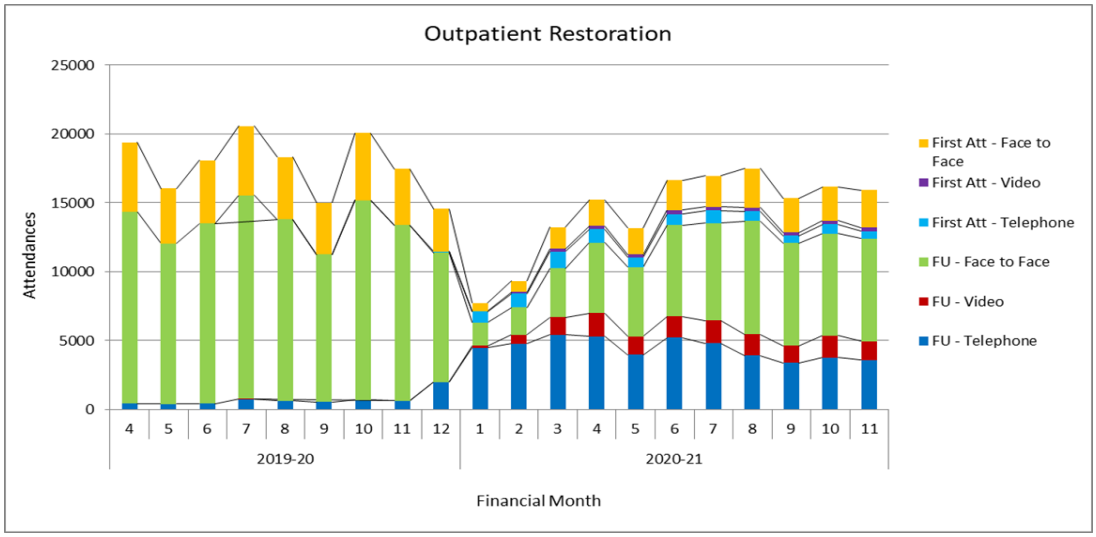

- Accounts for clinical prioritisation, including holistic assessment of clinical need

# 4. Restoration status by service area

## 3.1 Outpatients

In February outpatient restoration was 92% of 2019-20 activity levels. Our performance relative to last year is improving and the volume of patients seen per working day is stable. We are focused on restoring to 100% of activity levels in outpatients. To achieve this, we are taking the following actions:

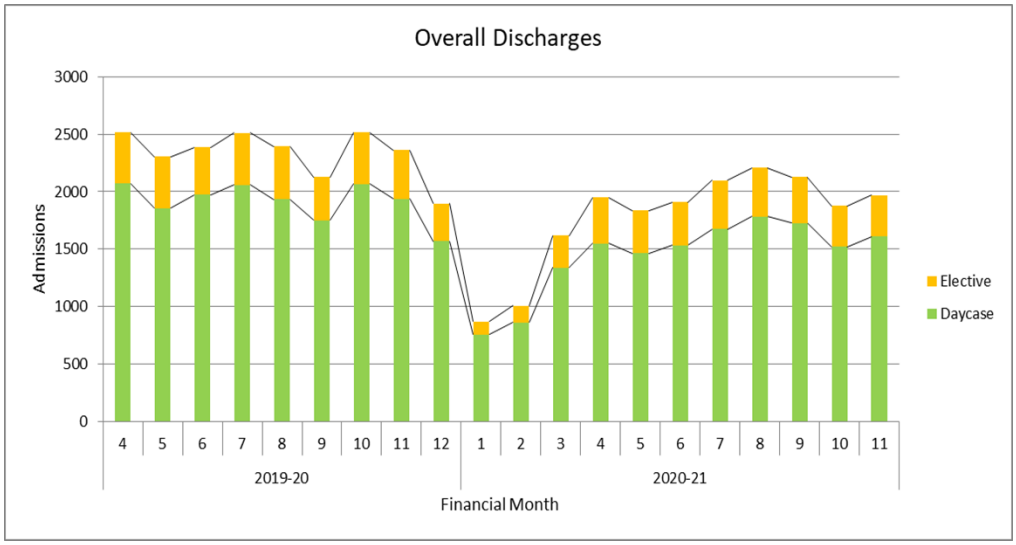
- Consolidate evening sessions into Tuesday, Wednesday and Thursday, and book further ahead to 19 June 2021
- Infection prevention practices and social distancing review in OPD with Dr Bea Larru. Walkabout w/c 1 March 2021
- Progress actions in the outpatient transformation programme




## 3.2 Elective & Day Case Activity

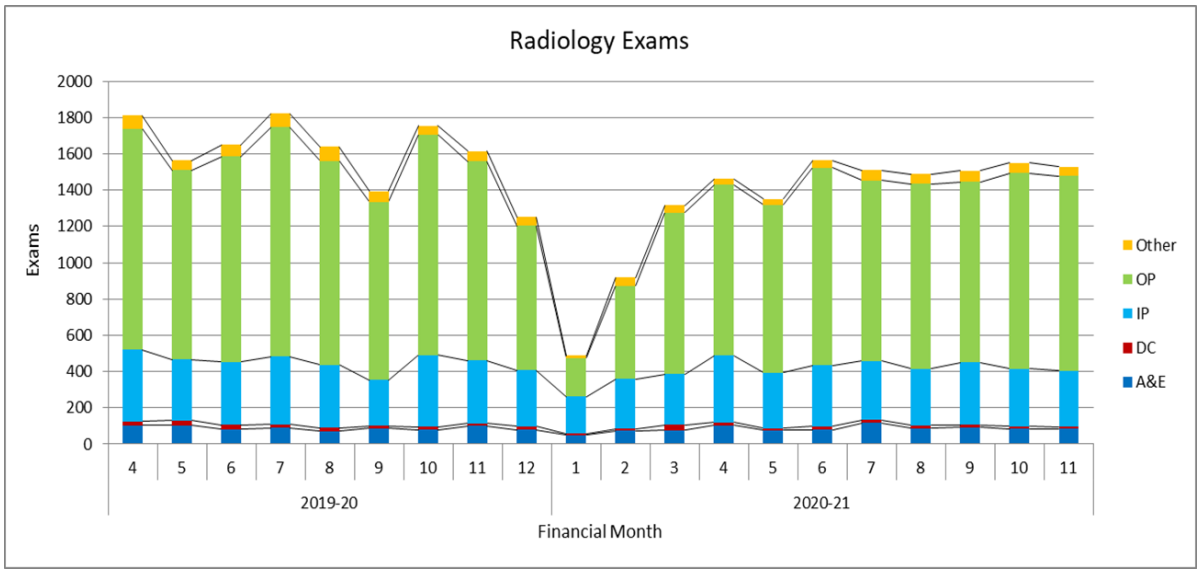
Elective activity restoration has reduced following the commencement of mutual aid and the reduction of theatre lists. In March we are forecasting a good recovery of elective activity and predict we will be operating at 95% of 2019-20 activity levels. We expect to achieve the following:

- Restore the full theatre schedule
- Undertake an additional 6 theatre lists on a Saturday every fortnight until 19 June 2021 (prior to 21 June lifting of restrictions)




## 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. In terms of DM01 (all 15 diagnostics), the percentage of diagnostic tests performed within 6 weeks has continued to improve and again increased in February.

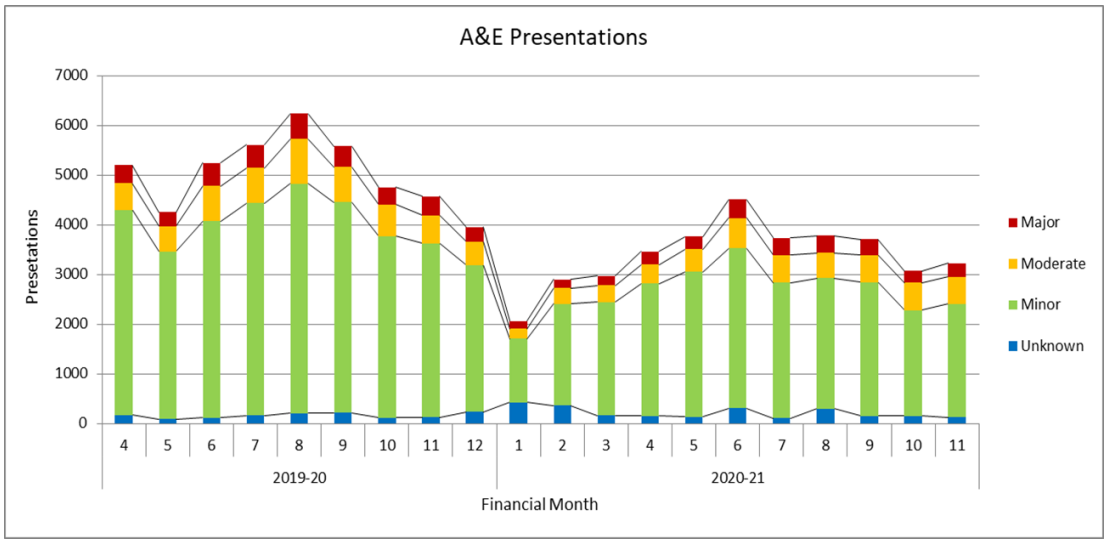



**Diagnostics (DM01) Performance against 99% standard**

| DM01 | June | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|
| **%perf** | 81.9% | 82.9% | 78.9% | 87.0% | 91.8% | 97.1% | 92.3% | 93.7% | 95.8% |

## 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 |
|---|---|
| Nov-20 | 97.51% |
| Dec-20 | 98.63% |
| Jan-21 | 98.47% |
| Feb-21 | 97.89% |

### 3.5 Cancer Performance

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

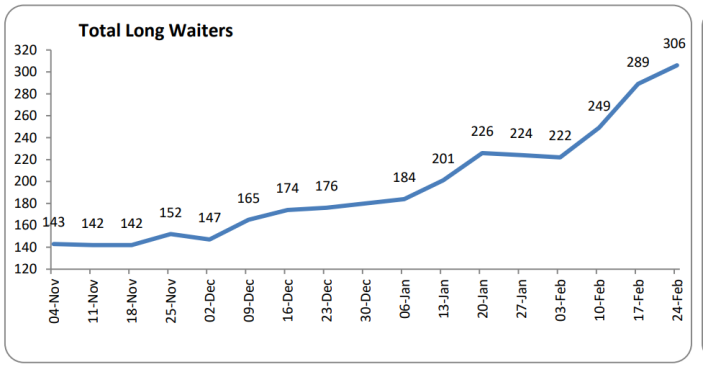
| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | 100.0% | 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% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

## 5. Planned care

In February our waiting times status is as follows:

| | |
|---|---|
| **Open pathway RTT performance (18 weeks)** | ↑ 63.4% |
| **Total number of patients > 52 weeks** | ↑ 306 |

There has been an increase in the number of patients waiting over 52 weeks, driven by an increase in the number of patients waiting for admitted care in surgical services:




The waiting time position for all Trusts in the region is shown below:

| Org code | Org Name | w-e 07 Feb 21 | w-e 14 Feb 21 | w-e 21 Feb 21 | w-e 28 Feb 21 | w-e 07 Mar 21 | Change from previous week |
|---|---|---|---|---|---|---|---|
| RBS | ALDER HEY CHILDREN'S NHS FOUNDATION TRUST | 249 | 289 | 289 | 307 | 310 | 3 |
| RJR | COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST | 3,507 | 3,742 | 3,896 | 3,987 | 4,362 | 375 |
| RJN | EAST CHESHIRE NHS TRUST | 589 | 656 | 720 | 760 | 781 | 21 |
| RBQ | LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST | 81 | 94 | 97 | 101 | 109 | 8 |
| REM | LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 3,619 | 3,916 | 4,126 | 4,436 | 4,685 | 249 |
| REP | LIVERPOOL WOMEN'S NHS FOUNDATION TRUST | 157 | 163 | 174 | 198 | 247 | 49 |
| RBT | MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST | 609 | 668 | 746 | 797 | 858 | 61 |
| RVY | SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST | 110 | 126 | 140 | 158 | 195 | 37 |
| RBN | ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST | 859 | 934 | 1,031 | 1,128 | 1,288 | 160 |
| REN | THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST | 0 | 0 | 0 | 0 | 0 | 0 |
| RET | THE WALTON CENTRE NHS FOUNDATION TRUST | 222 | 241 | 259 | 274 | 284 | 10 |
| RWW | WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST | 1,250 | 1,349 | 1,400 | 1,463 | 1,559 | 96 |
| RBL | WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST | 999 | 1,028 | 1,069 | 1,149 | 1,217 | 68 |
| **C&M Total** | | **12,251** | **13,206** | **13,947** | **14,758** | **15,895** | **1,137** |

We have undertaken detail modelling to determine the capacity required to clear the waiting list backlog and our timescales are set out at specialty level below:

| | | | A | B | C | | |
|---|---|---|---|---|---|---|---|
| **Specialty** | **Current patients >= 52 wks** | **Patients > 52 wks with TCI** | **Patietns > 52 wks with no TCI** | **Conversion from OP backlog/ Tip-in** | **Patients 40 - 52 wks with no expected TCI** | **Total backlog (A+B+C)** | **Clearance timescale** |
| Paediatric Surgery | 23 | 5 | 18 | 28 | 25 | 71 | 6-9 months |
| Orthopaedic & Trauma | 54 | 9 | 45 | 7 | 18 | 70 | 6-9 months |
| Ear Nose & Throat | 64 | 38 | 26 | 66 | 14 | 106 | 6-9 months |
| UROLOGY | 12 | 3 | 9 | 8 | 0 | 17 | 1-3 months |
| Plastic Surgery | 14 | 6 | 8 | 1 | 0 | 9 | 1-3 months |
| Paediatric Dentistry | 25 | 2 | 23 | 273 | 15 | 311 | 12 months |
| Spinal Disorders | 49 | 5 | 44 | 3 | 23 | 70 | 12 months |
| Neurosurgery | 3 | 2 | 1 | 0 | 0 | 0 | 12 months |
| Oral Surgery | 10 | 6 | 4 | 0 | 0 | 4 | 1-3 months |
| Cardiothoracic | 4 | 2 | 2 | 0 | 0 | 2 | 1-3 months |
| Gastroenterology | 13 | 4 | 9 | 0 | 0 | 9 | 1-3 months |
| Craniofacial | 1 | 1 | 0 | 0 | 0 | 0 | 1-3 months |
| **Trust total** | **272** | **83** | **189** | **386** | **95** | **669** | |

Alder Hey Children's NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday 25th March 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<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>■ |
| **Background Papers and/or supporting information:** | COVID 19 | |
| **Action/Decision Required:** | To note<br>To approve | ☐<br>■ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation**<br>**Strong Foundations** | ■<br>■<br>■ |
| **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 **16** risks identified on the COVID risk register, inclusive of **1** high risk identified on the register (2183). The risk profile is outlined at appendix 1, table 1.

Number of risks removed/closed/transferred from the risk register = **3** (1560,2138,2285 ) – refer to appendix 1, table 2.

Number of new open risks = **0**

Number of risks with an overdue review date = **1**

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. Infection to CYP, families and our staff.

**Risk ref: 2183 (4x4=16)** *"Risk that staff, patients and the public will not be able to socially distance whilst waiting in ED".* This risk was increased to high on 17th March, due to Increasing attendances and reduced capacity in waiting room, due to building work. Assessment with external agency planned to take place imminent, to review use of Perspex screens and air filtration systems, to help mitigate the risk.

**Risk ref: 2180, 4x2 = 8** "*Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained".* The National supply route for PPE supplies is now stable and the Trust is holding ample stocks of all of the required products. The use of the Inventory App has assisted with the general day to day stock replenishment activities and the PPE Oversight Group is kept updated on a regular basis. This risk is likely to close before the next reporting period.

There are **4** additional risks identified relating to Staff becoming infected with COVID 19 i.e. 2268 low moderate, 8) 2263 (low 6) , 2267 (low, 6) . 2268 (low moderate, 8) 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. Extension of H&S Advisors contracts until end March 21 has been authorised. This will enable ongoing monitoring of CV19 RAs. Any breaches in compliance are fed back to tactical command regularly and via liaison with managers. Operational managers are expected to own these assessments, but H&S will continue to floor walk and monitor and assist with any new issues arising.

### 3.2. 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 incident report shows no harm incidents reported.

**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. However, 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.

**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. Since the latest lockdown this group of children are not attending school again. In the meantime, children are being seen at home where appropriate. Risk remains active in line with lockdown road map and school returns being planned. Implementation of task and finish group to scope what additional support may be required to assist children regaining their physical condition once they are able to access therapy again.

**Appendix 1 Risk Register Profile – 18th March 2021 (Total 16)**

**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** | **0** | **5** | **3** | **5** | **1** | **1** | **0** | **1** | **0** | **0** | **0** |
| **0 (0.00%)** | | | **5 (31.25%)** | | | **10 (62,5%)** | | | | **1 (6.25%)** | | | | **(0.00%)** |

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

**Table 2 Closed/ removed / transferred risks - 3**

| Risk reference | Risk description | Target |
|---|---|---|
| **1560 transferred** | "*New patients referred to CAMHS Liverpool may breach 18-week referral to treatment target."* This risk remains active, although removed from the COVID register. The Trust successful in securing Winter monies from the CCG to put towards staff overtime and extending staff members contracts to support Choice and Partnership appointments. The Covid anxiety support project first round engaged with 15 young people currently on Liverpool's Partnership waiting list. **Current risk rating 3x4 =12**. | **3x1=3** |
| **2138 closed** | "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 closed as staffing has remained at Green status throughout winter. Currently all areas fully staffed following commencement of ECP nurses and international nurses. Return to business as usual from the perspective of management of safe staffing and no current requirement for risk on register. This risk can be re-opened and / or superseded by a new risk as and when required as staffing is subject to continuous monitoring corporately and divisionally. Risk score reduced to 6 and closed. **Risk at target.** | **2X3 =6** |
| **2285 removed** | "*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 Has been removed from the Trust risk register as this is a cardiology network risk | |

**END**

Alder Hey Children's NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday 25th March 2021**

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

## 2. Summary

**Section 1**- **StEIS reported incidents performance**
Table 1 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 incidents, of which **3** had been carried forward from the previous financial year. Table 2 shows at the time of reporting there have been a total of **15** StEIS reported incidents this year and **2** 'Never Events'.
.
**Section 2 - open ongoing investigation -** shows there are **8** ongoing StEIS reported incidents, currently under investigation, all previously reported to Board. **Zero** new incidents meeting Serious Incident criteria reported during this month and **zero** 'Never Events' reported.

**Closed investigations** – there were **zero** investigations closed 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 | 0 | |
| Open (Total) | 4 | 4 | 1 | 4 | 8 | 9 | 8 | 6 | 8 | 8 | 8 | |
| Closed | 1 | 0 | 3 | 1 | 0 | 1 | 2 | 2 | 0 | 2 | 0 | |
| **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 | 0 | |
| | | | | | | | | | | | | |
| Open (Total) | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Closed | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

**Note* 3 incidents 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. | 10/03/2021 |
| 2020/23828 | 09/12/2020 | Waiting list data quality issues | 21/04/2021 |
| 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 | 02/04/2021 |

**END**

Alder Hey Children's NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday 25th March 2021**

| | |
|---|---|
| **Paper Title:** | **Quarter 3 2020/21 Complaints, PALS and Compliments report** |
| **Date of meeting:** | 25th March 2021 |
| **Executive Lead:** | Nathan Askew Chief Nurse |
| **Paper Prepared by:** | Pauline Brown Director of Nursing<br>Val Shannon Patient Experience Lead |

| | |
|---|---|
| **Purpose of Paper:** | The purpose of this paper is to provide the Trust Board with an update and assurance on the performance against complaints and PALS targets, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and proposed developments planned in Q4 2020/21 and Q1 2021/2022. |
| **Summary and/or supporting information:** | There has been an increase in formal complaints received during Q3 (45) compared to Q2 (26). However, there has been a decrease in the number of informal concerns received during Q3 (223) compared to Q2 (278). The top reason for formal complaints received in Q3 2020 continues to be treatment and procedures. The main reason for informal PALS concerns is regarding appointments and communication. 50 compliments are recorded centrally in the Ulysses system<br><br>Compliance with the 3 working day acknowledgement for formal complaints is 98%. Compliance with the internal Trust target of 25 working day response time is 27%, this is a downward trend compared to 52 % compliance in Q2 however the percentage is related to the increased number of complaints in Q3; 12 out of 45 complaints were resolved within the 25 day timeframe in Q3 and 12 out of 34 in Q2. 91% of complaints were successfully resolved following the initial complaint response, with 9% proceeding to second stage (7 of 74 in Q2 and Q3). Compliance with the 5 day target to resolve informal concerns is 61%. The Trust has 1 complaint which continues to be investigated by the PHSO.<br><br>The Chief Nurse has commissioned a review of the structure, responsibilities and process for management of complaints and PALS in the Trust to include a central corporate function which will sit within the Patient Experience team. It is expected that this action, together with the additional proposed actions and developments outlined in this report, will lead to a demonstrable improvement in compliance with KPI's, and more importantly a more timely and effective resolution for families who wish to raise concerns. This work has been commenced in Q3 and continued |

| | |
|---|---|
| | during Q4 |
| **Financial Implications** | None |
| **Key Risks Associated** | Reputational risk associated with not meeting the Quality priorities and the Trust targets. |
| **Quality Implications** | Poor patient experience due to not meeting the required time frame for response and resolution |
| **Link To:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | **Delivery of outstanding care**<br>**The best people doing their best work**<br>Sustainability through external partnerships<br>Game-changing research and innovation<br>Strong Foundations |
| **Resource Impact:** | Yes |
| **Action/Decision Required:** | The Trust Board are asked to note the content of this report and support the proposed developments outlined in section 5 of this report. |

Alder Hey Children's NHS Foundation Trust

## 1. Introduction

The Trust is committed to ensuring all of our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate and compassionate response. Compliments, concerns and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services.

This report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO).

This report provides an overview of formal complaints and informal PALS concerns received and completed between October to December 2020/21 (Q3). The report aims to provide assurance that the Trust is responding to the concerns raised by children, young people and their families in line with Trust procedures, Department of Health legislation and standards expected by the PHSO, to provide themes that the Trust needs to address to make improvements to services, and to highlight action taken.

## 2. Formal Complaints

### 2.1 Number of formal complaints received Q3 2020/21

The Trust experienced a significant increase in the number of formal complaints in Q3 2020/21, with 45 submitted compared to 34 in the previous quarter, and 26 in the same reporting period in 2019/20. The increased number of formal complaints is seen in the Medical Division and associated with a specific issue regarding the Neurology service as outlined in section 2.2. There have been 102 formal complaints received thus far in 2020/21 as shown in Figure 1.

**Figure 1: Number of formal complaints 2020/21**

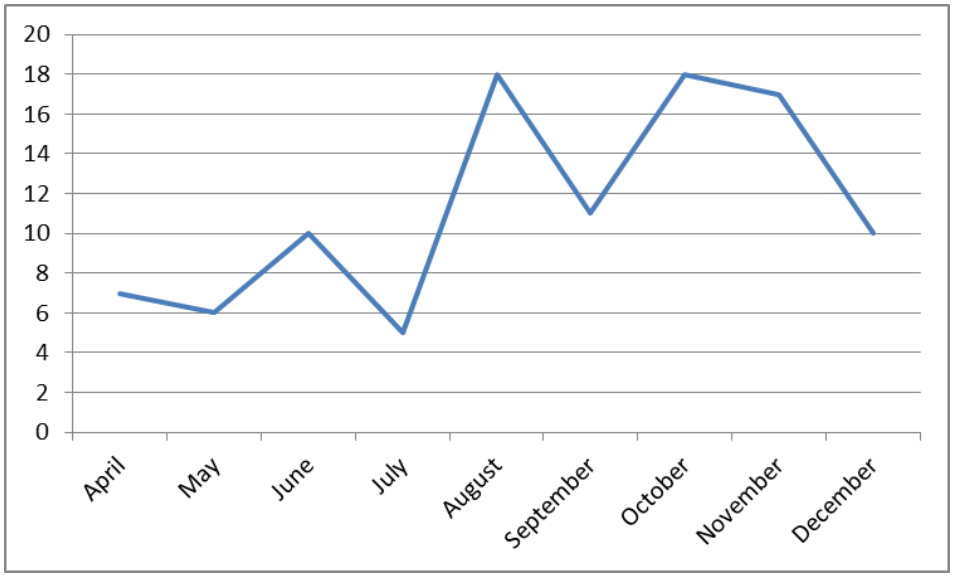


Figure 2 shows the number of complaints by Division in Q3 2020/21 compared with the same period in 2019/20; and Figure 3 shows the breakdown of complaints received by service. These graphs clearly demonstrate the increase in complaints in the Medical Division due to a specific issue in the Neurology service.

**Figure 2: Number of formal complaints in Q3 2020/21 compared to same period in 2019/20**

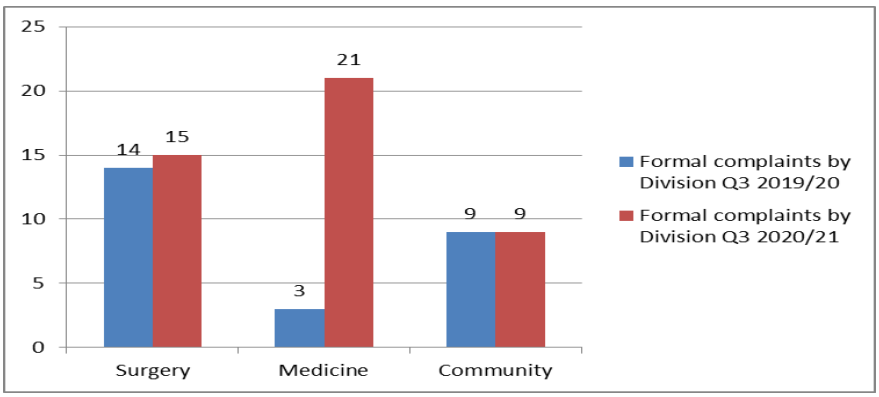
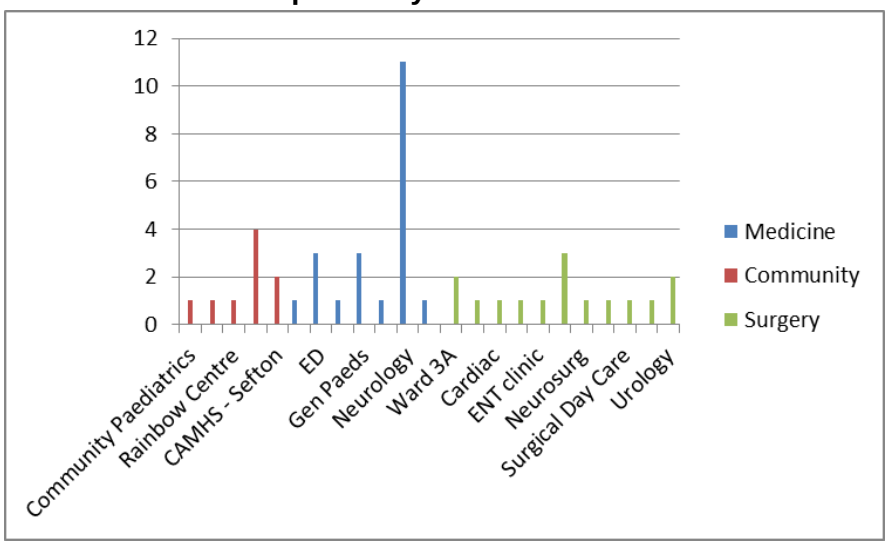



**Figure 3: Number of formal complaints by service**

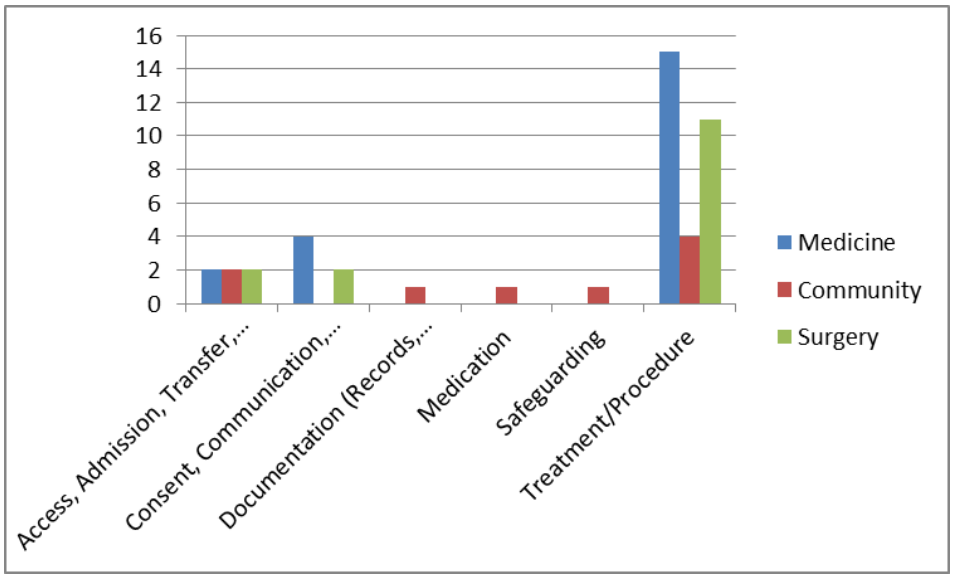



## 2.2 Complaints received by category Q3 2020/21

Complaints are categorised by subject as set in the Trust Ulysses complaints system. A complainant may raise several issues that the Trust must respond to, and all concerns expressed by families are categorised within the record, however the primary issue is used within this report to monitor key trends.

Figure 4 below demonstrates that the main theme in this quarter continues to be in relation to treatment and procedure with a total of 30 complaints (66%).

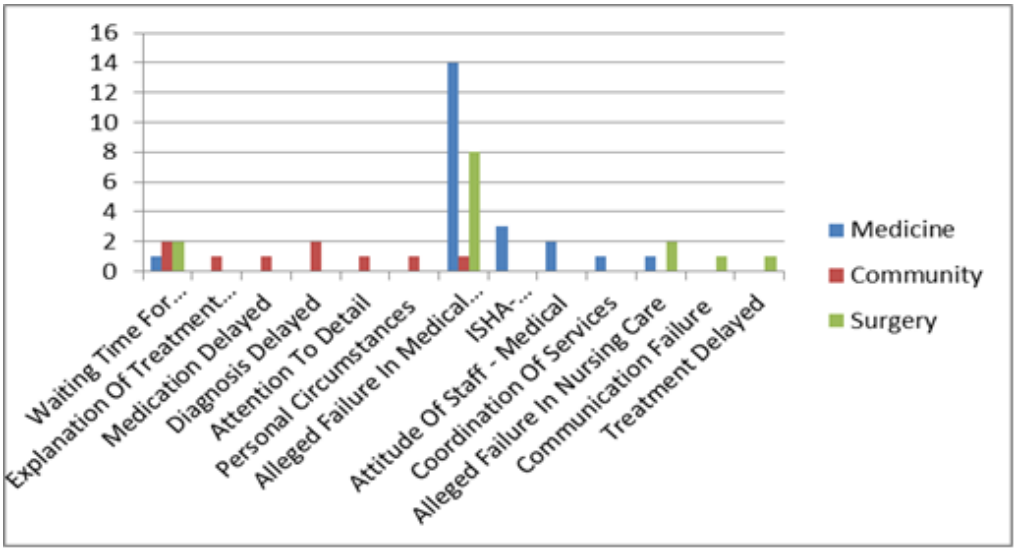
**Figure 4: Primary categories of complaints**




Sub-category identification provides further detail regarding the primary issues raised by families. Figure 5 demonstrates that the main theme within the treatment and procedure category is in relation to alleged failure in medical care (23 complaints; 45%), of which 14 (60%) relate to the Medical Division and are due to the concerns involving the Neurology service regarding the cessation of a service for patients with Tourettes Syndrome.

The specialty and Divisional leadership team continue to work to mitigate parental concerns regarding the discontinuation of treatment regimens for some patients. Complainants are raising common themes within their complaints and several have referred to an online petition regarding the commissioning of a service for this patient group. The Medical Division have worked with each case to provide a tailored response, assessing each child's individual clinical need.

**Figure 5: Sub categories of complaints**



A review of the Ulysses complaints module has been commissioned by the Director of Nursing; this will include a review of the categories to ensure they are in in line with the NHS Digital complaints categorisation.

## 2.3 Trust performance against Key Performance Indicators (KPI)

### 2.3.1 National context

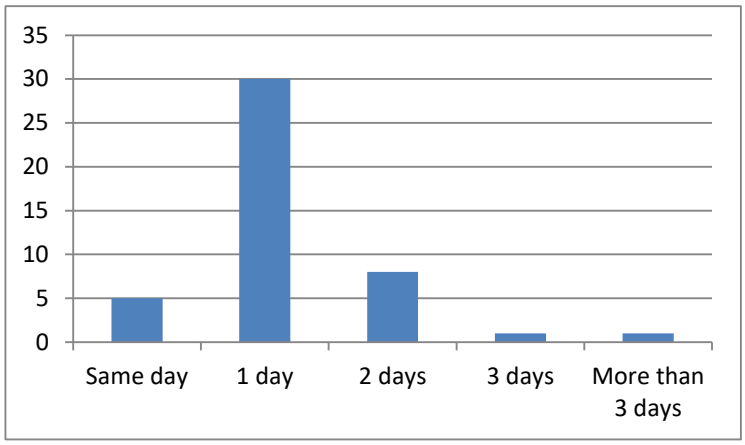
In response to the ongoing pandemic, NHSE/I have set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledge that in some settings it may take longer to respond to a complaint and consider it currently permissible for this to go beyond the usual six month maximum time period. However, organisations should opt to operate as usual regarding the management of complaints if they are able to do so. Throughout the pandemic, the Trust aim has continued to be to respond to complaints in line with RM6 Complaints and Concerns policy.

### 2.3.2 Compliance with 3 day acknowledgement

The NHS Complaints Guidance (updated January 2021), sets out that complaints should be formally acknowledged within 3 working days; reflected in the Trust policy (RM6 Complaints and Concerns policy). The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwatch Advocacy. The Complaints Officer may also telephone the complainant to discuss their concern further.

In Q3, 44 out of 45 (98%) formal complaints received were acknowledged within 3 working days, with 35 (78%) being acknowledged within 1 working day. The complaint outside of this was timescale was acknowledged after 13 days; this was due to an administrative error that has been addressed. Figure 6 below shows a breakdown of acknowledgment times providing the Trust assurance with continued high compliance with the standard.

**Figure 6: Compliance with 3 day acknowledgement**



### 2.3.3 Complaints responded to and closed in Q3

A total of 56 complaints were responded to and closed in Q3 of which 40 were received during Q3; 15 were received in Q2; and 1 was received in Q4 2019/20. The complaint received in Q4 2019/2020 was received by the Medical Division in relation to the Neurology service and took 181 days to close due to the complexity of the complaint.

### 2.3.4 Compliance with 25 day response

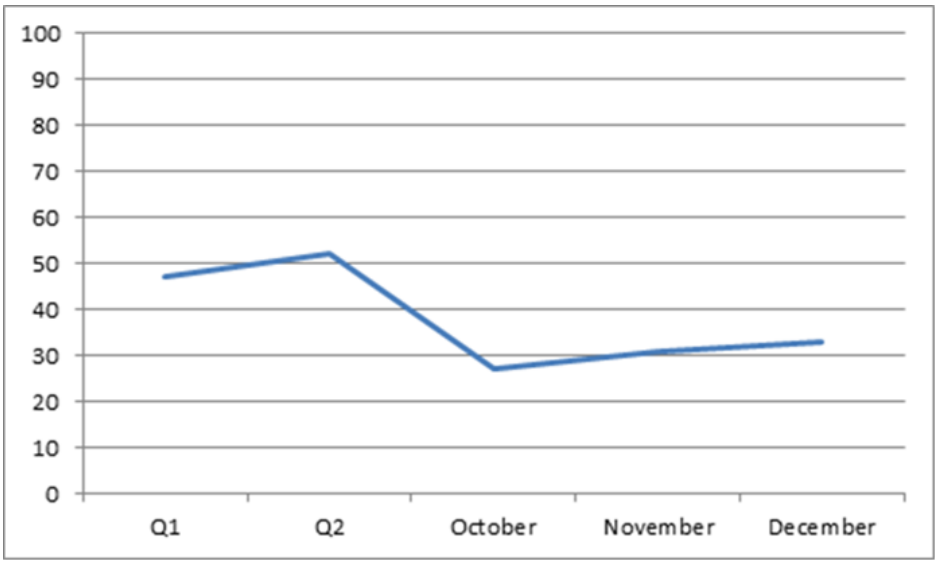
Whilst the NHS Complaints Guidance states that there is no set timeframe to respond to a formal complaint, as this is dependent on the nature of the complaint, the Trust has set an internal timeframe in the Complaints and Concerns policy to respond to formal complaints within 25 working days. Where a complaint is complex and / or multi organisational, this is discussed with the complainant to negotiate an extended timeframe with them and agree a new date for response. A meeting with appropriate Trust representatives is also offered as this is can lead to a successful resolution of the concerns raised. The complaint from Q4 2019/20 which took 181 days to complete was discussed and negotiated with the family and, whilst it did not meet the Trust internal timeframe for response, the management did meet the standard set by NHSE/I.

40 of 45 complaints received in Q3 were responded to during the same quarter. The response times are illustrated in the table below and Figure 7 and demonstrates that 12 (30%) of complaints were responded to within 25 days; whilst this is a downward trend in the overall percentage compliance compared to 52% compliance in Q2 and 47% compliance in Q1, it should be noted that there has been an increase in the number of formal complaints received in Q3 and the actual number of complaints responded to was 12 in both Q2 and Q3 therefore the same response position in real terms.

| | Total complaints received in Quarter | Complaints received and responded to in same Quarter | 0-25 days | 26-35 days | 36-45 days | 46-55 days | 56-65 days | 66-75 days | 76-85 days | More than 100 days |
|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | 23 | 17 | 8 (47%) | 3 (18%) | 3 (18%) | 2 (12%) | | | | 1 (6%) |
| Q2 | 34 | 23 | 12 (52%) | 8 (35%) | 1 (4%) | | | | 2 (8%) | |
| Q3 | 45 | 40 | 12 (30%) | 23 (57%) | 2 (5%) | 2 (5%) | | *1 (3%) | | |

*Complex neurology complaint

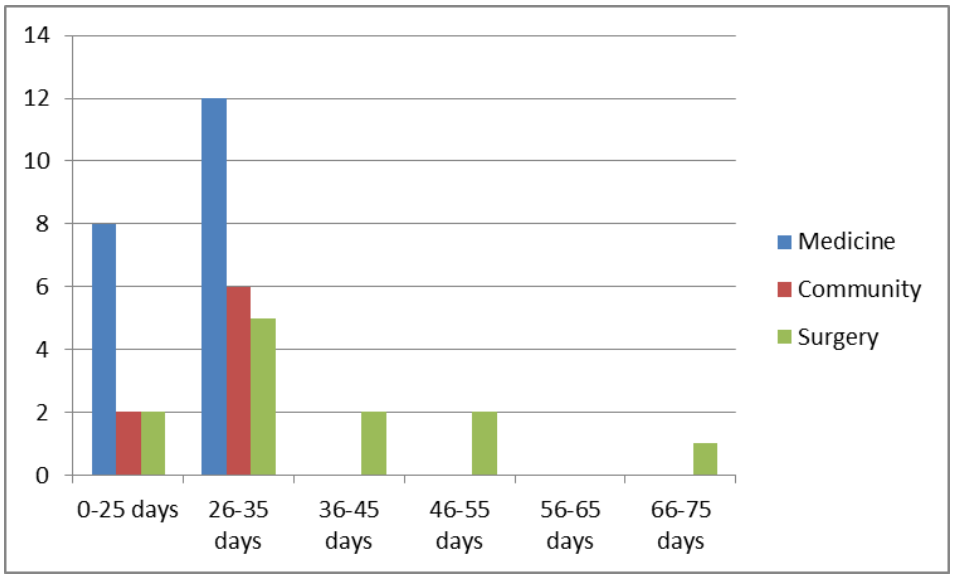
**Figure 7: Percentage compliance with 25 day response Q1-3 2020/21 (Q3 by month)**




Going forward, the complaint report will detail compliance by month as it is recognised that monthly data can provide greater insight into good practice and also factors affecting compliance which can be acted upon in a more timely and appropriate manner.

Figure 8 demonstrates the compliance with the 25 day response by Division related to complaints received and responded to within Q3.

**Figure 8: Compliance with 25 day response – complaints received and responded to in Q3**

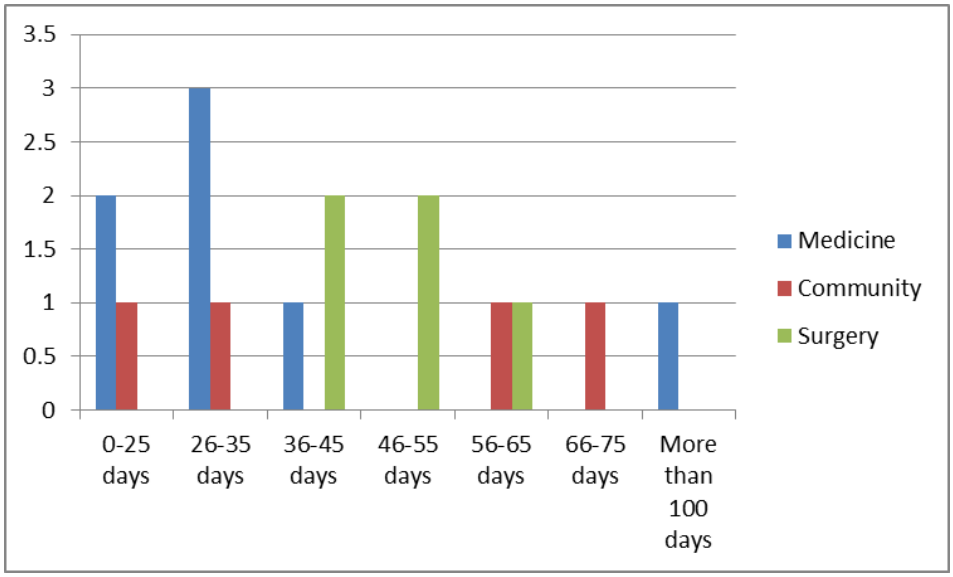



Of the 45 complaints received during this period, 5 have ongoing investigations however they have all exceeded the 25 working day response time (1 in Community; 1 in Medicine; 3 in Surgery).

16 complaints were closed in Q3 which had commenced investigation in a previous quarter; 15 complaints in Q2 one of which was withdrawn by the complainant (as shown in Figure 9);

and 1 complaint in Q4 2019/20 (181 days). There are no initial complaints now open which date back further than Q3 2020/21.

**Figure 9: Compliance with 25 day response by Division – complaints received in Q2 and responded to in Q3**




Delays in completion of responses have on occasion been a result of complex complaints. There has been a delay where corporate quality check of the complaint has identified that further work is required by the associated Division to ensure that the complaint response fully answers the concerns raised, demonstrates compassion, apologises, and identifies what action will be taken as a result of the learning from the complaint; some responses have required multiple corporate quality checks to ensure they attain the expected standard. The increased number of complaints received in Q3 has also been identified as a reason for responses being delayed in the Medical Division, however despite receiving the highest number of complaints within Q3, the Medical Division achieved the highest response rate. The Surgical Division have had a gap in Complaints Officer however this is resolved from March 2021.

There is absolute recognition by the Trust and the Divisions that it is essential that complaints are responded to in a comprehensive and timely manner and the current response times are not considered acceptable.

The Chief Nurse has commissioned the Director of Nursing to undertake a full review of the structure and process for responding to complaints, including corporate and divisional roles and responsibilities relating to complaints management and this review has commenced in collaboration with Divisional leads and the Trust Patient Experience lead. The aim is that once established, implemented and embedded there will be an improving trend of responding to complaints within the Trust timescale of 25 days demonstrated in 2021/22.

The new process will include a procedure whereby any request to extend the investigation and response period is reviewed and authorised by the Chief Nurse in the first instance before discussing the response timeframe with the family. Future Complaints Report will then be in a position to provide greater assurance and oversight of complaints that have an

agreed extended response and those that have not been authorised and are in breach of our standards. This will provide further trend analysis and enable targeted improvement work to be identified and undertaken.

The Chief Nurse and the Medical Director have established a monthly investigation performance review with each Division where the management of complaints will be further monitored and supported.

### 2.3.5 National complaint reporting: KO41a return

The Trust is mandated to submit data nationally regarding the status, categories and outcome of complaints on a quarterly basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool.

The information obtained from the KO41a collection monitors written complaints received by the NHS. It also supports the commitment given in equity and excellence to improve the patient experience by listening to the public voice.

For assurance, Q3 data is due for submission in April; Q2 data was submitted in November 2020.

## 2.4 Outcome of the complaint

### 2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the corporate team. In Q3 20 (50%) of complaints were not upheld; 7 (17%) were partially upheld, and 13 (32%) were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 10, 11 and 12 show the outcome of complaints by Division.

**Figure 10: Outcome of 40 complaints closed in Q3 received in Q3 2020/21**

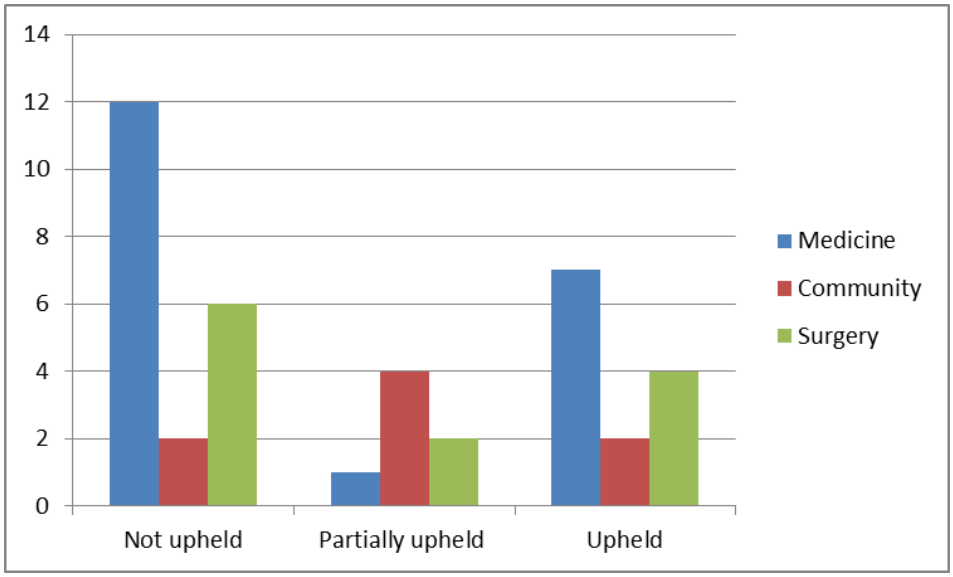


**Figure 11: Outcome of 16 complaints closed in Q3 received in Q2 2020/21**

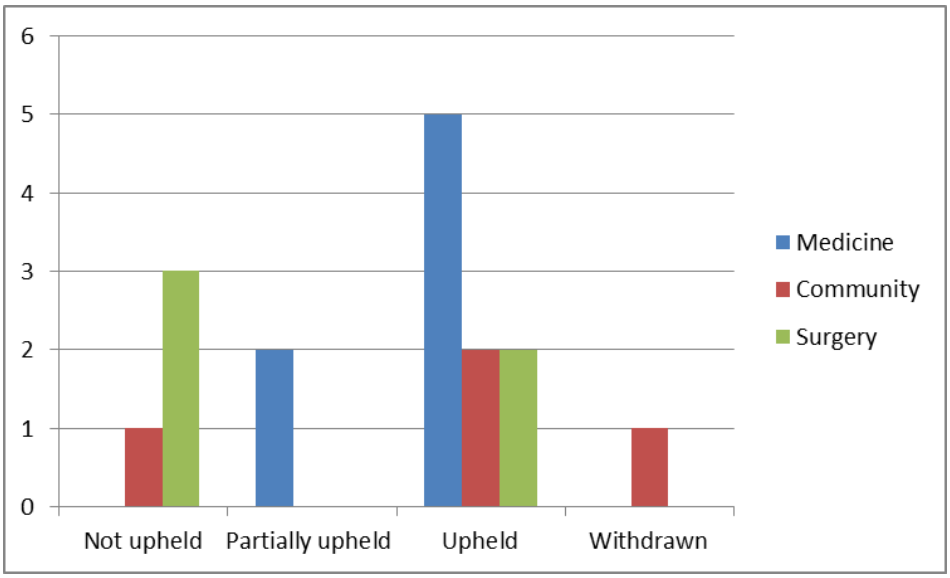
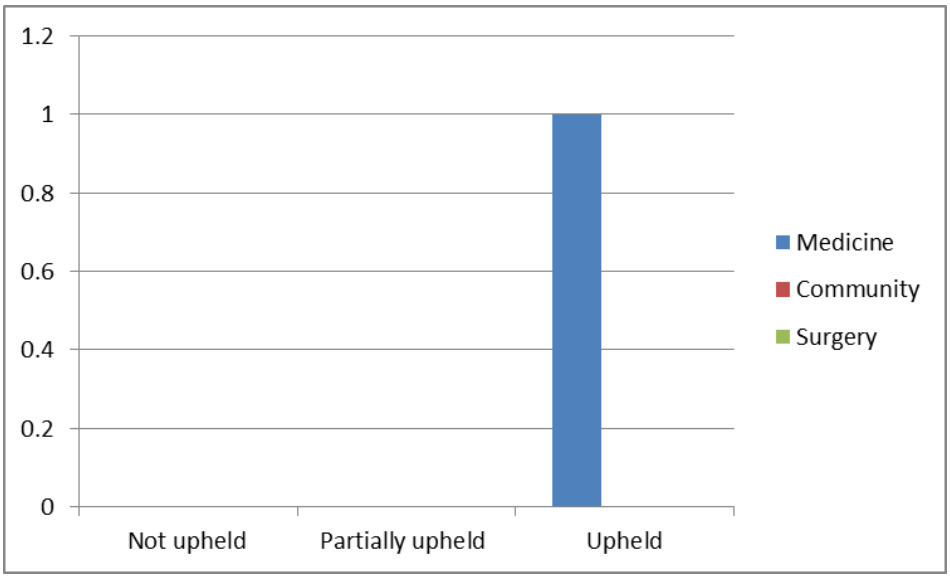



**Figure 12: Outcome of 1 complaint closed in Q3 received in Q4 2019/20**




## 2.4.2 Second stage complaints

Previous complaints reports have not included data regarding second stage complaints, however it is recognised that this is a rich source of valuable data and a key indicator of our performance which can be triangulated to inform the Trust of how satisfied our families are with the quality of our response and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Going forward, second stage complaints will be monitored on a monthly basis as a key performance indicator, and will be reported on in subsequent Trust Board complaint reports.

The initial response letter advises the complainant that should they be dissatisfied with any part of the initial complaint response, or require further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

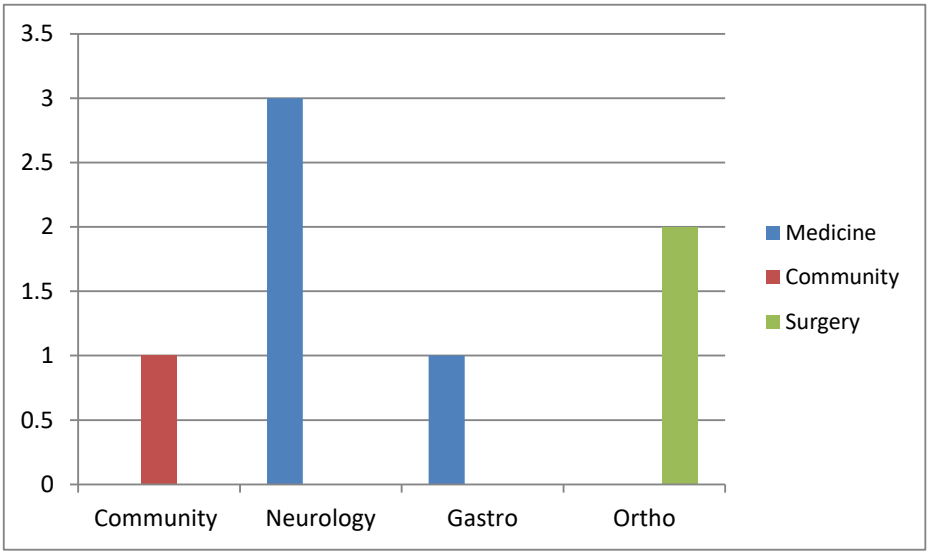
In Q3, 7 families informed us that they were not satisfied with the outcome of their initial complaint response: 6 of 34 complaints received in Q2 and responded to in Q2 / Q3; and 1 of 40 complaints received and responded to in Q3. This equates to 9% of the complaint responses (7 of 74). Whilst this indicates a majoritively high level of satisfaction with the quality and content of the initial complaint response, there is a need to monitor and review the reasons why families remain dissatisfied in order to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. One parent also justifiably raised that she was dissatisfied with the length of time she waited to receive an initial response, which took 73 days.

The 7 cases were investigated and responded to as second stage complaints; the 6 complaints that originated in Q2 have subsequently been closed and largely successfully resolved to the satisfaction of the complainants; 1 complaint received in Q3 remains open. Unfortunately some of our families continue to be dissatisfied with the cessation of a service for patients with Tourettes Syndrome. The outcome of the 6 complaints closed did not change following further review and investigation (2 not upheld; 4 partially upheld).

A breakdown of the speciality and the Division can be seen in Figure 13.

**Figure 13: Second stage complaints by service**




## 2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There were no referrals to the Parliamentary & Health Service Ombudsman during this period. There is one ongoing investigation related to the Surgical Division.

## 2.6 Actions and learning from complaints

Complaint Officers log actions and learning within Ulysses however the system requires significant development to enable actions to be pulled into an action log which can be monitored and tracked to completion; currently this requires manual input which is resource and labour intensive.

Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

Examples of improvements made to services as a result of concerns raised are:

### Medical Division:

**Concern**: PCO not responsive to Mother's telephone messages
**Action:** Service Manager to reiterate to the administration team the importance of responding to messages. The communication process with families was highlighted for discussion at the Divisions DIG meeting.

**Concern:** Communication failure – Administration
**Action:** Implement a robust process for the recording and escalation of parental contacts. A Task & Finish Group has been launched to review and improve the systems in place and to ensure consistency across the Division for parents wanting to contact specialty team – this is including a point of contact email address and single point of contact phone number on the specialty internet page

**Concern:** Query re the material a mask is made from
**Action:** Liaison with manufacturer and feedback to family

### Community Division:

**Concern:** Disputing son not being given an ADHD diagnosis
**Action:** Clinical letter to be amended to allow letters to correctly reflect when a telephone consultation has taken place

**Concern:** Waiting time for assessment and communication with PCO
**Action:** To ensure PCOs follow the process to complete the logging of appointments promptly at the same time that a date and time is confirmed.

**Concern:** Patient with Tourette's Syndrome falling between the two services of Neurology and CAMHS – no team taking the lead
**Action:** Where a patient is falling between two teams, a joint appointment may be the best option to agree a way forward

### Surgical Division:

**Concern:** Patient waiting over a year for confirmation of deep brain stimulation surgery due to lack of physio support

**Action:** Physio assessment obtained. Long waiting patient now treated. Service now supported long term with physio aligned to service

**Concern:** Patient refused procedure as mother did not want them to undergo covid swab
**Action:** Review of process and liaised with theatres and IPC team. Patient now offered procedure via 'red pathway' and communications around refusal of swab shared to enable surgery for children where swab is refused

**Concern:** Patient had a poor experience on surgical ward previously relating to mother not being offered meals whilst child is breastfeeding as child over 6 months of age
**Action:** Ward manager undertaking a review of policy to ensure approach is in line with peer organisations

## 3. PALS informal concerns

### 3.1 Number of informal PALS concerns received Q3 2020/21

There were 223 informal concerns received during Q3, a reduction of 55 from the previous Q2 when there were 278 reported, as shown in Figure 14, and a reduction of 70 compared to the 293 reported in the same period in Q3 2019/20, as shown in Figure 15. This decrease in contacts is due to the ongoing impact of the pandemic and a reduced volume of patients accessing our services, and also due to the introduction of the Family Support telephone helpline which aims to quickly resolve any issues.

The PALS service has been fully operational during the pandemic although the front facing office has been closed. The Family Support helpline was established as part of the Trust pandemic response as many families had enquiries and concerns they needed assistance with, and call handlers have been able to resolve a large number of issues and enquiries immediately thus negating informal PALS concerns or formal complaints being raised. PALS issues raised through the telephone support line are escalated to the relevant Division to support, contact and investigate with the concerned family member.

Whilst the PALS office has been closed for families to raise concerns face to face, clear posters has been displayed advising how concerns could be raised, in addition to information on how to raise a concern available on the Trust website. The PALS office has been fully Covid risk assessed and has re-opened from January 2021 with appropriate infection control measures taken. The learning from the family support line processes will be utilised in the development of a first contact resolution principle for the new PALS processes as part of the overall review.

**Figure 14: Number of PALS concerns 2020/21**

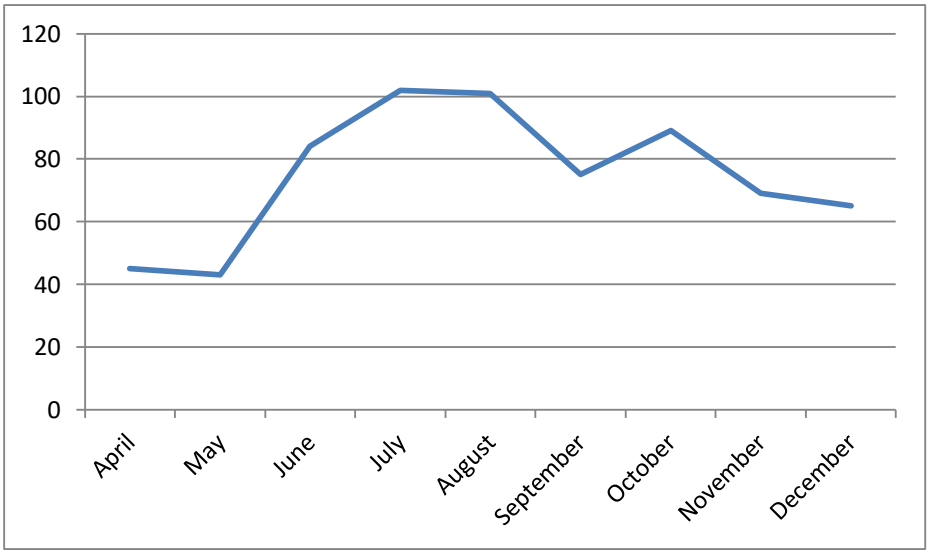



**Figure 15**

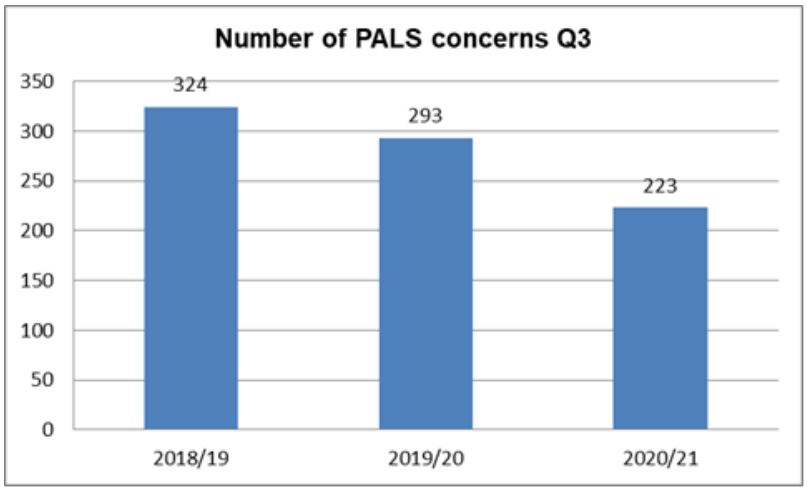
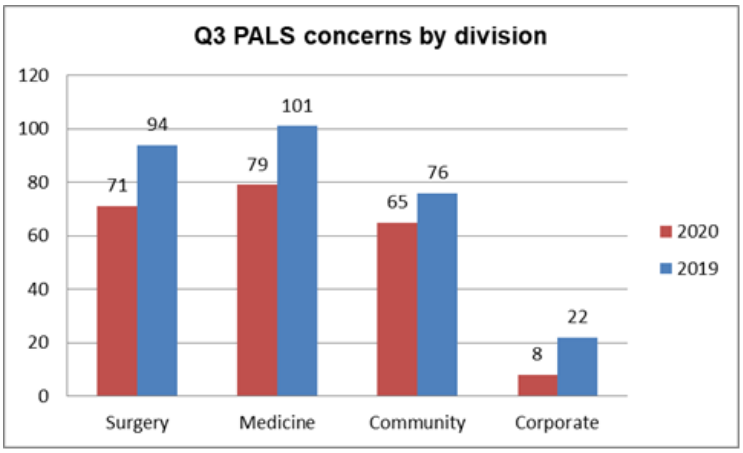



Figure 16 shows the number of informal PALS concerns by Division in Q3 2020/21 compared with the same period in 2019/20; demonstrating a reduction in all Divisions.

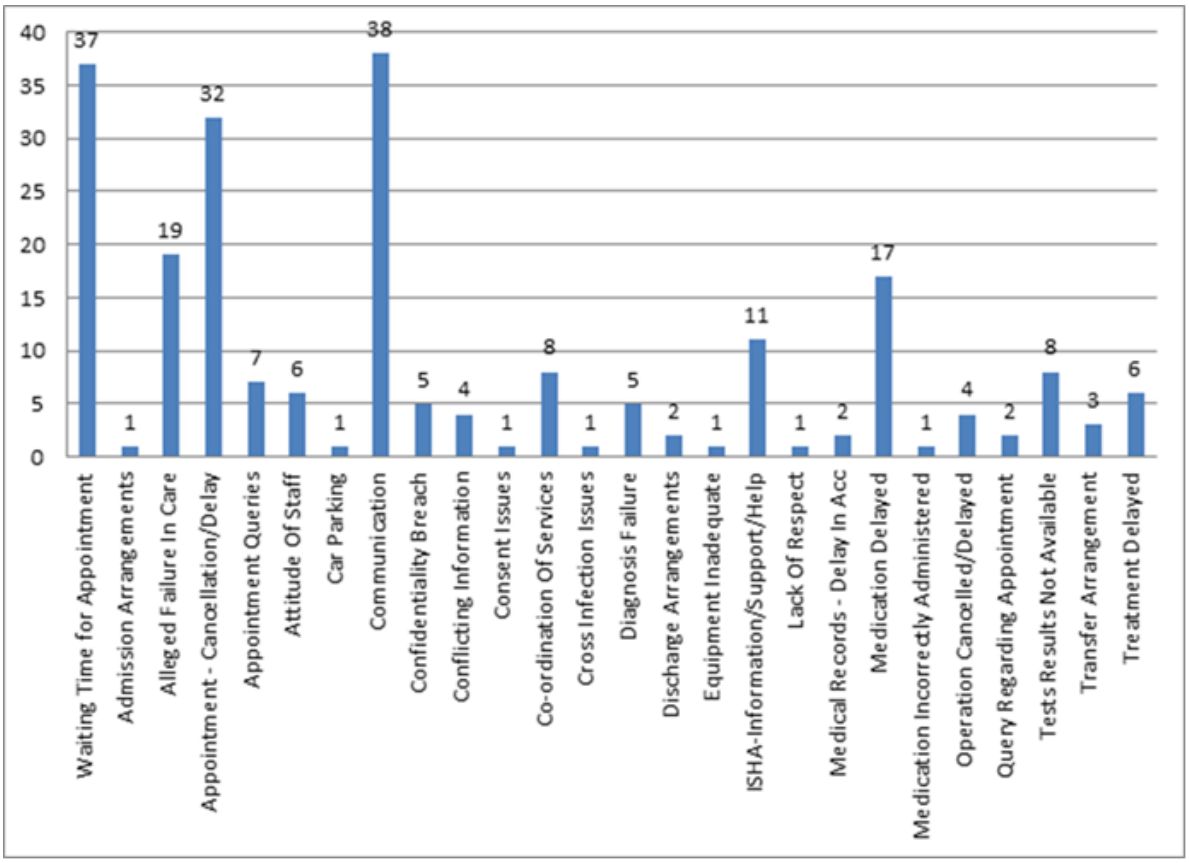
**Figure 16**



## 3.2 Informal PALS concerns received by category Q3 2020/21

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q3 continue to relate to appointment waiting times or appointment cancellations, and communication as shown in Figure 17.

**Figure 17: Categories of informal PALS concerns**

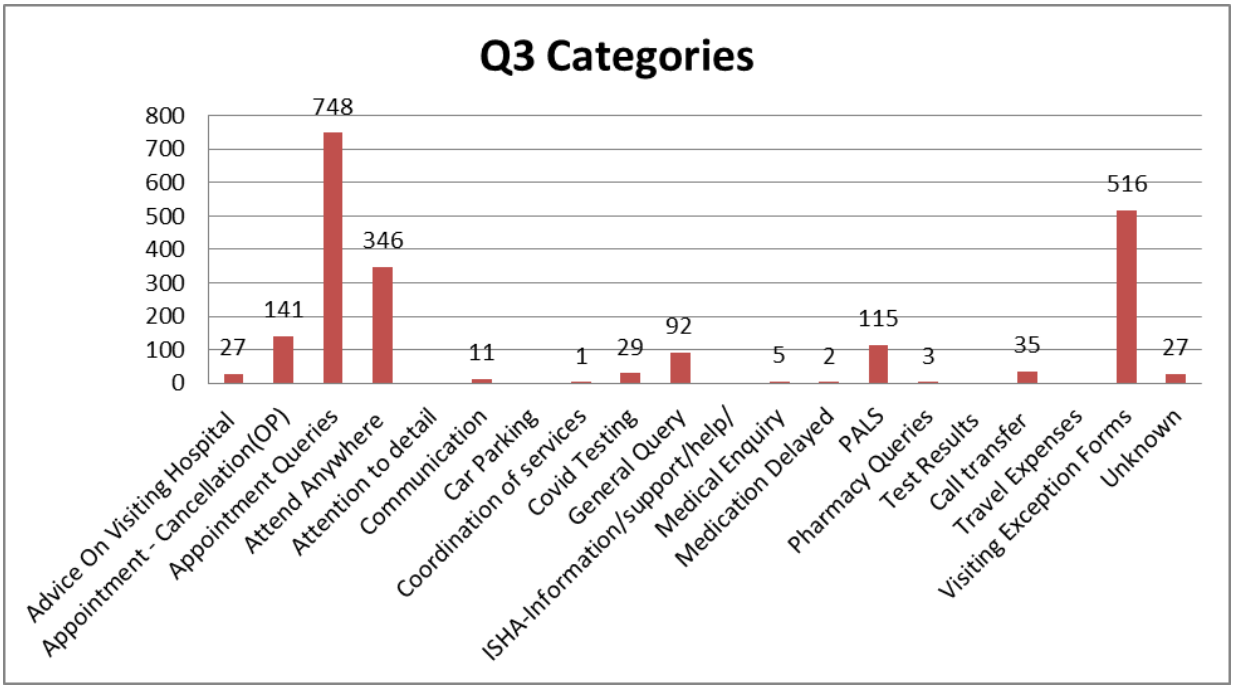



As described above, a significant improvement for families wishing to raise an enquiry or needing support has been through the establishment of the Family Support helpline initially set up as a pandemic helpline. In Q3, 2098 calls were received, an increase of 380 compared to the 1718 calls received in Q2; this figure is inclusive of any informal PALS concern raised by telephone. The call line is currently staffed by members of the Patient Experience team who are shielding or the Concierge staff. The call line currently operates from 0900-1800 Monday to Friday and 0900-1500 at the weekend, providing increased accessibility for our families needing help, and has responded to an average of 146 calls per week through Q2 and Q3. It is acknowledged that a proportion of these calls will have been made to different services within the Trust prior to establishing the helpline however families have fed back that the central point of contact has been useful in ensuring their call is directed appropriately as required.

The data shows that a large number of families contact the Trust for help, support and advice in relation to appointments: 748 appointment queries, 141 related to cancelled appointments, and 346 regarding Attend Anywhere (see Figure 18). Triangulation of this data with the PALS numbers (37 waiting time for appointment and 32 cancellations)

demonstrates that this is the highest contact reason for families. The Patient Experience Team are working in collaboration with the Out Patient Department senior leadership team to review the most appropriate model to respond to appointment enquiries or concerns.

**Figure 18: Categories of calls to the Family Support telephone helpline**




## 3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5 day response

The PALS and Complaints teams endeavour to respond to concerns within the 5 day timeframe in order to try and obtain quicker resolution for children and young people. For Q3, the KPI of 90% of concerns responded to within 5 days was not met, with only 61% of PALS reported to be concluded within this time period as recorded within the Ulysses system and shown in the table below.

| PALS | Received Q3 | Q3 5 day response | Q3 overdue |
|---|---|---|---|
| Surgery | 71 | 36 (50.7%) | 35 (49.3%) |
| Medicine | 79 | 53 (67.1%) | 26 (32.9%) |
| Community | 65 | 39 (60%) | 26 (40%) |
| Corporate | 8 | 3 (37.5%) | 5 (62.5%) |
| **Total** | **223** | **136 (61%)** | **87 (39%)** |

The Chief Nurse has commissioned the Director of Nursing to undertake a full review of the structure and process for responding to PALS, including corporate and divisional roles and responsibilities relating to the management of concerns in order to improve compliance and resolve concerns in a timely way for children, young people and their families. This review has commenced in collaboration with Divisional leads and the Trust Patient Experience lead.

The aim is that once established, implemented and embedded there will be an improving trend of responding to informal concerns within the Trust timescale of 5 days.

Going forward, compliance will be shown with a 12 month rolling graph where it is anticipated that improvements with compliance will be evident.

### 3.4 Actions and learning from informal PALS concerns

Themes and trends regarding informal PALS concerns are reviewed at the Divisional Integrated Governance meetings to ensure dissemination, learning and identification of local and strategic actions. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

## 4. Compliments in Q3

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback and demonstrating that a family feels compelled to share this with us by taking precious time to share what has been good about their experience. This feedback also provides important balance with concerns raised.

There is currently limited information recorded in the central Ulysses system in regards to compliments although it must be noted that the Community Division continue to input a large number of compliments as shown in the table below. It is acknowledged that the Trust receives many more compliments which have not been centrally recorded. Moving forward, the review of the complaints and PALS structure and roles will include capturing this important evidence of positive patient and family experiences.

| Division | No. of compliments |
|---|---|
| Community | 41 |
| Medicine | 7 |
| Surgery | 1 |
| Joint Medicine and Surgery | 1 |

Appendix I provides examples of compliments received during Q3.

## 5. Proposed developments in the management of complaints and PALS

The Chief Nurse has commissioned the Director of Nursing to review the structure, responsibilities and process for management of complaints and PALS in the Trust to include a central corporate function which will sit within the Patient Experience team. It is expected that this action, together with the additional proposed actions and developments outlined below, will lead to a demonstrable improvement in compliance with KPI's, and more importantly a more timely and effective resolution for families who wish to raise concerns.

- Review RM6 Complaints and Concerns policy and process
- Review Ulysses Complaints module to ensure full and effective electronic management system for complaints and PALS

- End to end review of the PALS and complaints process viewed through the perspective of the family in order to ensure simple and effective resolution
- Review Ulysses system to develop capture of issues raised and resolved locally in wards, departments and services. Currently issues raised locally may be documented in the patient's health record however a more clear comprehensive audit trail and monitoring of locally resolved issues can be achieved through central reporting via Ulysses in the same way that staff report incidents. This will be a training need and culture shift
- Provide appropriate training for use of the Ulysses Complaints module
- Further develop electronic dashboard to monitor status and compliance of complaints
- Review and development of the Alder Hey website to ensure appropriate advice and information for families who wish to provide a compliment or raise a concern with a clear and easy process; engage and involve users in the review
- Monitor calls to the Family Support line to identify themes, trends and improvements required
- Production of year end report in Q4 detailing greater analysis and comparison of annual trends, compliance, learning and improvements
- To develop a monthly report on compliments, PALS and complaints including greater oversight of compliance with KPI's which is reviewed at CQSG and reported to SQAC
- Greater oversight and monitoring of instant resolution to issues raised by families

## 6. Conclusion

The Trust Board are asked to note the content of this report and support the proposed developments outlined in section 5 of this report.

## Appendix I: Examples of compliments received during Q3

### Ward 4B

Mum asked ward sister to pass on that she found the staff very kind, helpful and professional during her daughters stay, particularly Jess, Beth and Lydia.

### ED and Burns Unit

*"I was advised to bring my daughter in on Thursday (1/10/20) with suspected sepsis from an abscess. The staff in A&E were wonderful and made my daughter feel so at ease. She was kept in to have an operation on her mouth, and was given a bed in the burns ward. Every single member of staff that we saw over the few days there, were absolutely incredible and such a credit to the hospital. They made my daughter feel at ease throughout everything and helped me when feeling overwhelmed. As much as it was a whirlwind of a time, the surgical staff made sure we knew every little thing, even the slightest change to the forms, and helped my daughter understand too. I don't think I could have got through seeing my daughter go through what she did if it wasn't for each one of them. I have messaged you because I couldn't find a place for compliments, only complaints, and I honestly do not have one of them.*
*Thank you all so much again."*

### Diabetes

*"Dr Deakin and the nurse in the appointment spoke to (patient) direct and asked her questions rather that going through me, her mum, which makes her feel more in control. They have given her some excellent advice on managing her diabetes better. Considering it is obviously busy clinics they never make you feel rushed or anything like that. They take the time to listen to any questions or concerns that we may have."*

### Dewi Jones Unit

*"I can't thank you all enough, you saved her life time and time again, I don't have the words. You've done a fantastic job and you have done so much for (child) it means everything, how can I say thank you? The mind boggles at how you all do what you do, a big thumbs up and thanks you to you and to all the staff at the Dewi'."*

### Developmental Paediatrics

*"I would just like to express my sincere thanks to Laura-Secretary for all her prompt responses and support she has given to our little family at this time. Laura ensures emails are answered with speed, she will seek out information for you, from specialist and if she says she will "get back to you", she will. Like many of our services, Laura, IBS and Dr Chahal's team are under tremendous pressure, helping children like my son, and sadly this has been a very difficult time for my son, but the team have been excellent and we couldn't thank them enough.*

### CAMHS – Liverpool

Patient brought to a planned face to face appointment a Christmas Card for member of staff with the following message:

*"Dear Claire,*
*Thank you for working with me for the last six months! I always look forward to seeing you. You make me feel a bit better and helped me to understand some things about myself, for example, the reasons why I get angry and violent. I hope that you and your family and all your cats have a really good Christmas and New Year. Thank you for always being patient and listening to me."*

## Pain Service

*"Dear Louise*
*I am writing with thanks to an Alder Hey staff member. I have put feedback on the website also. Our daughter is under the care of Mr Healey at Alder Hey. She constantly struggles with pain and I am in frequent contact with Linda Hounsell who is Mr Healey's secretary.*

*Linda is such an amazing lady, polite caring and extremely efficient. Even though I tell her how much I appreciate what she does when I speak to her, I want to pass on my thanks through you. As a nurse myself but no longer working for the NHS but now as an advisor within occupational Health I have an awareness of how busy and stretched the NHS is. Not only that, I feel that it is important to recognise the people behind the scenes that are often forgot.*

*Having a child in constant pain is stressful in itself but when I email or contact Linda for further treatment she answers straight away and even though she is not clinical she is such an extremely caring lady that she puts me at such ease. This lady is amazing and such an asset to Alder hey.*

*My local hospital in North Wales have Seren (star) awards which gives awards to exceptional staff and I really hope Linda could receive an equivalent at Alder hey.*

*This lady has a heart of gold and we think she's amazing. I'd be grateful if you could pass on our thanks and let her know what an amazing lady she is and an asset to the NHS and thank her for her continued help with Meg.*
*Thank you so much"*

Alder Hey Children's NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday 25th March 2021**

| | |
|---|---|
| **Paper Title:** | **Update regarding current demand and access to Locality Based Specialist Mental Health Services & Eating Disorder Service** |
| **Report of:** | **Lisa Cooper, Director Community & Mental Health Services** |
| **Paper Prepared by:** | **Rachel Greer, Associate Chief Operating Officer**<br>**Kate Holian, General Manager** |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☐<br>Information ■<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | Previous paper submitted June 2020 |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Impact:** | Investment required has been shared with CCGs |
| **Links to risk register** | Following risks identified on risk register:<br>• Risk 1560 (score 12) – waiting times<br>• Risk 2360 (score 12) – wait for treatment<br>• Risk 2361 (score 9) – wait for assessment<br>• Risk 2219 (score 10) – waiting times (EDS) |

## 1. Introduction

The purpose of this paper is to provide an update to Trust Board regarding:

- Current access times for Locality Based Specialist Mental Health Services and Eating Disorders Service
- Current position statement relating to capacity and demand challenges within Locality Based Specialist Mental Health Services and Eating Disorders Service
- Workforce requirements to reduce and maintain waiting times to the agreed internal standard presented at Trust Board in June 2020 for Locality Based Specialist Mental Health Services (Liverpool and Sefton)

## 2. Background

Alder Hey currently provides a wide range of Specialist Mental Health Services to children and young people living in Liverpool and Sefton as part of a wider partnership of mental health support offered including third sector organisations. The following services are provided Eating Disorders Service; Crisis Care Service; Specialist Locality Based Services; Intensive Support Team (Pilot); Tier 4 In patient Unit (regional under 13s) and Health Psychology (Regional and Local).

At Trust Board in January 2020, it was agreed to introduce the following internal monitoring standards for locality based mental health services:

- 92% Referral to Choice within 6 weeks
- 92% Choice to Partnership within 12 weeks
- 92% overall pathway wait (referral to partnership) within 18 weeks
- Number of young people waiting over 52 weeks
- No average waits to be reported

In June 2020, an update was provided to Trust Board regarding the impact of COVID-19 on waiting times within Specialist Mental Health Services and proposed a revised trajectory to meet 92% which included two scenarios: trajectory based on pre-COVID 19 referral rates and a trajectory based on an anticipated 15% increase in referrals to Specialist Mental Health Services.

## 3. Impact of COVID-19 on Specialist Mental Health Services

Throughout COVID-19 Alder Hey has continued to support all Specialist Mental Health Services to remain open and provide support to children and young people who need to access care. Staff have worked flexibly and undertaken additional hours to ensure that those children and young people most at risk have continued to receive safe and effective care. All services have fully embraced and led the move to virtual appointments for children and young people.

The pandemic continues to impact on Specialist Mental Health Services who have experienced a higher number of children and young people presenting with deteriorating mental health and increased complexity. This has resulted in an increasing number of children and young people who are requiring urgent assessment and treatment.

## 4. Eating Disorder Service

The Eating Disorder Service is currently commissioned via CCGs to provide a service based on an expectation of 150 referrals per year. At the start of the Covid-19 period, referral rates were comparable to 2019. However, it is estimated that by the end of 2020/21, the service will have received 170 referrals **(Tables 1 & 2)**.

**Table 1: Referral rates to Eating Disorder Service (CCG)**

| CCG | 2019/20 | 2020/21 (M10) | 2020/21 (Forecast FYE) |
|---|---|---|---|
| Liverpool | 84 | 73 | 88 |
| South Sefton | 26 | 39 | 47 |
| Southport & Formby | 33 | 28 | 34 |
| Out of area | 4 | 2 | 2 |
| **Total** | **147** | **142** | **170** |

**Table 2: Referral rates to Eating Disorder Service by month**

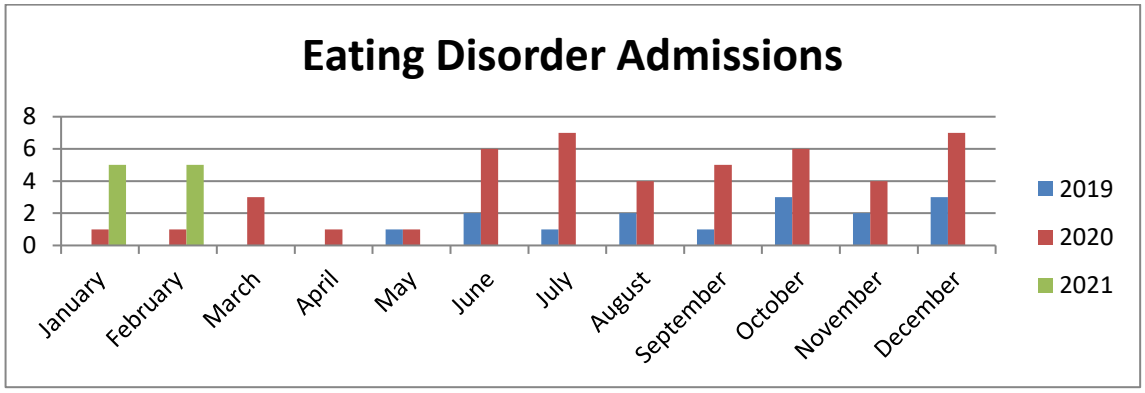
| Month | 2019/20 | 2020/21 |
|---|---|---|
| November | 9 | 16 |
| December | 13 | 13 |
| January | 8 | 18 |
| February | 28 | 23 |
| **Total** | **58** | **70** |

In addition to increased referral rates the service has also seen:

- An increase in the number of children and young people that are presenting at their first assessment as being at high physical risk, due to weight loss and requiring a paediatric admission to stabilise their physical health risk and to support refeeding.
- A decline in the health of young people known to the service that, prior to lockdown, were recovering from an eating disorder and working towards improving both their physical and mental health. The impact of the period of lockdown, with the lack of routine, isolation from peers, increase in opportunities to exercise has significantly affected their eating disorder symptoms with their physical and mental health risk increasing.

During COVID-19 the service has seen the highest number of paediatric admissions for young people with an eating disorder since the service commenced **(Figure 1)**.

**Figure 1: Eating Disorder Inpatient admissions by year**




The Service has continued to offer both face to face monitoring and treatment for children and young people that are in the high risk category and have increased the intensity of treatment for this cohort by providing home visits to support meal times. The Alder Hey Charity has also supported with telemedicine monitoring for those children at home to ensure continuity of care.

The increase in children and young people that fall into the high risk category has resulted in the service needing to offer support over a seven day period, using overtime at weekends to support the paediatric ward and to provide telephone support to parents and young people to try to support avoidance of admission. This remains a cost pressure within the Community and Mental Health Division.

The increase in referrals has been managed within the team with additional overtime, with no breaches of national waiting times since June 2020. In June 2020, there was one breach of routine target, due to a young person's choice. However, due to the increase in referrals in February 2021, there will be at least 15 young people breaching the routine waiting time target in February and March 2021 **(Table 3)**. It is anticipated that this increase will continue as are no available new routine appointment slots until May 2021.

**Table 3: Compliance with national waiting times targets - Eating Disorder Service**

| Metric | April 2020 | May 2020 | June 2020 | July 2020 | Aug 2020 | Sept 2020 | Oct 2020 | Nov 2020 | Dec 2020 | Jan 2020 | Feb 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Routine (28 days) | 69.2 % | 90% | 87.5 % | 100 % | 100 % | 100 % | 100 % | 100 % | 100 % | 100 % | 31.2 % |
| Urgent (7 days) | 66.7 % | 100 % | 100% | 100 % | 100 % | 100 % | 100 % | 100 % | 100 % | 100 % | 100% |

In order to meet the current increased demand within the Eating Disorder Services an additional 2.0 wte Band 7 staff are required.

## 5. Locality Based Mental Health Services (Liverpool & Sefton)

Whilst there was an initial reduction in referrals at the start of the COVID-19 period, referrals to locality based mental health services have increased since the first lockdown, with a 20% increase during August – December 2020 compared to the same period in 2019.

**Table 5: Number of accepted referrals to Locality Mental Health Services**

| Year | Jan | Feb | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019 | 203 | 211 | 232 | 190 | 218 | 173 | 175 | 125 | 161 | 251 | 176 | 151 | **2266** |
| 2020 | 207 | 230 | 169 | 67 | 93 | 143 | 154 | 147 | 268 | 193 | 231 | 196 | **2098** |
| 2021 | 157 | | | | | | | | | | | | |

Both Liverpool and Sefton locality services have seen a significant increase in the urgency, complexity and risk contained within referrals received, which has resulted in children and young people needing to be seen within 2 weeks. This cohort of children and young people require higher intensity work requiring several contacts per week. **Table 6** shows the access times for locality based mental health services (28 February 2021).

**Table 6: Current Locality Based Mental Health Services (Liverpool and Sefton)**

| Appointment Type | Standard | Liverpool | Sefton |
|---|---|---|---|
| | | February 2021 | February 2021 |
| Choice | Number of young people waiting for Choice | 154 | 55 |
| | % of young people assessed within 6 weeks of referral (Choice) | 56.5% | 72.7% |
| | Waiting times (weeks) | 0-15 | 0-13 |
| Partnership | Number of young people waiting for treatment | 335 | 159 |
| | % of young people assessed within 18 weeks of referral (Partnership) | 72.5% | 58.5% |
| | Waiting times (weeks) | 0-50 | 0-53 |

There was 1 young person waiting over 52 weeks at the end of February 2021 who was seen in early March 2021.

The following actions are in place to provide a sustainable reduction in waiting times:

- Increase in number of Choice and Partnership appointments being offered through existing staff job plans and additional weekend/evening activity.
- Utilisation of fixed term winter funding provided by CCGs to support additional capacity on a short term basis.
- Review of staff job plans to identify additional capacity
- Implementation of evidence-based group interventions targeted at the specific needs of children and young people waiting for an appointment. A Single Session Therapy model has been introduced in Liverpool locality and group interventions are due to be rolled out April 2021 in Sefton locality.
- A request for investment to Sefton and Liverpool CCGs is developed and submitted as part of contract discussions.

- Robust Clinical Lead and Assistant Clinical Lead oversight of caseload management, in addition to ongoing work with Business Intelligence to develop real-time case load management dashboards
- Introduction of Calm and Connected COVID-19 peer support groups (temporarily funded by National Lottery); this is undergoing review to determine whether this can be extended/integrated into service subject to further charitable funding.

In addition, the following strategic service developments are taking place to provide long term improvements to access and capacity in the service:

- Strengthening of the consultation model provided into the Local Authority and schools to provide improved management of cases at the point of referral
- Implementation of a five year workforce staffing plan to review new routes into Mental Health, and improve workforce retention and sustainability
- Improvements in multi-agency care planning to support discharge/ transition of children and young people who no longer require specialist mental health services
- Provision of three additional Mental Health Support Teams (1 x Liverpool, 2 x Sefton) to support school facing services and support for mental health leads in schools.

In June 2020, two trajectories were provided to Trust Board based on two scenarios. Scenario 1 assumed no increase in referrals for locality based mental health services in comparison to 2019/20 and scenario 2 modelled a potential 15% increase in referrals (Cheshire & Merseyside regional modelling). However, national predictions are for a 30% increase in referrals over the next two years, with the majority of referrals being in the next 12 months. Additional guidance is expected regarding increasing complexity of presentations.

In order to meet the predicted 30% increase in demand and complexity of children and young people presenting to the Trust's locality based mental health services the following investment in workforce is required:

- 12.0wte Mental Health Practitioners (Sefton x 7.0wte; Liverpool x 5.0wte)
- 1.0wte Consultant Psychiatrist

Whilst non-recurrent funding has been provided by Sefton CCGs to provide short term capacity in Sefton, this is for a period of six month and will not support the service to maintain the agreed internal waiting time targets.

Provided that capacity meets demand for the service and based on the current waiting list size, the recovery period to achieve 92% RTT will take approx. **6 months.**

Whilst this could be reduced with additonal short term capacity to address the waiting lists, there are significant challenges in recruiting fixed term posts in specialist mental health services.

## 8. Governance and Monitoring Arrangements

The agreed actions are designed to deliver safe, effective and evidence based Specialist Mental Health services within a maximum 18 week overall pathway for all children and young people referred to the services. This is an internal Trust target.

The agreed actions were developed using the current data available to the Community and Mental Health Division and are made with a number of key assumptions:

- Staff absence reduces and service provision is not affected by further waves of COVID-19
- Staff maintain clinical caseloads within the level recommended by the Clinical Service Leads
- Referrals do not increase over a predicted 30% increase
- The number of children and young people requiring urgent assessment and treatment does not increase further than current levels

The action plan is monitored on a weekly basis within the division and monthly through the Trust's Access to Care group. In addition, waiting times are reported through CCG contract monitoring processes and to relevant Liverpool and Sefton Mental Health Partnership Boards.

## 9. Next Steps

The Trust Board is asked to note the contents of this report.

NHS
Alder Hey Children's
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# TRUST BOARD Report February 2021

How Did We Do?

**Executive Summary** **Month: February** **Year: 2021**



Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

## Safe

- All incidents reported resulted either in no harm, minor harm or non - permanent harm
- Work continues around the target for sepsis treatment both in AED and for in patients. There are challenges around the pathway and patient acuity which are being reviewed

### Highlight

- 0 clinical incidents resulting in moderate harm or above
- 0 category 3 or 4 pressure ulcers
- 0 never events

### Challenges

- 3 medication errors resulting in harm -An insulin dose was calculated and given to the wrong patient. IV infusion pumps were mixed up resulting in 2 drugs being given at the wrong rate to a patient. There was a delay in a patient receiving adequate post-op analgesia. Practitioners involved in these errors have reflected on them and we are planning to roll out a scheme to help reduce interruptions to medicines administration across the hospital.
- 1 Hospital acquired MSSA relating to a 6/12 month old baby with an undiagnosed metabolic disorder. A portacath inserted on the 16/2 became infected and was subsequently removed and the baby treated with antibiotics. Blood cultures were positive on the 25/2.

The Best People Doing their Best Work

## Caring

- Friends and Family responses continue to be extremely positive with those recommending the Trust consistently over 90% of those completing the survey
- PALS and complaint numbers are at a consistent level. Work is ongoing to look at the review, QC and sign off process at Divisional and Corporate level.

### Highlight

- 96.7% of those completing the survey in community would recommend the Trust
- 96% of those completing the survey in OPD would recommend the Trust

### Challenges

- Only 90.4% of those completing the survey in inpatient wards would recommend the Trust. The lowest figure of the year
- Only 90.3% of those completing the survey in CAMHS would recommend the Trust

Delivery of Outstanding Care

## Effective

- Our performance against the effective domain is strong with excellent timeliness of care in the ED, treating 97.7% of patients within 4 hours; and low numbers of re-admissions to PICU and cancelled operations.

### Highlight

- Timeliness of care in the Emergency Department
- 1.9% of children who were discharged from PICU were readmitted within 48 hours
- Low number of cancelled operations

### Challenges

Delivery of Outstanding Care

## Responsive

- Consistently high performance across all the in- patient survey scores particularly around the questions of being treated with respect and knowing the planned discharge date
- There has been a significant increase in the number of children and young people waiting over 52 weeks for treatment. The majority of patients with a long waiting time are awaiting admitted elective care. The primary driver of this increase is the contraction in access to operating theatre sessions during wave 3 of COVID-19. The full theatre schedule has since been restored (following closure of the AICU) and a significant programme of weekend operating is scheduled for March to June. We have submitted to the Cheshire & Merseyside recovery cell an elective recovery plan with a 12-month clearance timescale.

### Highlight

- 85.9% of people completing the in- patient survey said they were involved in Play. The highest score of the year reflecting improved engagement during COVID due to process review and Play staff returning to work
- 92.9% of people completing the in- patient survey said they were involved in learning, which continues to be a much improved position.
- Access to cancer care
- Improvement in timeliness of diagnostic care

### Challenges

- 307 patients waiting greater than 52 weeks reflecting the impact of COVID.
- Access to planned care including an increase in the number of patients waiting over 52 weeks for treatment

The Best People Doing their Best Work

## Well Led

For the Month of February (Month 11), the Trust is reporting an in-month deficit of £0.4m which is £0.6m ahead of plan.

The year to date deficit is now £3.6m which continues to improve following the recognition of a reduction in PDC dividend payable of £0.6m, primarily given the Trusts large cash balance to fund the capital programme. The Trust is currently forecasting a £1.2m deficit which is in line with NHSI's revised expectations.

Elective & Daycase activity in February was 387 spells down on the same period last year, outpatient activity was also lower than the corresponding period in 2020 (1,450 attendances), however non-elective activity was also 450 spells below the prior year.

Mandatory Training has increased to 86% as of 1st March 2021. We continue to work with SMEs and topic leads to improve compliance in order to achieve our 90% target. All staff not 100% compliant received a direct email last month to advise them of their outstanding training and instructions of how to complete.

Sickness absence in February saw a significant decrease of 1.3%, in line with the decrease of Covid-19 cases in the wider Community. The HR team continue to work closely with managers and leaders across the Trust to provide advice and guidance and to ensure appropriate support is in place.

The PDR window is due to re-open in April 2021 for this year's appraisal process which is scheduled to run until the end of July 2021. This year it will also include a wellbeing conversation between staff and managers.

### Highlight

- Financial Performance
- Sickness Levels

### Challenges

- Activity Levels
- Mandatory Training
- PDR's

Game Changing Research and Innovation

## Research and Development

Month 11 Research Activity:

- 116 research studies currently open (incl. 10 Urgent Public Health studies)
- 403 patients recruited to research studies (5145 in 20/21)

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**

- Reaching the patient recruitment target for Recovery trial (Urgent Public Health study)

**Challenges**

- Progress with restarting suspended NIHR studies

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Alder Hey Children's NHS
NHS Foundation Trust

# 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 |
|---|---|---|---|---|---|
| 0 | 0 | 0 | 3 | 0 | 80.56 % |
| Feb 2021 | Feb 2021 | Feb 2021 | Feb 2021 | Feb 2021 | Feb 2021 |

| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients |
|---|
| 84 % |
| Feb 2021 |

**CARING**

| Friends & Family: Overall Percentage Recommended Trust |
|---|
| 94.94 % |
| Feb 2021 |

**EFFECTIVE**

| ED: 95% Treated within 4 Hours |
|---|
| 97.74 % |
| Feb 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 % | 95.78 % |
| Feb 2021 | Feb 2021 | Feb 2021 | Feb 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 % | 63.43 % | 307 | 11535 |
| Feb 2021 | Feb 2021 | Feb 2021 | Feb 2021 |

**WELL LED**

| Cash in Bank (£'000s) | Control Total In Month Variance (£'000s) | Mandatory Training | Safer Staffing (Shift Fill Rate) | Sickness |
|---|---|---|---|---|
| 110871 | 590.55 | 85.83 % | 94.50 % | 5.77 % |
| Feb 2021 | Feb 2021 | Feb 2021 | Feb 2021 | Feb 2021 |

Delivery of Outstanding Care

SAFE


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of Near Miss, No Harm & Minor Harm | D | 99.8% | 100.0% | 99.6% | 100.0% | 100.0% | 98.9% | 99.1% | 100.0% | 100.0% | 100.0% | 99.8% | 99.1% | 100.0% | | >=99 % N/A <99 % | ✔ |
| Clinical Incidents resulting in Near Miss | D | 72 | 48 | 39 | 48 | 60 | 86 | 54 | 50 | 79 | 104 | 78 | 52 | 66 | | No Threshold | |
| Clinical Incidents resulting in No Harm | D | 335 | 237 | 138 | 261 | 285 | 380 | 318 | 338 | 323 | 401 | 309 | 288 | 327 | | No Threshold | |
| Clinical Incidents resulting in minor, non permanent harm | D | 82 | 62 | 48 | 57 | 89 | 92 | 83 | 72 | 68 | 87 | 75 | 80 | 80 | | No Threshold | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 1 | 0 | 1 | 0 | 0 | 6 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | | No Threshold | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 | ✔ |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 | ✔ |
| Medication errors resulting in harm | D | 2 | 2 | 1 | 5 | 7 | 6 | 2 | 8 | 1 | 11 | 0 | 6 | 3 | | <=2 N/A >2 | ✔ |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 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 | ✔ |
| Never Events | W | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Sepsis: Patients treated for Sepsis - A&E | D P | 86.5% | 83.3% | 60.9% | 95.5% | 96.2% | 79.2% | 77.3% | 85.2% | 74.1% | 79.2% | 73.7% | 89.5% | 80.6% | | >=90 % N/A <90 % | ✔ |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 88.2% | 88.9% | 93.8% | 87.5% | 90.9% | 88.5% | 85.2% | 86.1% | 94.3% | 80.8% | 70.8% | 87.5% | 84.0% | | >=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 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - MSSA | D | 2 | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 0 | 1 | 0 | 3 | 1 | | No Threshold | |

The Best People doing their best Work

CARING


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D Drive W Watch P Programme

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family: Overall Percentage Recommended Trust | W | 94.3% | | 96.9% | 94.2% | 94.9% | 94.6% | 93.8% | 90.6% | 94.7% | 93.7% | 91.5% | 95.3% | 94.9% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family A&E - % Recommend the Trust | D | 87.6% | | 96.1% | 92.9% | 92.3% | 90.7% | 91.5% | 84.4% | 92.1% | 89.2% | 91.5% | 93.2% | 93.1% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Community - % Recommend the Trust | D | 91.8% | | 100.0% | 100.0% | 95.2% | 95.2% | 92.3% | 89.1% | 94.7% | 98.8% | 100.0% | 92.7% | 96.7% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Inpatients - % Recommend the Trust | D | 95.7% | | 94.4% | 90.8% | 93.3% | 97.0% | 95.1% | 92.4% | 94.5% | 95.5% | 93.4% | 94.2% | 90.4% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Mental Health - % Recommend the Trust | D | 80.0% | | 100.0% | 90.9% | 100.0% | 100.0% | 82.4% | 92.3% | 89.7% | 91.3% | 100.0% | 96.3% | 90.3% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Outpatients - % Recommend the Trust | D P | 96.1% | | 97.4% | 96.9% | 96.6% | 96.0% | 95.7% | 94.1% | 95.5% | 93.9% | 90.4% | 96.1% | 96.0% | | >=95 % >=90 % <90 % | ✔ |
| Complaints | W | 10 | 9 | 7 | 6 | 10 | 5 | 20 | 11 | 19 | 15 | 10 | 16 | 12 | | No Threshold | |
| PALS | W | 114 | 74 | 45 | 44 | 86 | 105 | 105 | 77 | 96 | 71 | 65 | 67 | 88 | | No Threshold | |

Delivery of Outstanding Care

## EFFECTIVE


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | 0.0% | 0.0% | 0.0% | 0.0% | 4.0% | 1.4% | 0.0% | 0.0% | 1.6% | 4.2% | 1.4% | 0.0% | 1.9% | | <=3 % | N/A | >3 % | ✔ |
| ED: 95% Treated within 4 Hours | D | 86.8% | 89.5% | 97.2% | 97.8% | 98.5% | 97.3% | 97.7% | 95.1% | 96.8% | 97.1% | 98.6% | 98.5% | 97.7% | | >=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 | 41 | 36 | 6 | 5 | 3 | 7 | 18 | 17 | 19 | 16 | 10 | 5 | 7 | | <=30 | N/A | >30 | ✔ |
| 28 Day Breaches | W | 4 | 7 | 24 | 1 | 2 | 0 | 0 | 8 | 2 | 1 | 3 | 3 | 1 | | 0 | N/A | >0 | ✔ |

Delivery of Outstanding Care

RESPONSIVE


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 97.8% | 96.4% | 91.5% | 93.2% | 94.1% | 99.3% | 95.9% | 95.4% | 95.4% | 95.7% | 97.5% | 99.3% | 93.6% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Treated with respect | W | 97.6% | 98.1% | 100.0% | 97.7% | 94.1% | 98.5% | 97.9% | 96.0% | 98.3% | 98.6% | 97.5% | 100.0% | 98.1% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Know their planned date of discharge | D P | 89.6% | 91.1% | 87.3% | 95.5% | 95.8% | 98.5% | 93.2% | 97.1% | 96.7% | 97.8% | 95.0% | 98.5% | 98.1% | | >=90 % >=85 % <85 % | ✔ |
| IP Survey: % Know who is in charge of their care | W | 97.6% | 96.1% | 88.7% | 90.9% | 90.8% | 91.1% | 99.3% | 98.3% | 100.0% | 99.3% | 91.7% | 100.0% | 94.9% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Patients involved in Play | D | 92.5% | 94.2% | 60.6% | 78.4% | 64.7% | 72.6% | 81.5% | 82.3% | 83.3% | 84.9% | 76.7% | 80.3% | 85.9% | | >=90 % >=85 % <85 % | ✔ |
| IP Survey: % Patients involved in Learning | D | 78.0% | 79.2% | 74.6% | 61.4% | 84.0% | 83.0% | 78.1% | 75.4% | 88.3% | 71.9% | 81.6% | 94.9% | 92.9% | | >=90 % >=85 % <85 % | ✔ |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 92.0% | 86.7% | 66.7% | 58.1% | 45.9% | 39.6% | 43.1% | 48.2% | 54.2% | 59.0% | 60.8% | 61.3% | 63.4% | | >=92 % >=90 % <90 % | ✔ |
| Waiting List Size | W | 12,895 | 12,162 | 11,046 | 10,909 | 11,248 | 11,022 | 11,402 | 11,000 | 10,939 | 10,832 | 10,520 | 10,722 | 11,535 | | <=12899 N/A >12899 | ✔ |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 5 | 15 | 52 | 82 | 79 | 158 | 131 | 143 | 144 | 182 | 222 | 307 | | 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% | 95.0% | 100.0% | 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% | 0.0% | 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% | 42.8% | 67.0% | 81.9% | 82.9% | 78.9% | 91.8% | 96.4% | 97.1% | 92.3% | 93.7% | 95.8% | | >=99 % N/A <99 % | |
| PFI: PPM% | | 95.0% | 99.0% | 99.0% | 100.0% | 100.0% | 100.0% | 99.0% | 99.0% | 100.0% | 98.0% | 99.0% | 99.0% | 99.0% | | >=98 % N/A <98 % | ✔ |

The Best People doing their best Work

## WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -488 | 693 | 0 | 0 | 0 | 0 | 0 | 0 | -358 | 332 | 687 | 243 | 591 | | >=-5% >=-20% <-20% | ✔ |
| Capital Expenditure In Month Variance (£'000s) | W | 3,820 | 300 | 1,287 | 1,792 | 3,503 | 936 | -483 | 4,518 | 187 | -1,733 | 1,610 | -1,979 | -3,207 | | >=-5% >=-10% <-10% | ✔ |
| Cash in Bank (£'000s) | W | 76,536 | 90,030 | 107,738 | 111,270 | 107,221 | 107,221 | 107,763 | 108,756 | 109,084 | 110,503 | 110,776 | 110,776 | 110,871 | | >=-5% >=-20% <-20% | ✔ |
| Income In Month Variance (£'000s) | W | 30 | 6,889 | 3,146 | -692 | 1,342 | 1,825 | 1,077 | 2,492 | -792 | 748 | 235 | 228 | 2,310 | | >=-5% >=-20% <-20% | ✔ |
| Pay In Month Variance (£'000s) | W | -627 | -709 | -1,433 | 691 | -312 | -340 | -291 | -1,160 | 20 | 492 | -192 | -373 | -387 | | >=-5% >=-20% <-20% | ✔ |
| Non Pay In Month Variance (£'000s) | W | 110 | -5,487 | -1,713 | 1 | -1,029 | -1,485 | -786 | -1,333 | 414 | -909 | 644 | 387 | -1,333 | | >=-5% >=-20% <-20% | ✔ |
| AvP: IP - Non-Elective | W | 1,181 | 953 | 11 | 0 | 0 | 0 | 0 | -349 | -398 | -456 | -402 | -499 | -450 | | >=0 N/A <0 | ✔ |
| AvP: IP Elective vs Plan | W | 404 | 318 | 0 | 0 | -2 | 0 | -1 | 49 | 9 | 11 | 51 | -44 | -14 | | >=0 N/A <0 | ✔ |
| AvP: Daycase Activity vs Plan | W | 1,926 | 1,563 | 0 | 2 | 5 | 2 | 2 | -62 | -183 | 39 | 68 | -341 | -140 | | >=0 N/A <0 | ✔ |
| AvP: Outpatient Activity vs Plan | W | 21,024 | 17,993 | 167 | 301 | 1,057 | 1,399 | 1,382 | 1,133 | -1,104 | 2,300 | 2,567 | -1,362 | 624 | | >=0 N/A <0 | ✔ |
| PDR | W | 90.1% | 90.1% | 90.1% | 1.3% | 5.4% | 13.4% | 20.7% | 29.5% | 62.6% | 72.4% | 74.6% | 74.4% | 74.4% | | >=90 % >=85 % <85 % | ✔ |
| Medical Appraisal | W | 90.6% | 95.1% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.9% | 95.9% | 95.9% | | >=95 % >=90 % <90 % | ✔ |
| Mandatory Training | W | 95.1% | 93.2% | 92.1% | 90.8% | 91.0% | 90.5% | 90.6% | 89.3% | 88.6% | 85.8% | 85.0% | 86.0% | 85.8% | | >=90 % >=80 % <80 % | ✔ |
| Sickness | D | 5.7% | 6.2% | 5.9% | 5.3% | 5.0% | 5.2% | 5.0% | 5.2% | 6.0% | 5.4% | 5.5% | 7.1% | 5.8% | | <=4 % <=4.5 % >4.5 % | ✔ |
| Short Term Sickness | D | 1.7% | 2.3% | 1.6% | 1.0% | 0.9% | 1.0% | 1.1% | 1.4% | 1.9% | 1.3% | 1.1% | 2.2% | 1.2% | | <=1 % N/A >1 % | ✔ |
| Long Term Sickness | D | 4.0% | 4.0% | 4.4% | 4.3% | 4.1% | 4.1% | 4.0% | 3.9% | 4.1% | 4.2% | 4.5% | 4.9% | 4.6% | | <=3 % N/A >3 % | ✔ |
| Temporary Spend ('000s) | D | 974 | 1,514 | 990 | 740 | 565 | 934 | 946 | 1,015 | 1,061 | 1,365 | 1,392 | 1,373 | 1,279 | | <=800 <=960 >960 | ✔ |
| Staff Turnover | D | 10.6% | 10.3% | 9.8% | 9.8% | 10.0% | 9.6% | 10.2% | 9.9% | 9.6% | 9.4% | 9.3% | 9.4% | 9.2% | | <=10 % <=11 % >11 % | ✔ |
| Safer Staffing (Shift Fill Rate) | W | 92.8% | | 92.2% | | 95.6% | 90.3% | 91.3% | 94.2% | 94.2% | 94.9% | 93.6% | 90.5% | 94.5% | | >=90 % N/A <90 % | ✔ |
| Domestic Cleaning Audit Compliance | W | 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

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Open Studies - Academic | W | 165 | 146 | 21 | 23 | 43 | 47 | 50 | 61 | 66 | 71 | 76 | 80 | 80 | | >=130 | >=111 | <111 | ✔ |
| Number of Open Studies - Commercial | W | 46 | 42 | 21 | 19 | 20 | 25 | 27 | 28 | 34 | 37 | 36 | 36 | 36 | | >=30 | >=21 | <21 | ✔ |
| Number of New Studies Opened - Academic | W | 1 | 0 | 4 | 3 | 3 | 1 | 3 | 4 | 1 | 4 | 4 | 1 | 0 | | >=3 | >=2 | <2 | ✔ |
| Number of New Studies Opened - Commercial | W | 1 | 0 | 1 | 0 | 0 | 1 | 2 | 0 | 2 | 1 | 0 | 0 | 0 | | >=1 | N/A | <1 | ✔ |
| Number of patients recruited | W | 917 | 665 | 407 | 537 | 560 | 134 | 508 | 413 | 665 | 832 | 182 | 504 | 403 | | >=100 | >=86 | <86 | ✔ |

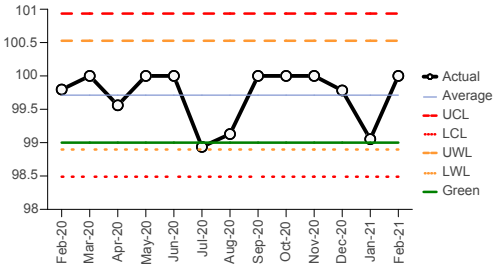
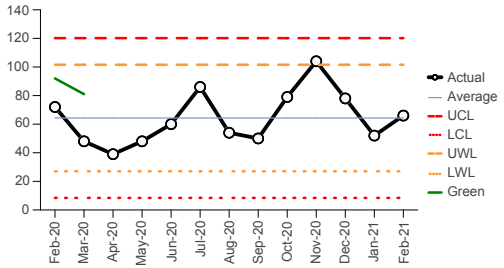
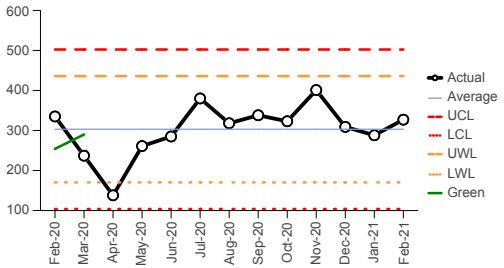
Delivery of Outstanding Care

## 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<br>Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 100 % | R <99 %<br>A N/A<br>G >=99 % |  | No Action Required |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in Near Miss** D<br>Total number of Near Miss Incidents reported<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 66 | No Threshold |  | |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in No Harm** D<br>Total number of No Harm Incidents reported.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 327 | No Threshold |  | |

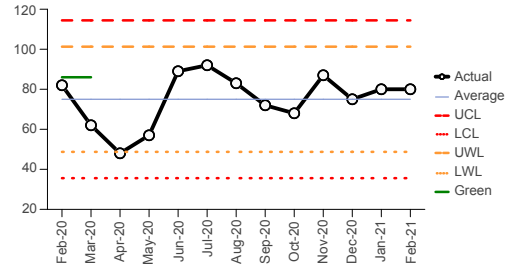
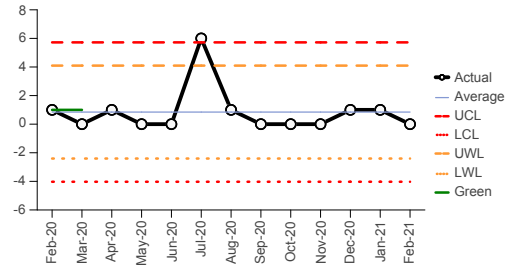
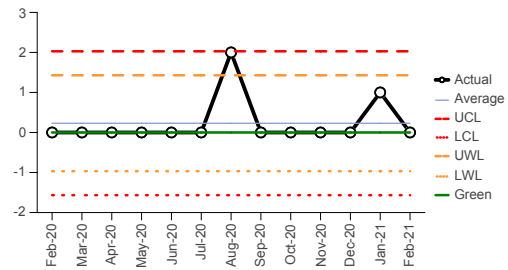
Delivery of Outstanding Care

## 7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

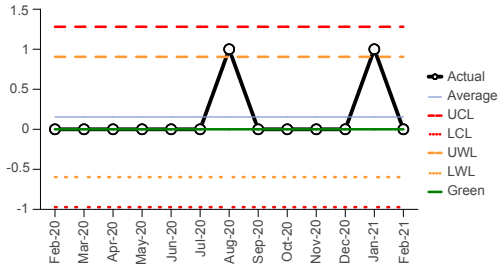
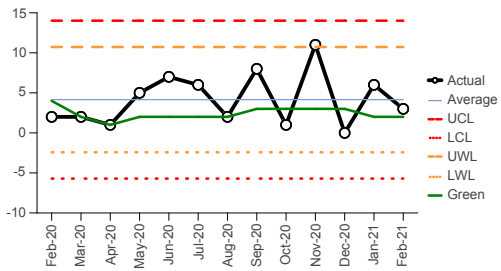
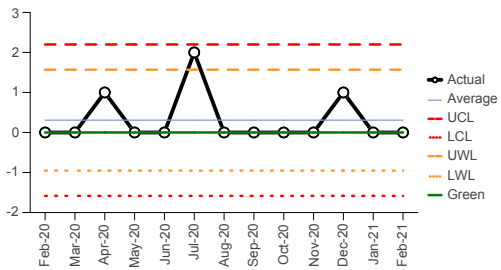
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in minor, non permanent harm** D<br>Total number of Minor Harm Incidents reported.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 80 | No Threshold |  | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in moderate, semi permanent harm** D<br>Incidents reported resulting in moderate harm.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | No Threshold |  | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in severe, permanent harm** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

Delivery of Outstanding Care

## 7.3 - QUALITY - SAFE

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<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Medication Errors | **Medication errors resulting in harm** D<br>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.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 3 | R >2<br>A N/A<br>G <=2 |  | Three errors involved minor harm in February. An insulin dose was calculated and given to the wrong patient; IV infusion pumps were mixed up resulting in 2 drugs being given at the wrong rate to a patient; there was a delay in a patient receiving adequate post-op analgesia. Practitioners involved in these errors have reflected on them and we are planning to roll out a scheme to help reduce interruptions to medicines administration across the hospital. |
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 3)** W<br>Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

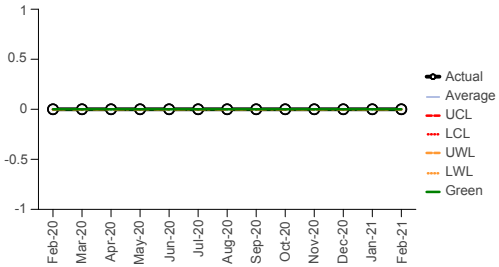
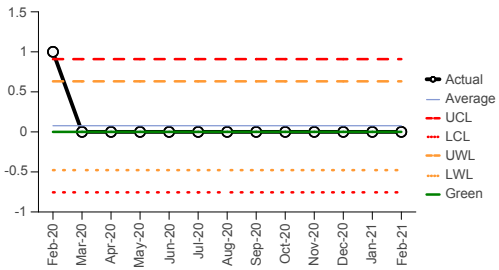
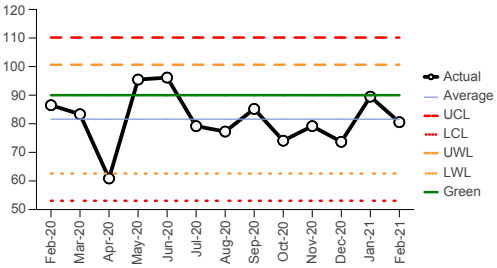
Delivery of Outstanding Care

## 7.4 - 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 Pressure Ulcers | **Pressure Ulcers (Category 4)** W<br>Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Never Events | **Never Events** W<br>Never Events. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Sepsis | **Sepsis: Patients treated for Sepsis - A&E** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 20/21 aim is 90%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 80.56 % | R <90 %<br>A N/A<br>G >=90 % |  | Seven patients did not receive antibiotics within 60 minutes; in the main due to difficulty gaining intravenous access and unsuccessful attempts at obtaining samples from lumbar puncture. Those with no clear cause for delay were incidented for further investigation. |

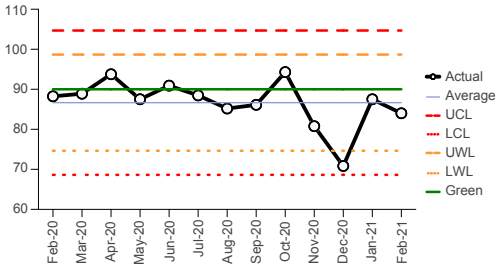
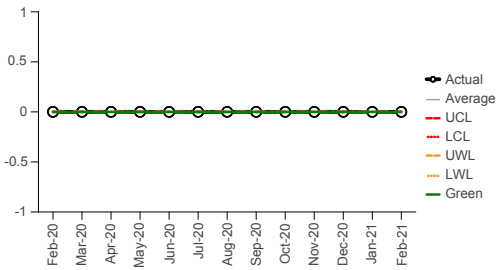
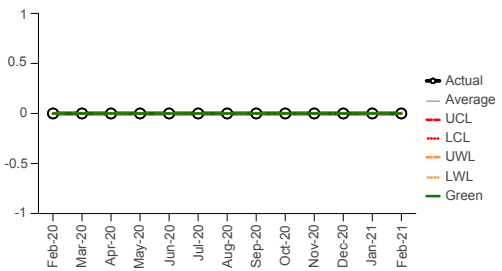
Delivery of Outstanding Care

## 7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

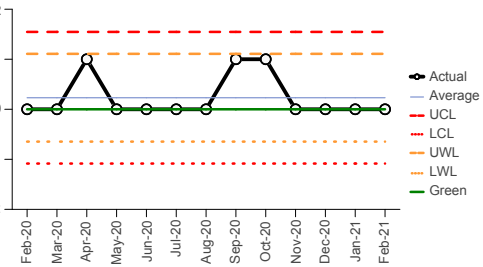
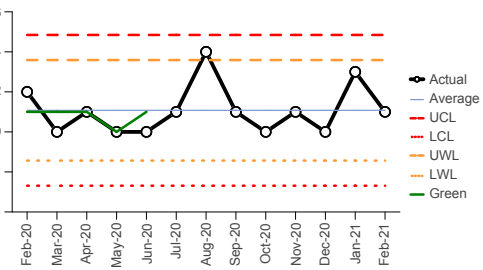
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 20/21 aim is 90%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 84 % | R <90 %<br>A N/A<br>G >=90 % |  | 25 patients identified with 4 treated >60mins. Times 61, 75, 76, 87 min. Number of clinical deteriorations requiring sepsis bundle management. Time 87mins patient required LP and IVAB given immediately after. Positive reinforcement to staff about sepsis bundle management as well as newsletter sent to all wards providing updates. Sepsis review template for all delays to be submitted to divisional nursing leads to start in March. |
| Mortality | **Number of children that have experienced avoidable factors causing death - Internal** W<br>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.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MRSA (BSI)** D<br>The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

Delivery of Outstanding Care

## 7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Reducing Infections | **Hospital Acquired Organisms - C.difficile** D<br>The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MSSA** D<br>Hospital Acquired Organisms - MSSA . 20/21 aim is to reduce by 10% or more.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 1 | No Threshold |  | |

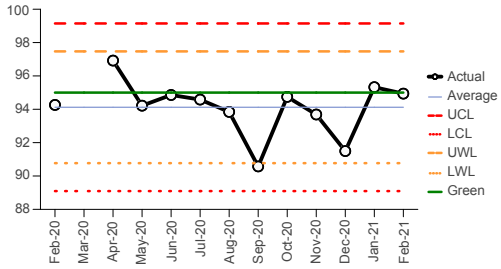
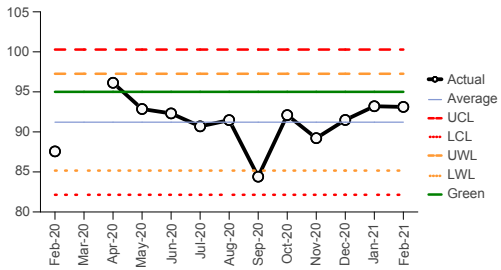
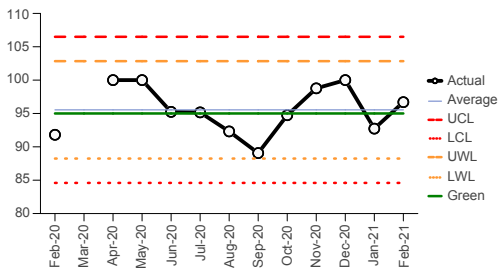
The Best People doing their best Work

## 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<br>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.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 94.94 % | R <90 %<br>A >=90 %<br>G >=95 % |  | Overall percentage has decreased from 95.3% to 94.9% from January 2021 to February 2021. There were 1,548 responses for February 2021. Medicine had a total of 763 responses with 20 negative (2.6%), Surgery had a total of 332 responses with 7 negative (2.1%), and Community had a total of 225 responses with 18 negative (8%). Only 3.03% of overall percentage accounted for poor or very poor scores. |
| Friends & Family | **Friends & Family A&E - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 93.12 % | R <90 %<br>A >=90 %<br>G >=95 % |  | Overall percentage has decreased by 0.1% from January 2020. There were 218 responses for February 2021. 10 (4.58%) responses were either poor or very poor. When asked how we could have improved, 14 respondents mentioned waiting times as a major issue and 11 respondents mentioned the attitude of triage staff. There were also multiple concerns (6) raised around the waiting area and whether it was COVID-19 safe. |
| Friends & Family | **Friends & Family Community - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 96.69 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |

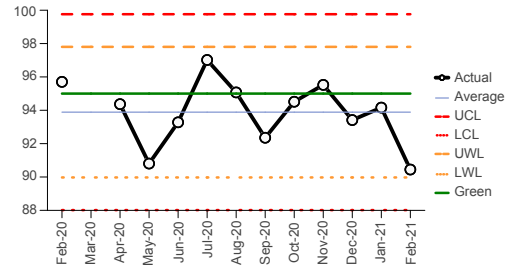
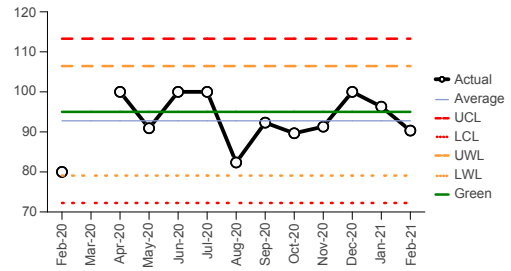
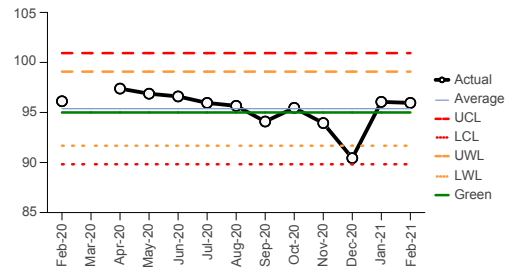
The Best People doing their best Work

## 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<br>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.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 90.45 % | R <90 %<br>A >=90 %<br>G >=95 % |  | Overall percentage has decreased by 3.71% since January 2021. There were 157 responses for February 2021. Out of these responses, there were two poor or very poor responses which accounted for only 1.27%. Overall percentage was mainly affected by respondents who found their experience neither good nor poor (5.73%). Comment analysis from the two negative responses related to communication, respect, and privacy between staff and the patient. Both of these negative responses were linked to Surgical Daycare. |
| Friends & Family | **Friends & Family Mental Health - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 90.32 % | R <90 %<br>A >=90 %<br>G >=95 % |  | Overall percentage has decreased by 6% since January 2021 to 90.32%. There were three (9.68%) very poor responses out of a total of 31. The three very poor responses all related to the Crisis Care team. Comment analysis into this found that there is a large demand for an intensive day patient service for young people with eating disorders. The remaining 28 responses were all classed as 'very good'. |
| Friends & Family | **Friends & Family Outpatients - % Recommend the Trust** D P<br>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.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 95.96 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |

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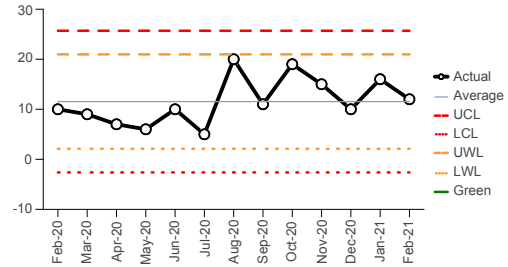
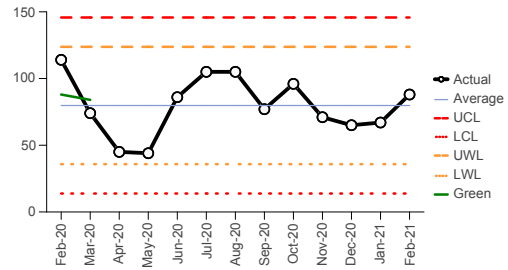
## 8.3 - QUALITY - CARING

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<br>Total complaints received.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 12 | No Threshold |  | |
| PALS | **PALS** W<br>Total number of PALS contacts.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 88 | No Threshold |  | |

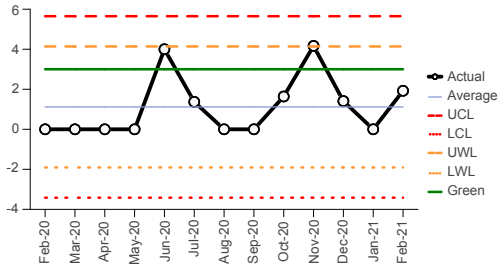
Delivery of Outstanding Care

## 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<br><br>% 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%<br><br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 1.92 % | R >3 %<br>A N/A<br>G <=3 % |  | No Action Required |

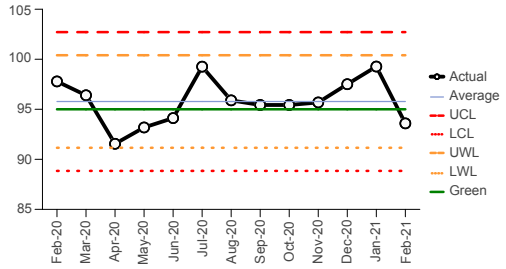
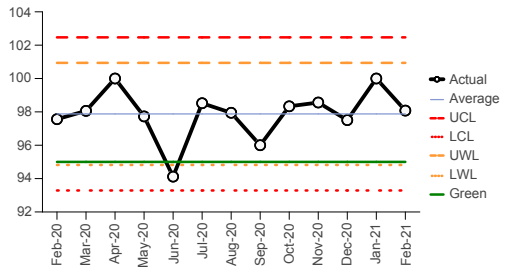
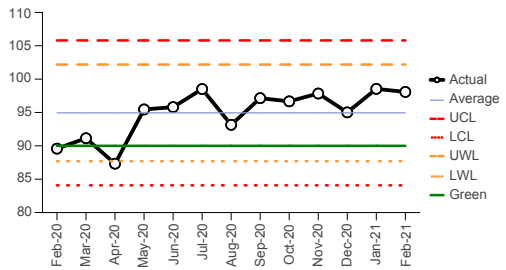
Delivery of Outstanding Care

## 10.1 - QUALITY - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

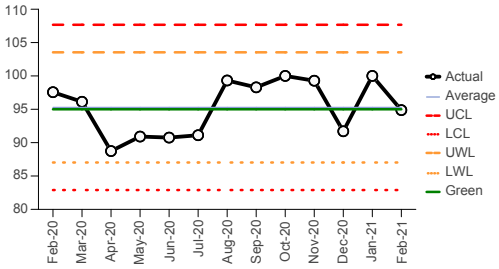
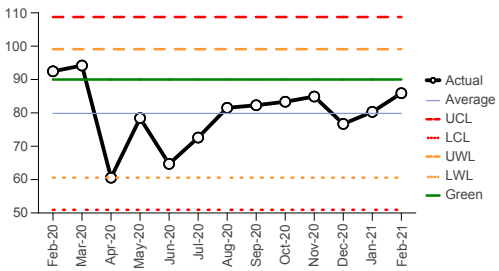
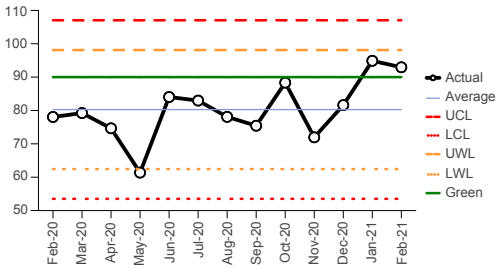
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Inpatient Survey: Choices | **IP Survey: % Received information enabling choices about their care** W<br>Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 93.59 % | R <90 %<br>A >=90 %<br>G >=95 % |  | The percentage has decreased by 5.7% to 93.59%. 146 out of 156 of respondents claimed that the received enough information about their care. No comment analysis attributed to this question to provide further qualitative feedback. Three responses regarding a lack of information were linked to Surgical Daycare. Other areas included Ward 3A, Ward 3C, Ward 4A, and Ward 1B. |
| Inpatient Survey: Respect | **IP Survey: % Treated with respect** W<br>Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 20/21 is 100%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 98.08 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Inpatient Survey: Date of Discharge | **IP Survey: % Know their planned date of discharge** D P<br>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.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 98.08 % | R <85 %<br>A >=85 %<br>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<br>% 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.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 94.87 % | R <90 %<br>A >=90 %<br>G >=95 % |  | Overall percentage of patients that report knowing who is in charge of their care this month was 94.9%, a decrease of 5.1% from January 2021. Surgery had 92.9% of respondents who reported that they knew who was in charge of their care. However, Medicine had 96% in this area. Out of 56 respondents in Surgery, four reported that they did not know who was in charge of their care. No respondents claimed that they were not introduced to the person in charge of their care but nine responded by saying that they were introduced only "sometimes", bringing the overall score down. |
| Inpatient Survey: Play | **IP Survey: % Patients involved in Play** D<br>% of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 85.90 % | R <85 %<br>A >=85 %<br>G >=90 % |  | Percentage of patients that reported engagement with play this month was 85.9%, an increase of 5.6%. February 2021 has been the highest percentage in patients reporting in Play since March 2020. Continued percentage increase can be attributed to the Play team focusing efforts on inpatient activity, coupled with an action plan 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<br>% of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 92.95 % | R <85 %<br>A >=85 %<br>G >=90 % |  | No Action Required |

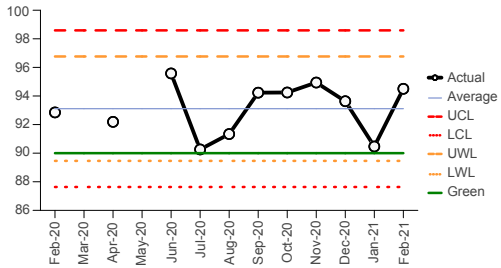
The Best People doing their best Work

## 11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

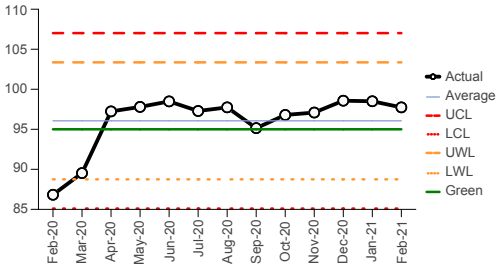
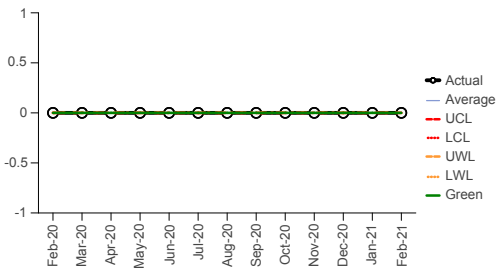
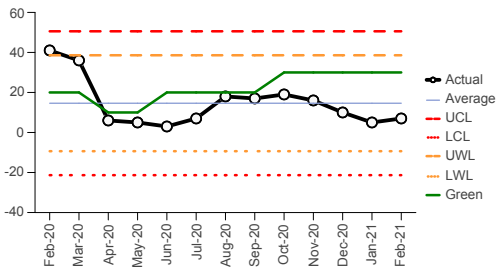
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Staffing | **Safer Staffing (Shift Fill Rate)** W<br>Safer Staffing. Threshold is based on National Target of 90% or above.<br><br>**Exec Lead:** Pauline Brown<br>**Committee:** SQAC | 94.50 % | R <90 %<br>A N/A<br>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<br>Threshold is based on National Guidance set by NHS England at 95%.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 97.74 % | R <95 %<br>A N/A<br>G >=95 % |  | No Action Required |
| ED 12 Hr Waits | **ED: Number of patients spending >12 hours from decision to admit to admission** W<br>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.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Cancelled Operations | **On the day Elective Cancelled Operations for Non Clinical Reasons** D<br>Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 7 | R >30<br>A N/A<br>G <=30 |  | No Action Required |

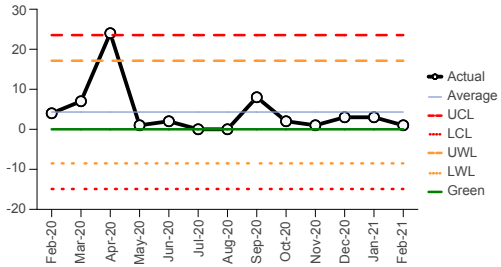
Delivery of Outstanding Care

## 12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

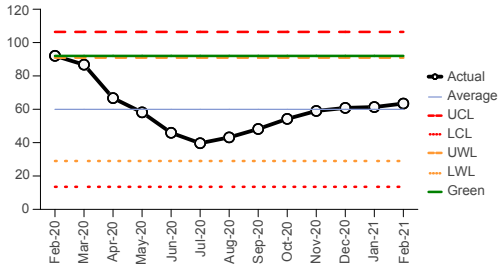
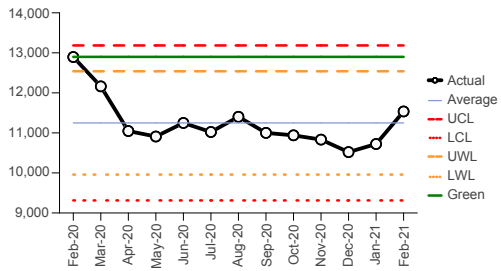
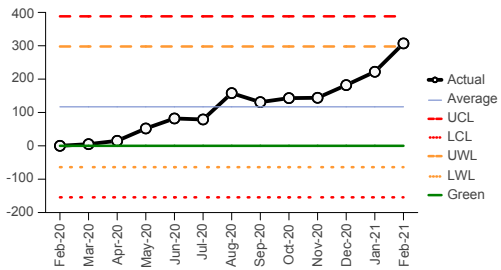
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Operation Breaches | **28 Day Breaches** W<br>Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance.<br><br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 1 | R >0<br>A N/A<br>G 0 |  | |

Delivery of Outstanding Care

## 13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

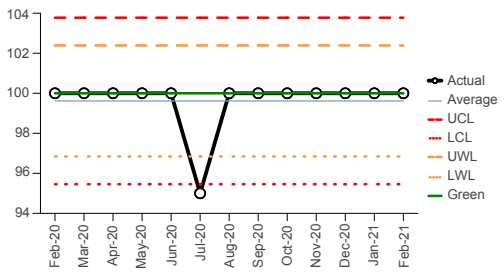
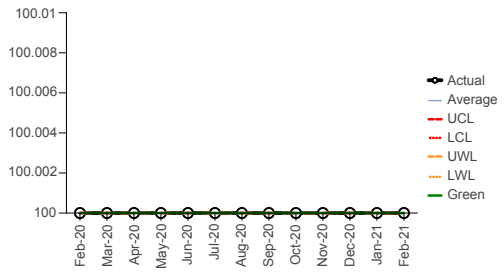
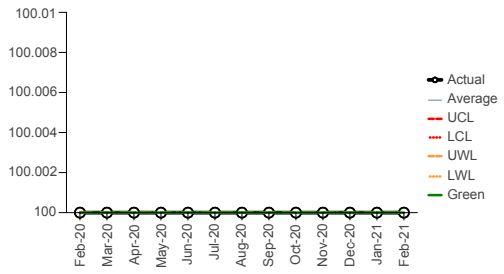
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| RTT | **RTT: Open Pathway: % Waiting within 18 Weeks** W<br>Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 63.43 % | R <90 %<br>A >=90 %<br>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<br>National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 11535 | R >12899<br>A N/A<br>G <=12899 |  | No Action Required |
| Waiting Times | **Waiting Greater than 52 weeks - Incomplete Pathways** W<br>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.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 307 | R >0<br>A N/A<br>G 0 |  | We're continuing to experience an increase in the number of C&Y people waiting over 52wks to receive treatment. The 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 as soon as possible. The reduction in theatre schedule during Jan and Feb has posed a greater challenge in treating patients however all continue to be reviewed/monitored weekly. Some of these children have also 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
NHS Foundation Trust

D Drive W Watch P Programme

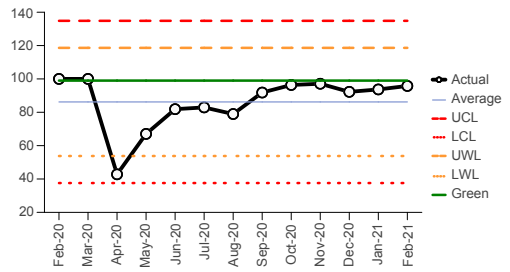
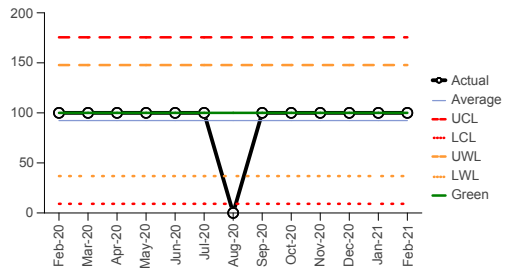
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Cancer RTT | **Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>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<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Cancer RTT | **All Cancers: 31 day wait until subsequent treatments** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>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<br>Threshold is based on National Guidance set by NHS England at 99%.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 95.78 % | R <99 %<br>A N/A<br>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<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |

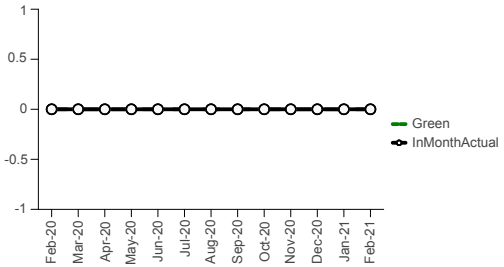
The Best People doing their best Work

## 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<br>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).<br><br>**Exec Lead:** Erica Saunders<br>**Committee:** SQAC | 0 | R >1<br>A <=1<br>G 0 |  | No Action Required |

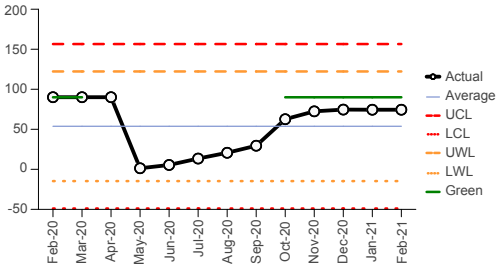
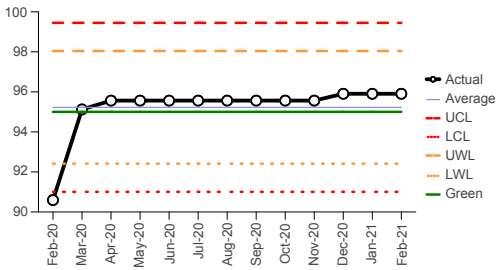
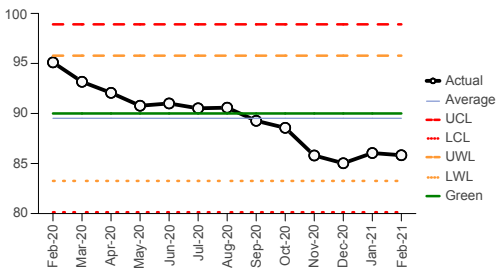
The Best People doing their best Work

# 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<br>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).<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 74.43 % | R <85 %<br>A >=85 %<br>G >=90 % |  | PDR remains the same as last month, new appraisal window – inclusive of wellbeing conversations is due to open in April 2021 and run until the end of July 2021. |
| Appraisal | **Medical Appraisal** W<br>Trust Target for compliance for medical staff, which is on a rolling 12mth period.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 95.90 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Training | **Mandatory Training** W<br>This is a Trust target that measures all required training including Resuscitation.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 85.83 % | R <80 %<br>A >=80 %<br>G >=90 % |  | Compliance currently 85% -5% below the target with annual updates for practical training still proving very difficult to improve compliance due to social distancing requirements as well as trainer availability issues.Personalised reminders have been sent out to all individuals who are not at 100% compliance to ensure they are aware of their compliance and how to improve it.A paper with proposals on the return of limited face to face training is currently being developed to support improved access opportunities for staff who are unable to access remote learning as easily. |

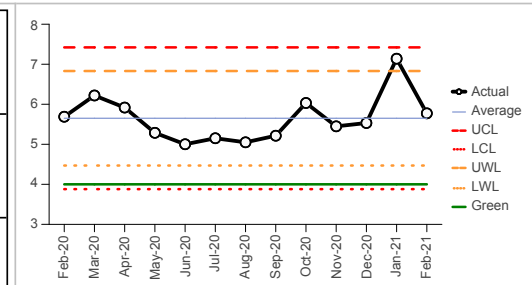
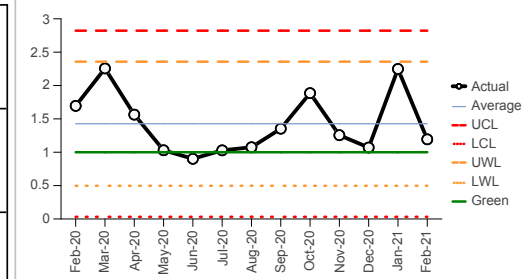
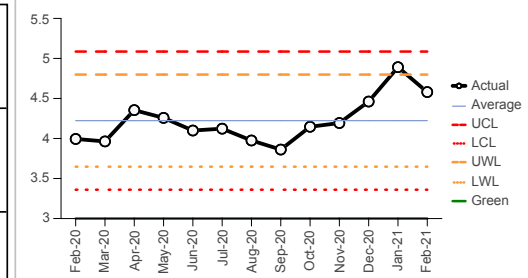
The Best People doing their best Work

## 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<br>% of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 5.77 % | R >4.5 %<br>A <=4.5 %<br>G <=4 % |  | Sickness absence as of February saw a significant decrease of 1.3%, in line with the decrease of Covid-19 cases in the wider Community. Both long term sickness and short term sickens figures have seen a significant decrease on last month. The HR team continue to work closely with managers and leader across the Trust to provide advice and guidance and ensure appropriate support is in place. 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. |
| Sickness | **Short Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting less than 28 days<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 1.19 % | R >1 %<br>A N/A<br>G <=1 % |  | See above. |
| Sickness | **Long Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting 28 days or more<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 4.58 % | R >3 %<br>A N/A<br>G <=3 % |  | See above. |

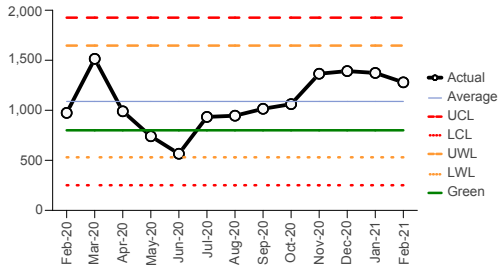
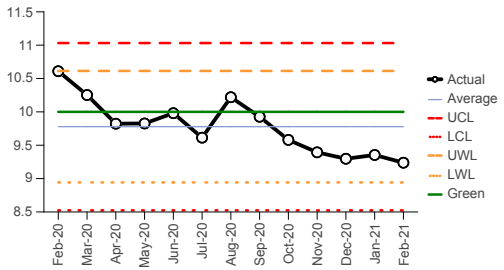
The Best People doing their best Work

## 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<br>Indicates the expenditure on premium temporary pay spend and monitors the reduction.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 1279.12 | R >960<br>A <=960<br>G <=800 |  | in line with reduction sickness absence figures, temporary spend is also decreasing and should continue to do so as we move out of the winter period and continue to see a significant decrease in Covid-19 cases. Regular reviews of spend will continue to take place with Service Leads, within Divisions to ensure appropriate spend in this area. |
| Staff Turnover | **Staff Turnover** D<br>Trust Target which is based on a rolling 12mth period<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 9.24 % | R >11 %<br>A <=11 %<br>G <=10 % |  | No Action Required |

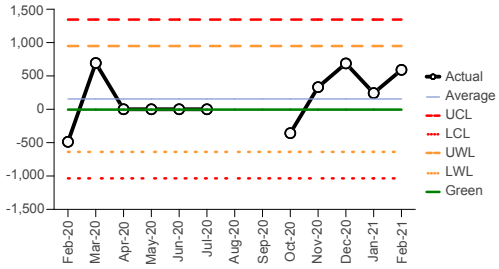
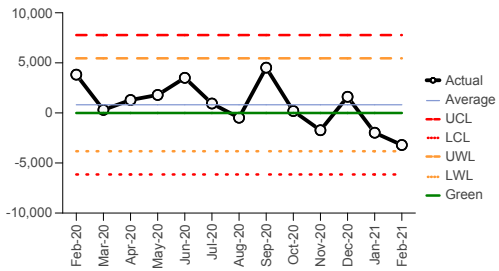
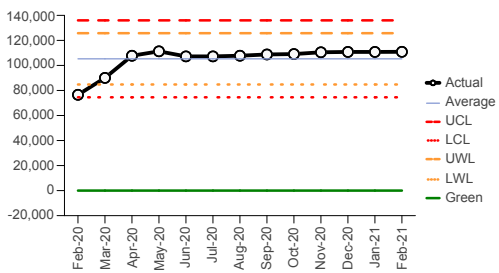
The Best People doing their best Work

# 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<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | 591 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |
| Finance | **Capital Expenditure In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | -3,207 | R <-10%<br>A >=-10%<br>G >=-5% |  | The capital expenditure in month appears high due to the a number of schemes catching up on slippage from previous months, most notably the large areas of spend are within the trusts own internal IM&T schemes £0.6m, and the STP led IM&T schemes which Alder Hey host £2.2m, along with some further catch-up within the replacement medical equipment programme £0.5m. |
| Finance | **Cash in Bank (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | 110,871 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |

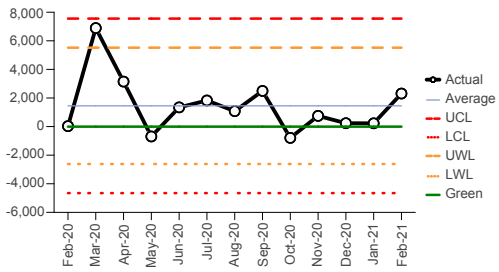
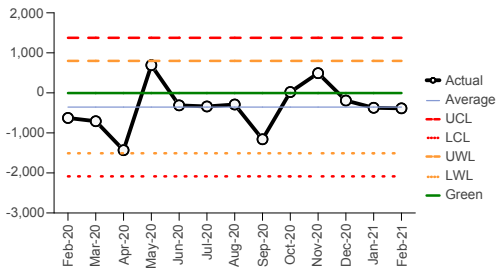
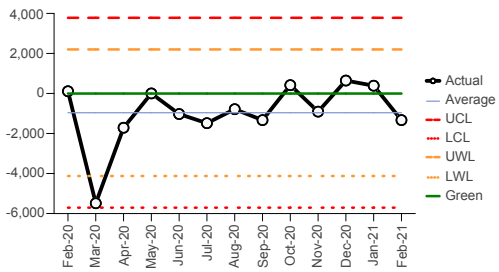
The Best People doing their best Work

## 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<br>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<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 2,310 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |
| Finance | **Pay In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -387 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |
| Finance | **Non Pay In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -1,333 | R <-20%<br>A >=-20%<br>G >=-5% |  | The variance within Non-Pay is primarily due to anticipated expenditure recorded against the revenue funded Share2Care programme which Alder Hey host. The corresponding income has been received in full from commissioners this month, the expenditure has been accrued and will be spent over the coming months in line with the programme deliverables. |

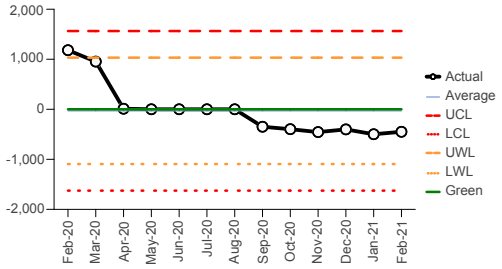
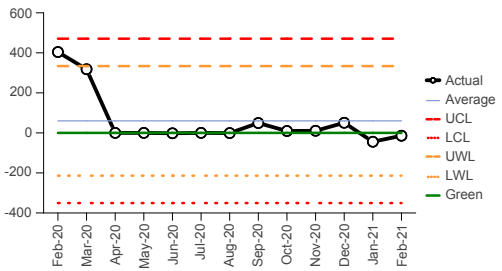
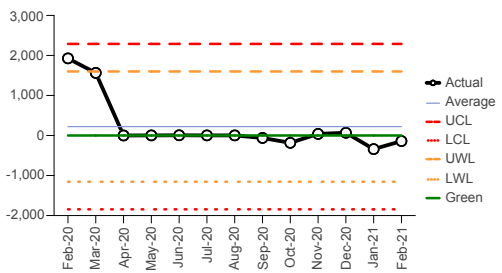
The Best People doing their best Work

## 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<br>Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | -450.00 | R <0<br>A N/A<br>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<br>Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | -14.20 | R <0<br>A N/A<br>G >=0 |  | Electives continue to be affected by capacity restrictions due to the impact of COVID regulations. |
| Finance | **AvP: Daycase Activity vs Plan** W<br>Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | -140.20 | R <0<br>A N/A<br>G >=0 |  | Daycase continue to be affected by capacity restrictions due to the impact of COVID regulations. |

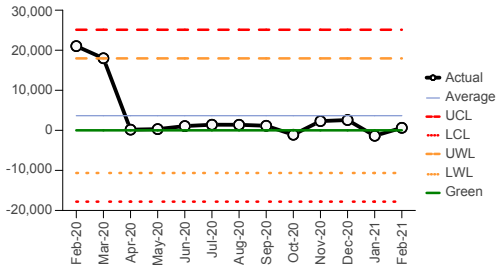
The Best People doing their best Work

# 16.4 - FINANCE - WELL LED

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: Outpatient Activity vs Plan** W<br>Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher.<br><br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 624 | R <0<br>A N/A<br>G >=0 |  | No Action Required |

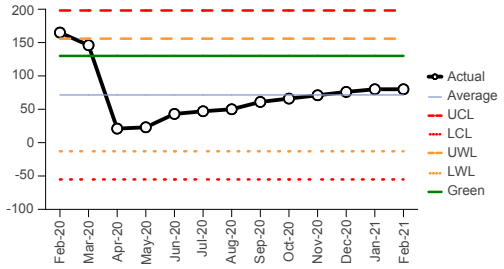
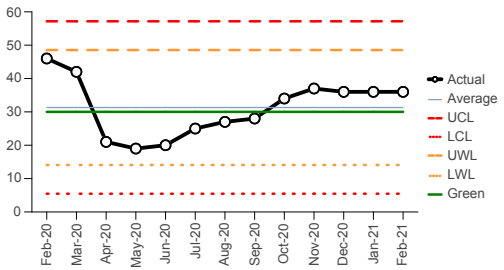
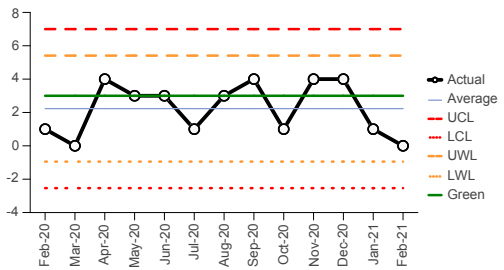
Game Changing Research & Innovation

## 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<br>Number of academic studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 80 | R <111<br>A >=111<br>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<br>Number of commercial studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 36 | R <21<br>A >=21<br>G >=30 |  | No Action Required |
| Clinical Research | **Number of New Studies Opened - Academic** W<br>Number of new academic studies opened in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 0 | R <2<br>A >=2<br>G >=3 |  | Opening of new studies largely paused due to reduced delivery capacity. |

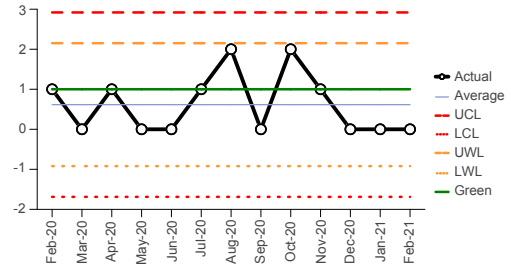
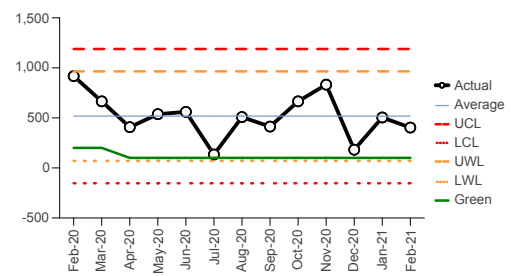
Game Changing Research & Innovation

## 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<br>Number of new commercial studies opened in month.<br>**Exec Lead:** Jo Blair **Committee:** RMB | 0 | R <1<br>A N/A<br>G >=1 |  | Opening of new studies largely paused due to reduced delivery capacity. |
| Clinical Research | **Number of patients recruited** W<br>Number of patients recruited to NIHR portfolio studies in month.<br>**Exec Lead:** Jo Blair **Committee:** RMB | 403 | R <86<br>A >=86<br>G >=100 |  | No Action Required |

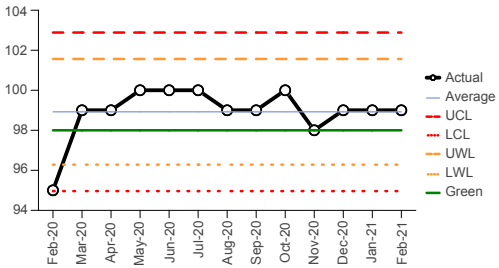
Delivery of Outstanding Care

## 18.1 - FACILITIES - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

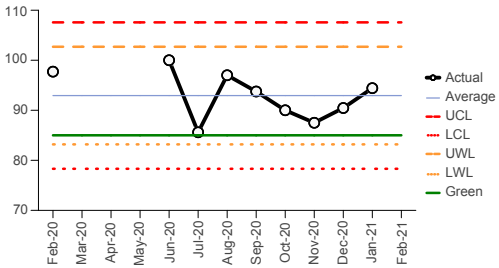
The Best People doing their best Work

# 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<br><br>Auditing for Domestic Services, aim is to ensure National Cleaning Standards.<br><br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | | R <85 %<br>A N/A<br>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 | 5 | 24 | 28 | No Threshold |
| Clinical Incidents resulting in No Harm | D | 75 | 94 | 140 | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 21 | 19 | 27 | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 0 | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 / N/A / >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 / N/A / >0 |
| Medication errors resulting in harm | D | 0 | 1 | 2 | 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 | | 84.6% | 83.3% | >=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 | 0 | No Threshold |

## CARING

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Complaints | W | 4 | 4 | 3 | No Threshold |
| PALS | W | 38 | 18 | 20 | No Threshold |

## EFFECTIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | | | 1.9% | <=3 % / N/A / >3 % |
| ED: 95% Treated within 4 Hours | D | | 97.7% | | >=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 | 7 | No Threshold | | |
| 28 Day Breaches | W | 0 | 0 | 1 | 0 | N/A | >0 |

## RESPONSIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | | 96.4% | 92.0% | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | | 100.0% | 97.0% | >=95 % | >=90 % | <90 % |
| IP Survey: % Know their planned date of discharge | D P | | 98.2% | 98.0% | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | | 92.9% | 96.0% | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | | 89.3% | 84.0% | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | | 94.6% | 92.0% | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 64.5% | 90.8% | 56.2% | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 911 | 2,110 | 8,432 | No Threshold | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 16 | 291 | 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 | | 96.0% | 90.0% | >=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 | 221 | 160 | 11 | No Threshold |
| Income In Month Variance (£'000s) | W | 996 | 36 | 83 | No Threshold |
| Pay In Month Variance (£'000s) | W | -81 | -52 | -169 | No Threshold |
| Non Pay In Month Variance (£'000s) | W | -694 | 176 | 98 | No Threshold |

## All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| AvP: IP - Non-Elective | W | | -410 | -47 | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 0 | 42 | -56 | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | | 52 | -192 | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 254 | 584 | -1,780 | >=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 | 88.6% | 87.1% | 86.9% | >=90 % | >=80 % | <80 % |
| Sickness | D | 4.6% | 5.1% | 6.8% | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 1.0% | 1.3% | 1.5% | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 3.6% | 3.8% | 5.3% | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 169 | 267 | 382 | No Threshold | | |
| Staff Turnover | D | 9.6% | 6.7% | 8.1% | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 99.4% | 97.8% | 92.7% | >=90 % | >=80 % | <90 % |

## Medicine Division

| | | |
|---|---|---|
| **SAFE** | 1x RCA 1 47890 Use of incorrect device to access portacath resulting in damage to portacath<br><br>No never events<br><br>MSSA 1 recorded<br><br>Treatment of sepsis for inpatients within 60 mins at 84.4% | **Highlight**<br>• Significant reduction in the number of open incidents to 172 (from over 1000)<br>• Increase in number of lessons learnt being recorded and shared on review of incidents<br>**Challenges**<br>• Number of extensions required for ongoing RCA investigations due to complexity of cases and need for external expert opinion |
| **CARING** | Main theme - communication<br><br>Overall reduction in complaints and PALS in month.<br><br>4 complaints and 18 PALS contacts. | **Highlight**<br>• Work ongoing around improving communication processes for families/carers enquiring about their child's management<br>**Challenges**<br>• Complexity of complaints have led to delays in responses being completed – monitored and escalated weekly |
| **EFFECTIVE** | While ED attendances continue to rise back to pre Covid levels the performance of the department remains positive at over 97%.<br><br>Theatre utilisation is still lower than we aim to achieve but shows improvement. Workstreams underway with Gastro team to focus on improved utilisation. | **Highlight**<br>• Continued good ED performance despite increase in attendances.<br>• Improved theatre utilisation at 87%<br>**Challenges**<br>• WNB rate remains high at over 12% |
| **RESPONSIVE** | Big improvements on inpatient survey for involvement in play which was at 75% but now at 89%.<br><br>Teams challenged with long waits for outpatients and theatre showing sustained improvement which is reflected in overall RTT performance. Uptake of weekend theatre lists to reduce waits has been positive from both the teams and the families. | **Highlight**<br>▪ RTT performance for outpatients over 92% (95% at time of writing)<br>▪ Radiology performance against 6 week target<br>▪ No outpatients waiting over 52 weeks – only 3 now over 40 weeks<br>▪ Sustained improvement of outpatient pharmacy dispensing within 30 minutes at 84% compared to 53% last year<br>**Challenges**<br>▪ Diagnostic waiting times have deteriorated in EEG due to reappointing patients who have cancelled at short notice. |
| **WELL LED** | Risk register management at 100% compliance for reviews and actions. 3 risks with ratings of high (15+) with 2 of these expected to be significantly reduced or closed by end of March 2021.<br><br>Overall sickness has improved compared to Jan 21 as well as compared to the same period in 2020.<br><br>Division remains underspent overall. | **Highlight**<br>• Safer staffing rates<br>• Improved sickness after Jan 21 spike<br>**Challenges**<br>• Pay spend<br>• 44% of policies, procedures and guidelines overdue for review |

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# Medicine

D Drive W Watch P Programme

## SAFE

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss (D) | 28 | 15 | 13 | 19 | 18 | 29 | 19 | 16 | 29 | 34 | 23 | 16 | 24 | | No Threshold |
| Clinical Incidents resulting in No Harm (D) | 93 | 71 | 33 | 64 | 75 | 104 | 75 | 93 | 69 | 124 | 98 | 87 | 94 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm (D) | 19 | 7 | 12 | 13 | 19 | 26 | 21 | 16 | 11 | 18 | 19 | 22 | 19 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm (D) | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm (D) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 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 resulting in harm (D) | 1 | 0 | 1 | 5 | 3 | 2 | 0 | 4 | 0 | 0 | 0 | 4 | 1 | | No Threshold |
| Medication Errors (Incidents) | 30 | 15 | 13 | 25 | 29 | 26 | 23 | 18 | 24 | 31 | 36 | 33 | 28 | | 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 | 1 | 2 | 1 | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 1 | 0 | 2 | | 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% | 88.9% | 100.0% | 83.3% | 92.3% | 100.0% | 84.6% | 91.7% | 100.0% | 75.0% | 90.9% | 83.3% | 84.6% | | >=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 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - CLABSI | 1 | 0 | 1 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 2 | 2 | | No Threshold |
| Hospital Acquired Organisms - MSSA (D) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | No Threshold |
| Cleanliness Scores | 97.6% | | | | 98.5% | 97.7% | 97.8% | 98.0% | 98.0% | 96.0% | 95.1% | 98.3% | 97.2% | | No Threshold |
| Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region. | 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% | 49.3% | 64.6% | 71.3% | 53.9% | 68.2% | | >=50 % N/A <50 % |
| Pharmacy - Dispensing for Out Patients - Routine within 30 minutes | 53.0% | 58.0% | 65.0% | 65.0% | 64.0% | 78.5% | 84.0% | 77.3% | 85.0% | 85.0% | 85.0% | 85.0% | 84.0% | | >=90 % N/A <90 % |
| Pharmacy - Dispensing for Out Patients - Complex within 60 minutes | 88.0% | 67.0% | 67.0% | 69.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 77.0% | | 100.0% | 100.0% | | >=90 % N/A <90 % |

## CARING

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints (W) | 5 | 4 | 6 | 2 | 6 | 1 | 11 | 7 | 8 | 7 | 6 | 8 | 4 | | No Threshold |
| PALS (W) | 44 | 34 | 13 | 18 | 21 | 32 | 49 | 27 | 24 | 28 | 27 | 22 | 18 | | No Threshold |

## EFFECTIVE

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | 1,959 | 1,548 | 838 | 994 | 1,435 | 1,666 | 1,567 | 2,275 | 2,015 | 2,084 | 1,685 | 2,062 | 1,624 | | No Threshold |
| ED: 95% Treated within 4 Hours (D) | 86.8% | 89.5% | 97.2% | 97.8% | 98.5% | 97.3% | 97.7% | 95.1% | 96.8% | 97.1% | 98.6% | 98.5% | 97.7% | | >=95 % N/A <95 % |
| ED: Percentage Left without being seen (W) | 3.8% | 2.7% | 0.2% | 0.8% | 1.1% | 1.5% | 0.8% | 2.0% | 0.8% | 1.0% | 0.6% | 0.5% | 0.7% | | <=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 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 N/A >0 |
| ED: Re-attendance within 7 days of original attendance (%) (W) | 8.0% | 7.4% | 8.2% | 8.4% | 7.5% | 7.8% | 8.3% | 7.0% | 7.9% | 7.8% | 7.9% | 9.0% | 7.9% | | No Threshold |

# Medicine

D Drive W Watch P Programme

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-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 | 85.8% | 76.2% | 73.9% | 76.7% | 75.4% | 82.0% | 82.1% | 81.3% | 83.6% | 82.2% | 84.7% | 84.0% | 87.0% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons D | 5 | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 1 | 1 | 2 | 0 | 0 | | No Threshold |
| 28 Day Breaches W | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 0 | 0 | 1 | 0 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 41 | 67 | 175 | 1 | 2 | 12 | 55 | 20 | 33 | 20 | 47 | 16 | 14 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 15.3% | 25.8% | 46.0% | 21.8% | 15.6% | 13.1% | 11.4% | 12.2% | 11.2% | 12.3% | 13.6% | 12.0% | 12.0% | | <=5 % N/A >10 % |
| Was Not Brought Rate W P | 10.6% | 10.7% | 7.4% | 8.3% | 11.1% | 11.5% | 12.0% | 11.9% | 11.4% | 9.7% | 11.1% | 10.4% | 10.0% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) W | 14.3% | 15.0% | 15.6% | 13.3% | 14.1% | 14.9% | 13.4% | 16.0% | 12.4% | 11.7% | 12.4% | 12.2% | 11.2% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 9.5% | 9.7% | 5.9% | 7.3% | 10.4% | 10.8% | 11.8% | 11.1% | 11.1% | 9.2% | 10.9% | 10.0% | 9.8% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | 5.05 | 5.18 | 5.54 | 5.46 | 5.39 | 5.33 | 5.28 | 5.17 | 5.31 | 5.45 | 5.50 | 5.45 | 5.53 | | No Threshold |

## RESPONSIVE

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Convenience and Choice: Slot Availability | 89.6% | 66.7% | | | | | | | | | | | | | |
| IP Survey: % Received information enabling choices about their care W | 97.1% | 95.0% | 95.0% | 100.0% | 81.5% | 100.0% | 95.6% | 92.9% | 92.9% | 96.9% | 95.8% | 100.0% | 96.4% | | >=95 % >=90 % <90 % |
| IP Survey: % Treated with respect W | 97.6% | 98.1% | 100.0% | 100.0% | 88.9% | 96.8% | 97.8% | 100.0% | 97.2% | 100.0% | 95.8% | 100.0% | 100.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Know their planned date of discharge D P | 83.5% | 91.2% | 90.0% | 97.1% | 85.2% | 100.0% | 93.3% | 95.2% | 88.9% | 100.0% | 91.7% | 96.9% | 98.2% | | >=90 % >=85 % <85 % |
| IP Survey: % Know who is in charge of their care W | 97.1% | 95.0% | 87.5% | 97.1% | 85.2% | 90.3% | 100.0% | 97.6% | 100.0% | 100.0% | 87.5% | 100.0% | 92.9% | | >=95 % >=90 % <90 % |
| IP Survey: % Patients involved in Play D | 92.9% | 93.1% | 60.0% | 74.3% | 63.0% | 77.4% | 80.0% | 88.1% | 77.8% | 84.4% | 81.2% | 75.0% | 89.3% | | >=90 % >=85 % <85 % |
| IP Survey: % Patients involved in Learning D | 78.2% | 76.1% | 77.5% | 68.6% | 77.8% | 87.1% | 82.2% | 76.2% | 63.9% | 62.5% | 81.2% | 93.8% | 94.6% | | >=90 % >=85 % <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks W | 92.2% | 88.1% | 68.8% | 60.1% | 46.3% | 40.6% | 45.0% | 55.5% | 68.0% | 81.0% | 86.1% | 89.5% | 90.8% | | >=92 % >=90 % <90 % |
| Waiting List Size W | 3,495 | 3,361 | 3,381 | 3,266 | 2,791 | 2,484 | 2,420 | 2,151 | 1,916 | 1,778 | 1,785 | 1,731 | 2,110 | | |
| Waiting Greater than 52 weeks - Incomplete Pathways W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 16 | | 0 N/A >0 |
| Waiting Times - 40 weeks and above | 9 | 14 | 90 | 121 | 127 | 147 | 181 | 137 | 81 | 63 | 24 | 9 | 37 | | |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 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% | 39.1% | 64.9% | 82.1% | 84.6% | 77.9% | 91.4% | 96.2% | 97.7% | 91.7% | 94.6% | 96.0% | | >=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% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % |
| Pathology - % Turnaround times for urgent requests < 1 hr | 91.0% | 86.1% | 90.3% | 90.4% | 90.0% | 90.4% | 92.7% | 89.7% | 90.0% | 90.6% | 90.4% | 90.4% | 90.4% | | >=90 % >=85 % <90 % |
| Pathology - % Turnaround times for non-urgent requests < 24hrs | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% | 100.0% | 100.0% | 100.0% | 99.8% | 100.0% | 99.9% | 100.0% | | >=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 | 88.0% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% | 100.0% | 100.0% | 97.0% | 95.0% | 99.0% | 99.0% | | >=90 % >=85 % <90 % |
| Imaging - % Reporting Turnaround Times - Inpatients | 90.0% | 86.0% | | 98.0% | 98.0% | 97.0% | 97.0% | 98.0% | 93.0% | 98.0% | 92.0% | 99.0% | 98.0% | | >=90 % >=85 % <90 % |
| Imaging - % Reporting Turnaround Times - Outpatients | 95.0% | 75.0% | 100.0% | 98.0% | 97.0% | 81.0% | 69.0% | 71.0% | 74.0% | 72.0% | 51.0% | 75.0% | 77.0% | | >=85 % N/A <85 % |
| Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks | 86.0% | 84.0% | 16.8% | 63.6% | 62.6% | 82.4% | 59.1% | 98.0% | 98.8% | 100.0% | 94.2% | 100.0% | 95.0% | | >=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% | 100.0% | | >=99 % N/A <99 % |

# Medicine

D Drive W Watch P Programme

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-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% | 100.0% | | >=99 % N/A <99 % |

## WELL LED

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -361 | -81 | -2,544 | -1,842 | -1,048 | 278 | -1,111 | -1,201 | -264 | 153 | 41 | 189 | 160 | | No Threshold |
| Income In Month Variance (£'000s) | W | 80 | 271 | -2,416 | -2,220 | -1,103 | 347 | -1,170 | -622 | -647 | 561 | 142 | 10 | 36 | | No Threshold |
| Pay In Month Variance (£'000s) | W | -67 | -297 | 59 | 99 | 92 | 196 | 62 | -211 | -143 | 338 | 30 | -61 | -52 | | No Threshold |
| AvP: IP - Non-Elective | W | 826 | 610 | 0 | 0 | -1 | 0 | 1 | -222 | -333 | -421 | -355 | -411 | -410 | | >=0 N/A <0 |
| AvP: IP Elective vs Plan | W | 107 | 87 | -1 | -1 | 0 | 0 | 0 | 24 | 7 | 25 | 46 | 2 | 42 | | >=0 N/A <0 |
| AvP: OP New | | 1,132.00 | 852.00 | 3.00 | 7.00 | 6.00 | 0.00 | 12.00 | -460.00 | -18.00 | 48.00 | -128.05 | -322.00 | -62.00 | | >=0 N/A <0 |
| AvP: OP FollowUp | | 3,648.00 | 3,621.00 | 6.00 | 32.00 | 26.00 | 43.00 | 26.00 | 1,288.00 | 682.00 | 840.00 | 1,048.29 | 559.00 | 843.00 | | >=0 N/A <0 |
| AvP: Daycase Activity vs Plan | W | 1,084 | 980 | 0 | 1 | 2 | 0 | 2 | 15 | -5 | 141 | 105 | -74 | 52 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | 6,072 | 5,601 | 9 | 39 | 32 | 46 | 40 | 578 | 183 | 667 | 704 | -356 | 584 | | >=0 N/A <0 |
| PDR | W | 87.1% | 87.1% | 87.1% | 3.1% | 10.7% | 12.1% | 23.0% | 21.8% | 60.2% | 69.1% | 74.6% | 74.2% | 74.2% | | >=90 % >=85 % <85 % |
| Medical Appraisal | W | 91.5% | 94.9% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 94.1% | 94.1% | 94.1% | | >=95 % >=90 % <90 % |
| Mandatory Training | W | 94.6% | 93.1% | 92.3% | 91.9% | 91.6% | 91.3% | 91.3% | 89.9% | 90.2% | 88.9% | 86.7% | 88.1% | 87.1% | | >=90 % >=85 % <80 % |
| Sickness | D | 6.3% | 6.0% | 5.6% | 4.8% | 5.4% | 5.6% | 5.1% | 5.0% | 5.8% | 4.7% | 4.9% | 6.3% | 5.1% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 2.0% | 2.4% | 1.6% | 0.9% | 1.0% | 0.9% | 1.1% | 1.4% | 2.2% | 1.5% | 1.2% | 2.0% | 1.3% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 4.3% | 3.6% | 4.0% | 3.9% | 4.4% | 4.7% | 4.1% | 3.6% | 3.6% | 3.3% | 3.7% | 4.3% | 3.8% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 265 | 347 | 201 | 157 | 108 | 167 | 217 | 266 | 235 | 239 | 213 | 247 | 267 | | No Threshold |
| Staff Turnover | D | 9.7% | 9.8% | 9.6% | 9.1% | 8.2% | 7.5% | 7.5% | 6.6% | 6.6% | 7.0% | 7.3% | 6.9% | 6.7% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) | W | 94.6% | | 96.5% | | 97.7% | 96.4% | 94.9% | 94.9% | 93.2% | 93.6% | 93.2% | 91.2% | 97.8% | | >=90 % >=85 % <90 % |

Alder Hey Children's NHS
NHS Foundation Trust

# Surgery

D Drive W Watch P Programme

## SAFE

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss D | 29 | 22 | 18 | 18 | 30 | 42 | 26 | 24 | 31 | 49 | 34 | 26 | 28 | | No Threshold |
| Clinical Incidents resulting in No Harm D | 166 | 115 | 76 | 96 | 114 | 175 | 147 | 140 | 153 | 185 | 141 | 108 | 140 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm D | 40 | 38 | 22 | 26 | 48 | 48 | 51 | 40 | 38 | 49 | 42 | 36 | 27 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm D | 0 | 0 | 1 | 0 | 0 | 4 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm D | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death D | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm D | 0 | 2 | 0 | 0 | 4 | 4 | 1 | 4 | 1 | 11 | 0 | 1 | 2 | | No Threshold |
| Medication Errors (Incidents) | 38 | 38 | 16 | 22 | 34 | 61 | 36 | 38 | 38 | 70 | 42 | 25 | 40 | | No Threshold |
| Pressure Ulcers (Category 3) W | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 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 |
| Never Events W | 1 | 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 | 80.0% | 88.9% | 88.9% | 91.7% | 88.9% | 83.3% | 85.7% | 75.0% | 86.7% | 90.0% | 53.8% | 91.7% | 83.3% | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 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 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MSSA D | 2 | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 0 | 1 | 0 | 2 | 0 | | No Threshold |
| Cleanliness Scores | 96.3% | | | | 97.9% | 98.4% | 96.0% | 98.2% | 98.0% | 96.0% | 97.9% | 98.9% | 96.9% | | No Threshold |

## CARING

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints W | 2 | 3 | 1 | 2 | 2 | 0 | 7 | 2 | 10 | 4 | 2 | 2 | 3 | | No Threshold |
| PALS W | 30 | 20 | 13 | 7 | 37 | 39 | 33 | 22 | 29 | 21 | 23 | 11 | 20 | | No Threshold |

## EFFECTIVE

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Readmissions to PICU within 48 hrs D | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 1 | 2 | 1 | 0 | 1 | | No Threshold |
| % Readmissions to PICU within 48 hrs W | 0.0% | 0.0% | 0.0% | 0.0% | 4.0% | 1.4% | 0.0% | 0.0% | 1.6% | 4.2% | 1.4% | 0.0% | 1.9% | | <=3 % N/A >3 % |
| Referrals Received (Total) | 3,641 | 2,817 | 1,371 | 1,783 | 2,258 | 2,843 | 2,607 | 3,194 | 3,032 | 2,956 | 2,776 | 2,650 | 2,797 | | No Threshold |
| Theatre Utilisation - % of Session Utilised W | 88.4% | 86.2% | 66.4% | 68.1% | 86.6% | 88.6% | 89.1% | 88.8% | 89.2% | 88.6% | 85.0% | 87.6% | 90.3% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons D | 36 | 36 | 5 | 3 | 3 | 7 | 15 | 15 | 18 | 15 | 8 | 5 | 7 | | No Threshold |
| 28 Day Breaches W | 4 | 7 | 24 | 0 | 0 | 0 | 0 | 5 | 0 | 1 | 3 | 2 | 1 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 41 | 140 | 194 | 2 | 0 | 16 | 70 | 52 | 58 | 38 | 45 | 38 | 50 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 13.0% | 28.6% | 55.9% | 30.2% | 17.4% | 15.0% | 11.9% | 11.3% | 11.0% | 11.8% | 10.4% | 10.5% | 11.0% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate W P | 9.7% | 10.6% | 9.6% | 10.3% | 7.6% | 8.8% | 10.0% | 10.3% | 9.3% | 9.2% | 10.6% | 10.7% | 8.9% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) W | 10.5% | 11.2% | 9.9% | 11.3% | 8.9% | 10.6% | 11.2% | 12.0% | 9.8% | 9.8% | 11.9% | 11.8% | 10.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 9.3% | 10.3% | 9.5% | 9.9% | 7.1% | 8.2% | 9.6% | 9.7% | 9.1% | 9.0% | 10.1% | 10.3% | 8.1% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | 4.02 | 4.23 | 5.20 | 4.89 | 4.19 | 4.06 | 4.50 | 4.46 | 4.39 | 4.40 | 4.48 | 4.39 | 4.40 | | No Threshold |
| CCAD Cases | 28 | 36 | 21 | 26 | 24 | 29 | 23 | 30 | 31 | 27 | 26 | 25 | 26 | | No Threshold |

# Surgery

D Drive W Watch P Programme

## RESPONSIVE

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Convenience and Choice: Slot Availability | | 89.2% | 64.6% | | | | | | | | | | | | | |
| IP Survey: % Received information enabling choices about their care | W | 98.2% | 97.5% | 87.1% | 88.7% | 97.8% | 99.0% | 96.0% | 96.2% | 96.2% | 95.3% | 99.2% | 99.0% | 92.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Treated with respect | W | 97.5% | 98.0% | 100.0% | 96.2% | 95.7% | 99.0% | 98.0% | 94.7% | 98.8% | 98.1% | 99.2% | 100.0% | 97.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Know their planned date of discharge | D P | 93.2% | 91.1% | 83.9% | 94.3% | 98.9% | 98.1% | 93.1% | 97.7% | 100.0% | 97.2% | 98.4% | 99.0% | 98.0% | | >=90 % >=85 % <85 % |
| IP Survey: % Know who is in charge of their care | W | 97.9% | 97.0% | 90.3% | 86.8% | 92.4% | 91.3% | 99.0% | 98.5% | 100.0% | 99.1% | 95.9% | 100.0% | 96.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Patients involved in Play | D | 92.2% | 95.0% | 61.3% | 81.1% | 65.2% | 71.2% | 82.2% | 80.5% | 85.7% | 85.0% | 72.1% | 81.9% | 84.0% | | >=90 % >=85 % <85 % |
| IP Survey: % Patients involved in Learning | D | 77.9% | 81.7% | 71.0% | 56.6% | 85.9% | 81.7% | 76.2% | 75.2% | 98.8% | 74.8% | 82.0% | 95.2% | 92.0% | | >=90 % >=85 % <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 94.4% | 89.0% | 69.0% | 59.6% | 47.8% | 40.3% | 43.2% | 46.8% | 50.9% | 53.4% | 54.3% | 54.5% | 56.2% | | >=92 % >=90 % <90 % |
| Waiting List Size | W | 8,238 | 7,567 | 6,655 | 6,630 | 7,186 | 7,431 | 7,840 | 7,737 | 8,127 | 8,221 | 7,858 | 8,132 | 8,432 | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 0 | 7 | 31 | 60 | 137 | 121 | 135 | 143 | 147 | 183 | 221 | 291 | | 0 N/A >0 |
| Diagnostics: % Completed Within 6 Weeks | W | 100.0% | 100.0% | 100.0% | 92.9% | 66.7% | 53.3% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 50.0% | 90.0% | | >=99 % N/A <99 % |

## WELL LED

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -141 | -1,187 | -4,229 | -3,714 | -1,773 | -1,983 | -1,540 | -1,990 | -487 | 54 | -502 | -245 | 11 | | No Threshold |
| Income In Month Variance (£'000s) | W | 367 | -502 | -4,173 | -4,172 | -1,908 | -1,964 | -1,428 | -1,460 | 15 | 1 | 34 | 0 | 83 | | No Threshold |
| Pay In Month Variance (£'000s) | W | -342 | -241 | -133 | -111 | 32 | 67 | 35 | -457 | -68 | -67 | -398 | -364 | -169 | | No Threshold |
| AvP: IP - Non-Elective | W | 355 | 343 | 0 | 0 | 1 | 0 | -1 | -127 | -65 | -35 | -47 | -89 | -47 | | >=0 N/A <0 |
| AvP: IP Elective vs Plan | W | 297 | 230 | 1 | 1 | -2 | 0 | -1 | 25 | 3 | -16 | 4 | -47 | -56 | | >=0 N/A <0 |
| AvP: OP New | | 2,507.00 | 2,004.00 | 5.00 | 3.00 | 6.00 | 20.00 | 18.00 | -674.00 | -1,257.00 | -623.00 | -465.19 | -973.00 | -431.00 | | >=0 N/A <0 |
| AvP: OP FollowUp | | 7,136.00 | 5,633.00 | 0.00 | 7.00 | 16.00 | 25.00 | 46.00 | -660.00 | -1,603.00 | -273.00 | -183.57 | -1,677.00 | -1,101.00 | | >=0 N/A <0 |
| AvP: Daycase Activity vs Plan | W | 842 | 581 | 0 | 1 | 2 | 1 | 0 | -78 | -178 | -102 | -37 | -268 | -192 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | 11,111 | 8,790 | 5 | 10 | 22 | 43 | 65 | -1,767 | -3,562 | -1,250 | -780 | -3,196 | -1,780 | | >=0 N/A <0 |
| PDR | W | 94.3% | 94.3% | 94.3% | 0.0% | 1.1% | 17.1% | 24.7% | 35.5% | 57.8% | 67.5% | 67.6% | 66.1% | 66.1% | | >=90 % >=85 % <85 % |
| Medical Appraisal | W | 89.7% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 96.8% | 96.8% | 96.8% | | >=95 % >=90 % <90 % |
| Mandatory Training | W | 92.9% | 92.1% | 90.6% | 88.5% | 89.6% | 89.1% | 89.3% | 88.0% | 87.1% | 84.8% | 85.6% | 86.7% | 86.9% | | >=90 % >=85 % <80 % |
| Sickness | D | 5.8% | 6.3% | 6.5% | 6.7% | 5.8% | 5.8% | 6.1% | 6.1% | 6.8% | 5.8% | 6.2% | 8.4% | 6.8% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 2.0% | 2.2% | 1.6% | 1.5% | 1.1% | 1.4% | 1.4% | 1.7% | 2.1% | 1.2% | 1.3% | 3.1% | 1.5% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 3.8% | 4.2% | 4.9% | 5.2% | 4.7% | 4.4% | 4.7% | 4.4% | 4.8% | 4.6% | 4.8% | 5.3% | 5.3% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 397 | 504 | 457 | 322 | 204 | 310 | 332 | 286 | 446 | 505 | 415 | 434 | 382 | | No Threshold |
| Staff Turnover | D | 10.9% | 10.6% | 10.4% | 9.8% | 9.4% | 9.6% | 9.5% | 9.4% | 8.7% | 8.3% | 7.9% | 8.2% | 8.1% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) | W | 91.9% | | 90.3% | | 94.4% | 86.8% | 89.1% | 93.6% | 94.4% | 95.3% | 93.5% | 89.6% | 92.7% | | >=90 % >=85 % <90 % |

## Community & Mental Health Division

| | | |
|---|---|---|
| **SAFE** | Lessons learned:<br><br>As a result of a number of data protection incidents, the division issues a Safety Alert. This was shared with the Trust's IG Lead, Trust Risk Manager and Medical and Surgical Division governance leads for wider dissemination<br><br>Staff have been reminded of the requirement to record clinical information in a timely way following an incident reported in the community physiotherapy team | **Highlight**<br>• Zero incidents resulting in moderate or severe harm<br>• Zero incidents resulting in death<br>• Zero Pressure Ulcers (Category 3 and above)<br>• 125 incidents reported<br>• CALMS training carried out during February<br><br>**Challenges**<br>• Main incident themes relate to medication incidents (delays in receipt of prescriptions) |
| **CARING** | Lessons learned:<br><br>As a result of a complaint, the importance of sharing relevant information with children's social care has been highlighted with teams. | **Highlight**<br>• 21 Excellence Reports recorded<br>• 18 Compliments recorded<br>• FFT Scores – 90% of families scored services in the Community & Mental Health Division 'Very Good' or 'Good' with over 96% in OPD and Community services<br><br>**Challenges**<br>• Increase in PALS in Feb (38) compared to 15 in January. Communication issues and medication concerns being the main themes.<br>• 5 new complaints received in February. Themes regarding assessment process and feedback to families. |
| **EFFECTIVE** | The Eating Disorder team published a research article on the impact of Covid on referrals and service delivery. | **Highlight**<br>• Booking and Scheduling: The backlog for logging referrals has been eradicated. Work continues to ensure that this position is sustainable.<br><br>**Challenges**<br>• Referrals to Locality Mental Health Services continue to increase (30% increase between January - February) which is impacting on access times |
| **RESPONSIVE** | Improvements in waiting times across the division:<br><br>• 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.<br>• Continued improvement in RTT for Community Paediatrics now at 64% | **Highlight**<br>• No urgent breaches for Eating Disorders pathway<br>• Calls to Crisis Care service continue to increase with February 2021 seeing the highest number of calls to the team since commencement (798). |

| | | |
|---|---|---|
| | | **Challenges**<br>• Access times for specialist community Mental Health continue to be monitored closely due to impact of increased referrals. In February the RTT (referral to first partnership) within 18 weeks was 68%<br>• Waiting times for Liverpool SALT are above 18 weeks. Improvement plan in place to address this and monitored via Divisional access to care meeting |
| **WELL LED** | 4th Divisional Development Day held with first Divisional Schwartz round<br><br>Partnership with The Princes Trust developed with specific programme for young people from BAME background to commence work based programme in April 2021. | **Highlight**<br>• Staff sickness has reduced to 4.5%<br>• Medical Appraisal rates are at 100%<br><br>**Challenges**<br>• Mandatory training decreased 89% predominantly resuscitation training (sessions arranged March 2021) |

# Community

D Drive W Watch P Programme

## SAFE

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 5 | 5 | 4 | 6 | 6 | 8 | 4 | 8 | 16 | 10 | 15 | 4 | 5 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 57 | 42 | 29 | 92 | 84 | 83 | 73 | 88 | 84 | 75 | 52 | 64 | 75 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 10 | 4 | 4 | 3 | 10 | 6 | 5 | 9 | 11 | 12 | 9 | 11 | 21 | | 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) | | 2 | 6 | 6 | 7 | 6 | 11 | 10 | 20 | 33 | 26 | 16 | 19 | 17 | | 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 | | | | | | 78.3% | 100.0% | | 98.8% | 98.8% | | | | | | No Threshold |
| CCNS: Advanced Care Plan for children with life limiting condition | | 8 | 8 | | | | | | | | | | | | | No Threshold |
| CCNS: Supported early discharges from hospital care | | 100.0% | | 100.0% | 100.0% | 100.0% | | | | | | | | | | No Threshold |
| CCNS: Prescriptions | | 22 | 17 | 16 | 12 | 15 | | | | | | | | | | No Threshold |

## CARING

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 3 | 2 | 0 | 2 | 2 | 4 | 2 | 2 | 1 | 4 | 2 | 5 | 4 | | No Threshold |
| PALS | W | 36 | 18 | 19 | 19 | 26 | 29 | 22 | 26 | 32 | 17 | 15 | 14 | 38 | | No Threshold |

## EFFECTIVE

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | | 950 | 796 | 433 | 465 | 620 | 874 | 635 | 855 | 979 | 1,050 | 845 | 773 | 859 | | No Threshold |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 18 | 19 | 17 | 0 | 0 | 4 | 25 | 25 | 18 | 2 | 5 | 7 | 10 | | No Threshold |
| OP Appointments Cancelled by Hospital % | | 11.3% | 18.4% | 24.3% | 11.8% | 6.4% | 6.3% | 10.5% | 10.1% | 10.0% | 11.4% | 8.2% | 12.5% | 8.9% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate (New Appts) | W | 9.4% | 9.4% | 9.2% | 10.2% | 11.2% | 10.6% | 10.4% | 6.9% | 11.4% | 8.2% | 8.0% | 14.8% | 38.9% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) | W | 10.2% | 10.7% | 13.0% | 14.8% | 14.1% | 15.0% | 13.6% | 13.9% | 13.3% | 11.0% | 12.9% | 16.0% | 22.5% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (New Appts) - Community Paediatrics | | 11.7% | 9.1% | 9.3% | 12.5% | 11.5% | 8.9% | 12.1% | 9.1% | 14.6% | 9.9% | 11.4% | 17.8% | 48.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) - Community Paediatrics | | 7.8% | 8.2% | 13.2% | 13.3% | 11.0% | 14.7% | 14.1% | 17.6% | 15.0% | 12.0% | 14.9% | 27.5% | 48.1% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (CHOICE Appts) - CAMHS | | 13.1% | 24.9% | 26.1% | 22.4% | 28.3% | 25.7% | 23.6% | 9.7% | 12.8% | 13.3% | 13.6% | 19.7% | 11.5% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (All Other Appts) - CAMHS | | 11.9% | 12.1% | 13.6% | 15.8% | 16.0% | 15.8% | 13.9% | 13.1% | 13.3% | 11.6% | 13.2% | 12.0% | 11.4% | | <=14 % <=16 % >16 % |
| CAMHS: Tier 4 DJU % Bed Occupancy At Midday | | 76.8% | 82.5% | 90.5% | 91.2% | 85.7% | 87.6% | 75.6% | 91.4% | 107.8% | 91.0% | 109.7% | 110.1% | 106.6% | | No Threshold |
| CAMHS: Tier 4 DJU Bed Days | | 256 | 296 | 322 | 386 | 360 | 380 | 328 | 384 | 470 | 382 | 478 | 476 | 420 | | No Threshold |
| Coding average comorbidities | | | 5.00 | 3.00 | 3.00 | | 2.00 | 6.00 | | 4.50 | 3.33 | 3.00 | 3.00 | | | No Threshold |
| CCNS: Number of commissioned packages | | 10 | 10 | 9 | 9 | 9 | | | | | | | | | | No Threshold |

## RESPONSIVE

| | | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Tier 4 Admissions To DJU | | 1 | 1 | 1 | 1 | | 1 | 1 | 1 | | 2 | 2 | | 1 | | No Threshold |
| CAMHS: Referrals Received | | 383 | 315 | 110 | 163 | 259 | 262 | 257 | 356 | 348 | 416 | 339 | 268 | 351 | | No Threshold |

# Community

D Drive W Watch P Programme

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Referrals Accepted By The Service | 230 | 169 | 67 | 93 | 144 | 154 | 146 | 268 | 193 | 232 | 197 | 158 | 182 | | No Threshold |
| CAMHS: % Referrals Accepted By The Service | 60.1% | 53.7% | 60.9% | 57.1% | 55.6% | 58.8% | 56.8% | 75.3% | 55.5% | 55.8% | 58.1% | 59.0% | 51.9% | | No Threshold |
| Convenience and Choice: Slot Availability | 100.0% | 100.0% | | 100.0% | | | | | | | | | | | >=96 % N/A <96 % |
| RTT: Open Pathway: % Waiting within 18 Weeks W | 75.1% | 69.3% | 44.3% | 42.5% | 34.0% | 32.3% | 38.1% | 40.2% | 49.2% | 64.3% | 64.4% | 66.2% | 64.5% | | >=92 % >=90 % <90 % |
| Waiting List Size W | 1,161 | 1,234 | 1,010 | 1,013 | 1,184 | 1,032 | 1,109 | 1,051 | 795 | 756 | 800 | 785 | 911 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways W | 0 | 5 | 8 | 21 | 22 | 12 | 6 | 10 | 2 | 1 | 1 | 0 | 0 | | 0 N/A >0 |
| CAMHS: Crisis / Duty Call Activity | | | 288 | 422 | 413 | 550 | 494 | 516 | 596 | 718 | 697 | 649 | 798 | | No Threshold |
| CAMHS: RTT (First Partnership) % waiting within 18 weeks W | 59.6% | 58.6% | 53.0% | 53.6% | 49.3% | 44.0% | 53.2% | 59.1% | 68.8% | 70.0% | 69.9% | 65.9% | 67.9% | | >=92 % >=90 % <88 % |
| ASD: Completed Pathways | 63 | 55 | 23 | 26 | 80 | 119 | 133 | 103 | 113 | 88 | 40 | 41 | 52 | | No Threshold |
| ASD: Completed Pathway Compliance (% within 18wks) | 76.2% | 69.1% | 82.6% | 73.1% | 53.8% | 64.7% | 75.2% | 74.8% | 95.6% | 87.5% | 87.5% | 41.5% | 94.2% | | >=92 % >=90 % <90 % |
| EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) P | | | 69.2% | 90.0% | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 91.7% | 100.0% | | 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% | 100.0% | | >=95 % >=92 % <92 % |
| CCNS: Number of Referrals W | 102 | 131 | 107 | 134 | 149 | 188 | 122 | 144 | 146 | 151 | 127 | 119 | 139 | | No Threshold |
| CCNS: Number of Contacts D | 830 | 986 | 748 | 859 | 812 | 1,083 | 803 | 1,035 | 1,038 | 877 | 844 | 783 | 826 | | No Threshold |

## WELL LED

| | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) W | -65 | 165 | -92 | -27 | 175 | -26 | 0 | -70 | 369 | 270 | 45 | 321 | 221 | | No Threshold |
| Income In Month Variance (£'000s) W | 91 | 330 | -30 | -64 | 139 | -49 | -44 | 96 | 397 | 155 | 75 | 148 | 996 | | No Threshold |
| Pay In Month Variance (£'000s) W | -87 | 412 | 18 | 131 | -29 | -64 | -98 | -31 | -81 | 30 | 12 | 65 | -81 | | No Threshold |
| AvP: OP New | 531.00 | 454.00 | 0.00 | 1.00 | 3.00 | 0.00 | 0.00 | 181.00 | 122.00 | 186.00 | 108.43 | 55.00 | -190.00 | | >=0 N/A <0 |
| AvP: OP FollowUp | 2,766.00 | 2,759.00 | 1.00 | 9.00 | 9.00 | 3.00 | 9.00 | 667.00 | 652.00 | 904.00 | 1,051.48 | 503.00 | 445.00 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan W | 3,298 | 3,213 | 1 | 10 | 12 | 3 | 9 | 838 | 770 | 1,089 | 1,158 | 560 | 254 | | >=0 N/A <0 |
| PDR W | 91.3% | 91.3% | 91.3% | 2.1% | 9.8% | 16.6% | 23.1% | 41.3% | 73.4% | 81.9% | 81.9% | 83.1% | 83.1% | | >=90 % >=85 % <85 % |
| Medical Appraisal W | 91.2% | 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 % <90 % |
| Mandatory Training W | 95.9% | 94.7% | 93.8% | 93.0% | 92.8% | 92.1% | 92.0% | 91.4% | 91.7% | 89.2% | 88.4% | 89.2% | 88.6% | | >=90 % >=85 % <80 % |
| Sickness D | 4.7% | 6.3% | 4.0% | 3.5% | 2.7% | 2.5% | 2.7% | 3.8% | 4.0% | 4.3% | 4.5% | 5.5% | 4.6% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness D | 1.1% | 2.8% | 1.4% | 0.8% | 0.5% | 0.7% | 0.9% | 1.3% | 1.6% | 1.2% | 0.9% | 1.8% | 1.0% | | <=1 % N/A >1 % |
| Long Term Sickness D | 3.5% | 3.5% | 2.6% | 2.7% | 2.2% | 1.8% | 1.9% | 2.5% | 2.5% | 3.2% | 3.6% | 3.7% | 3.6% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) D | 148 | 183 | 122 | 47 | 21 | 189 | 194 | 169 | 173 | 212 | 355 | 226 | 169 | | No Threshold |
| Staff Turnover D | 11.8% | 10.8% | 10.2% | 11.5% | 11.5% | 10.8% | 10.7% | 10.5% | 9.8% | 9.1% | 8.8% | 9.4% | 9.6% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) W | 94.1% | | | | 96.2% | 99.5% | 99.8% | 99.8% | 100.1% | 98.5% | 98.6% | 99.9% | 99.4% | | >=90 % >=85 % <90 % |

# Research Division

| | | |
|---|---|---|
| **SAFE** | • Divisional Mandatory training demonstrates good compliance<br>• All current risks compliant with review dates<br>• CRF ICP (compliant)<br>• All patients screened for potential COVID 19 prior to hospital visit using telephone triage<br>• CRF ward compliant with all standards on Trust Dashboard<br>• Good uptake from Staff covid vaccine<br>• All Areas have been certified Covid Secure<br>• Increase in incident reporting under data security, action plan re training to be arranged. | **Highlight**<br>• Mandatory Training > 93%<br>• GCP training 97%<br>• SOP compliance 96%<br>• ANTT compliance 100%-CRF Ward<br>• All Covid RAs complete for CRD<br>**Challenges**<br>• Reduced space on CRF due to footfall.<br>• Risk free area with Oxford F/U's and flu vaccine sessions<br>• ANTT compliance score is incorrect and should be 98%<br>• X1incident reported |
| **CARING** | • 0 complaints received<br>• Patient centred follow up care for patients on clinical trials<br>• Patient feedback used to improve quality of patient care and experience<br>• Plans underway to capture experience patient experience data | **Highlight**<br>• X 0 Complaints<br>• New Children's PRES developed for 20/21, currently being rolled out<br>• Positive results from last survey reported<br>**Challenges**<br>• More work to do on local patient internal audits<br>• Collation of survey questionnaires from patients |
| **EFFECTIVE** | • Studies selected based on best possible outcomes for children and young people.<br>• Current portfolio regularly reviewed using NIHR stratification to allow for UPH prioritisation studies whilst maintaining all studies in level 2.<br>• No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients.<br>• Clinicians encourage children and young people to make informed decisions about participating in studies. | **Highlight**<br>• Project restart 80% NIHR CRN ambition on track for end of March. Current position , 56%<br>• Recruitment figures for UPH studies second highest<br>• Achieved national KPI of 10% recruitment for recovery study<br>• Have re-started CPP national study in line with increased covid activity<br>• X 10 UPH studies open within Trust<br>• Successful completion of Pilot of Lateral Flow Testing (LAVA study) with second phase in set up<br>• Covid staffing reduced to cover 5 days<br>**Challenges**<br>• CRF housekeeping<br>• Staffing for LAVA 2 study<br>• Siren had been extended and increased national priority<br>• Delivery workforce capacity to allow the opening of new studies |

| | | |
|---|---|---|
| **RESPONSIVE** | • All Staff Risk Assessments completed as required<br>• 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.<br>• H&S Covid RA's completed for all areas of research<br>• Coordinated and partnership working with local providers to offer joint training programmes. | **Highlight**<br>• COVID secure certificates received<br>• Agile working implemented to reduce footfall<br>• A.H supporting the wider system with Covid UPH activity<br>• Partnership working with external partners<br>• All adult patients offered alternative treatments under research whilst hosted at AH<br>• Research nurses supported mass vaccination programme internal clinics and other sites such as Aintree<br>• Adolescent vaccine study in set up to be open to recruitment mind March<br>**Challenges**<br>• Last minute requests for external support<br>• Effective clinical space to deliver HCW study clinics |
| **WELL LED** | • PDR compliance remains at 83.58%<br>• LTS absence rates have improved staff are supported through line managers and staff support.<br>• Engagement with partners in relation to upcoming starting well initiatives. | **Highlight**<br>• Shielding Staff have returned with reasonable adjustments in place<br>• Division supporting staff with Flexible working<br>• Overall sickness absence levels have improved across the division<br>• support arranged for staff with SALS<br>**Challenges**<br>• Increased numbers of staff having to self-isolate<br>• Late requests for help can be challenging<br>• Annual leave allowance for some staff |

Alder Hey Children's NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**

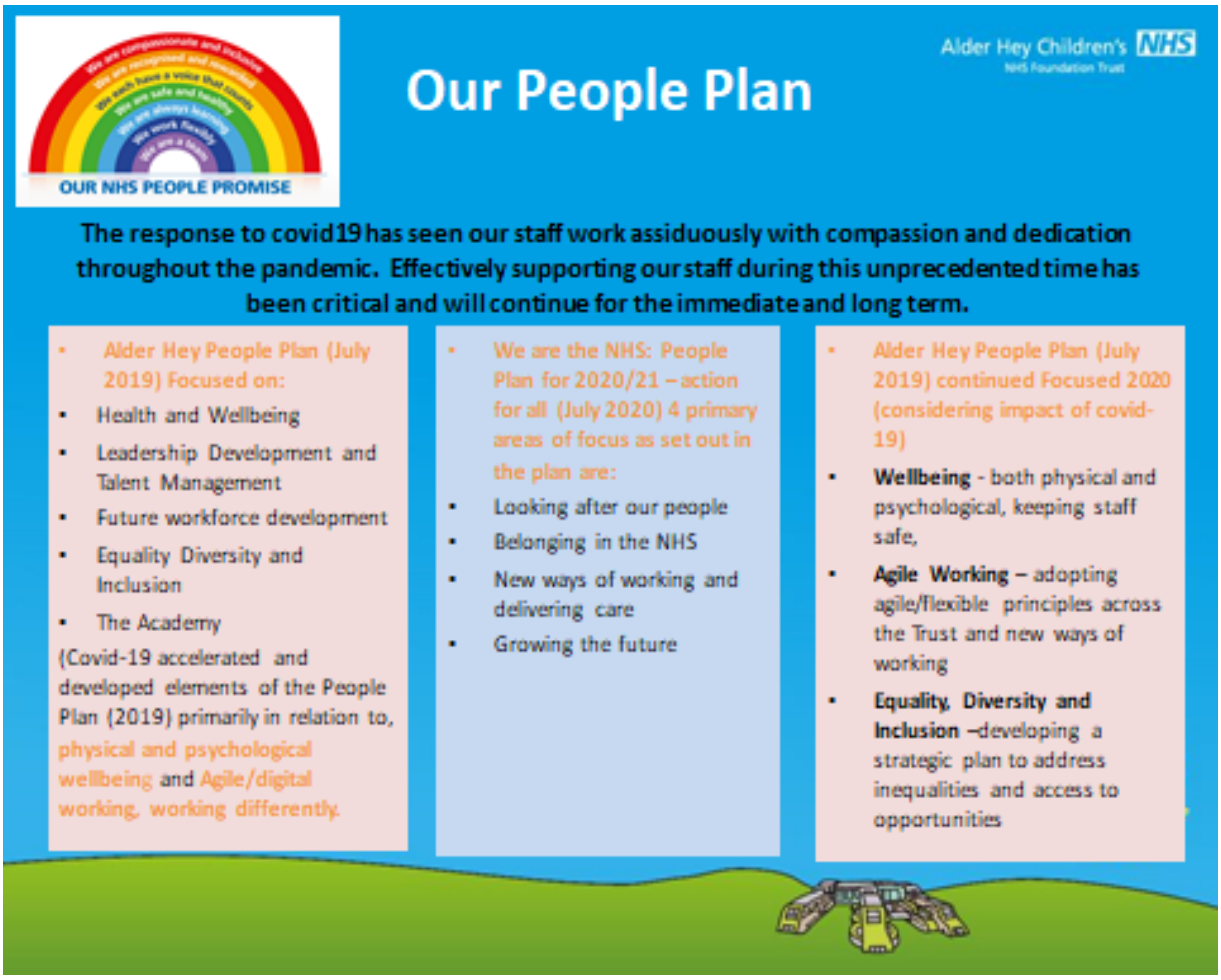
**Thursday 25th March 2021**

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

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ■<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | None |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**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 the majority of support focusing around staff experiencing stress and anxiety. As the service continues to embed into the organisation the referrals being received by the team are becoming increasing complex. To ensure staff receive the best possible support SALS are working in partnership with teams such as HR and Clinical Health Psychology.

As part of the Trust recovery plan a taskforce has been established with Dr Potier and the SALS team to support and inform the Trusts approach focusing on the themes of **rest, connect and share.**

The SALS service has received external recognition both locally and nationally. The team have been shortlisted for an HSJ award which will be announced on 17th March 2021 and have been working in partnership with NHSI & E to share learning and best practice from the service.

### 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:

- the Trainer funding identified in order that we can offer regular training and support.
- Health and Wellbeing conversations as part of regular support and embedded into the annual performance and appraisal discussions
- Utilisation of outdoor space for staff
- Launch of the 'Doing our Bit' virtual platform for fitness for all staff within the organisation.

### 2.3 Staff Availability

The staff availability position into March continues to improve with overall absences and COVID-19 related absences both decreasing and overall absence decreasing by 0.47%.

**Table 1 - Sickness position 15th March 2021**

| Reason | Trust | |
|---|---|---|
| | % | No of Staff |
| Non Covid Related Sickness | 4.89% | 196 |
| Covid Related Sickness | 0.52% | 21 |
| Absence Related to Covid - not inc sickness | 1.22% | 49 |
| Absence Related to Covid Inc Sickness | 1.75% | 70 |
| All Absence (total of above) | 6.63% | 266 |

Following the announcement by the Government of the Roadmap for the easing of lockdown measures on 22nd February 2021 the HR team are supporting managers to begin thinking about supporting individuals who have been absent due to shielding to hopefully return to work. Managers will be supported to facilitate risk assessments and occupational health referrals for staff and the HE team will continue to advise on the facilitation of home working and temporary redeployment into alternative roles as appropriate.

## 2.4 Staff Survey

The National Staff Survey feedback for the Trust is now available and detailed analysis has been shared to each of Division to inform 'big conversations'.

The survey responses are incredibly positive and highlight the great place that Alder Hey is. An analysis of the results has identified improvement in 8 of the 10 key themes and when benchmarked against other Acute and Acute & Community Trusts our responses were above average in all 10 themes.


| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement | Team working |
|---|---|---|---|---|---|---|---|---|---|---|
| Best | 9.5 | 6.9 | 7.3 | 6.9 | 8.1 | 8.7 | 9.8 | 7.4 | 7.6 | 7.1 |
| Your org | 9.4 | 6.4 | 6.9 | 6.6 | 7.6 | 8.7 | 9.8 | 7.1 | 7.4 | 6.8 |
| Average | 9.1 | 6.1 | 6.8 | 6.2 | 7.5 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 |
| Worst | 8.1 | 5.5 | 6.2 | 5.6 | 7.0 | 7.2 | 9.1 | 6.1 | 6.4 | 6.0 |
| Responses | 1,882 | 1,895 | 1,896 | 1,888 | 1,633 | 1,881 | 1,888 | 1,887 | 1,896 | 1,864 |

The HSJ have undertaken an analysis of the national staff survey results and the Trust has been identified in the top ten Trusts in the country for engagement and has also been identified as the 4th most improved Trust compared to last years results.

## 3. Equality, Diversity & Inclusion

The Trust EDI Taskforce led by Claire Dove OBE, continues to meet monthly to focus on improving and championing positive people practises within the organisation.

Three key workstreams have been identified to date focusing on recruitment, apprenticeships and zero tolerance with task and finish groups established with representatives from across the Trust working collaboratively.

## 4. Governance and Ongoing Business

### 4.1 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 March 2021 there are 12 cases currently ongoing as detailed below.

**Table 2- Employee relations activity per division as of 17th March 2021**

| Division | MHPS | Disciplinary | Grievance | B&H | Appeal | ET | Total |
|---|---|---|---|---|---|---|---|
| Surgery | 0 | 5 | 0 | 1 | 0 | 0 | **6** |
| Medicine | 1 | 0 | 1 | 0 | 0 | 0 | **2** |
| Community | 1 | 0 | 0 | 0 | 3 | 0 | **4** |
| Corporate | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Grand Total | **2** | **5** | **1** | **1** | **3** | **0** | **12** |

### 4.2 Training

As of the 15th March 2021, Mandatory Training was at 85.6% overall, over 4% below the Trust target of 90%. We continue to work with staff and managers to ensure training compliance is up to date via our monthly reporting to divisions and departments and through directly contacting staff who were not 100% compliant.

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.

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.

**Table 3- Mandatory Training compliance 15th February 2021**

| Division | Overall Mandatory Training |
|---|---|
| **Trust** | **85.64%** |
| Alder Hey in the Park | 75.68% |
| Community | 88.36% |
| Corporate Other Department | 87.57% |
| Facilities | 51.41% |
| Finance | 79.98% |
| Human Resources | 86.24% |
| IM&T | 94.28% |
| Innovation | 71.74% |
| Medicine | 87.06% |
| Nursing & Quality | 88.84% |
| Research & Development | 93.74% |
| Surgery | 86.59% |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday 25th March 2021**

| | |
|---|---|
| **Paper Title:** | **Staff Recovery Plan** |
| **Report of:** | **Director of HR & OD** |
| **Paper Prepared by:** | **Dr Jo Potier, Associate Director of OD/Consultant Clinical Psychologist** |

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

Alder Hey Children's NHS Foundation Trust

**Trust Board Committee - March 2021**

**Staff Advice and Liaison Service Proposal**

**Rest, Connect, Share - Support to Help you to Recover**

## 1. Purpose

The purpose of this paper is to share with the Trust Board the approach we will be taking in order to fully support our staff's physical and psychological recovery through the pandemic and beyond. The proposals in this paper have been discussed and endorsed by the Executive Team, and activity is already underway to progress the actions outlined in the report.

## 2. Recommendations

The Trust Board are requested to endorse and support the approach and activities as outlined in this paper.

## 3. What does recovery mean in this context?

Covid has brought a range of psychological and physical impacts brought about by prolonged and high levels of anxiety, loss, exhaustion, and existential crises to name but a few. We have also been dealing with unbearable levels of uncertainty for prolonged periods of time coupled with a constant overdose of novelty which has strained our capacity to organise our thinking and tasks.

Whilst evidence shows that our responses to disasters and incident vary, and not all people become distressed in the same way or to the same degree, research is already showing that we can and should expect to see some negative psychological effects. These include further burnout, compassion fatigue, anxiety, depression, moral injury and PTSD.

We also know that the most predictive risk factors for the onset of post traumatic mental ill-health are those that operate AFTER the incident is over. They are: access to effective social support; and the pressure that people experience as they try to recover (including the direct effects of the traumatic experience and secondary stressors such as financial difficulties, relationship problems, altered working conditions etc.). We have to actively avoid retraumatising staff through how we manage going forward.

It is therefore imperative that we put in place now interventions that facilitate coping and strengthen resilience. Whilst resources are traditionally put towards supporting staff once they've developed problems, prevention and mitigation are far more important than cure. Initial evidence suggests that individuals benefit from tangible and practical support and that preventative interventions and social support are mediators of Covid-19 related stress in the workplace. Whilst there are many negative aspects of the current situation, teams can grow stronger, individuals can develop and relationships can grow deeper as a result of this crisis. At Alder Hey we should do everything we can to promote this growth in adversity whilst

ensuring that we also have the right support in place for those who need more targeted help for their mental health.

Finally, as we move forward in our support of staff and return to business as usual, we need to hold in mind that recovery is non-linear, it is not a one-off event, and one size does not fit all. It is likely to take many months and will require creative approaches to the provision of informal opportunities to connect, share and strengthen community connections alongside more formal interventions designed to create spaces where people can talk and make sense of what has happened.

## 4. Proposal

Our proposal is that we sequence our recovery support and activities around the three key activities of Rest, Connect, and Share. Sequencing them in this order gives us the best chance of growing through this period of adversity by allowing us to strengthen natural coping mechanisms we already possess. We have to slow down to speed up. Asking our staff to share or even connect fully before they have rested risks overwhelming them, increases the chance of a lengthier recovery period, and will inevitably impact on their effectiveness at work.

- *Preparation*

We are also proposing that the first stage is a Preparation stage where there is active dialogue with staff about what would help them in these 3 core areas. This should include active attention to those groups who have been more vulnerable in this pandemic including our BAME colleagues, those who have been shielding and those who have been on the frontline of caring for our adult patients.

This dialogue will take place in 3 key ways:

1. Through the HWB conversations that will be offered to ALL staff as part of the PDR process from April onwards. The conversation will include a question “what does recovery look like for you?” and enable everyone to have the chance to talk about what it means for them personally.
2. Through a focussed online survey to be launched in April and a series of listening events.
3. Through a programme of organisational debriefing to launch in May, lead by the OD and SALS team and offered to all teams in the organisation.

Whilst this dialogue is crucial in shaping the early parts of the recovery plan, the ongoing debriefing programme will enable the conversation to continue throughout the coming months informing and shaping the plan as it progresses.

We have now established a Recovery Working Group, which will met for the first time on the 23rd March 2021, and whose membership will include SALS, OD, HR, Staff side, BAME colleagues, FTSU and others as appropriate. Activities of this group will report to the Wellbeing Steering group and PAWC.

- *Rest*

…and recognise. Our early activities should have the focus of giving staff breathing space and showing recognition for the work that they have done during this pandemic. We are proposing that the focus should be on physical rest (through annual leave, slowing down or pausing operational delivery where possible, support to help people to switch off for period during the workday through MS Teams rest days for example) and emotional rest. The latter is due to the high exposure to novelty and uncertainty which has impacted on our cognitive ability and "bandwidth". Rest in this context should involve giving consideration to delaying change processes where possible and feasible (e.g. organisational change or other changes). This period is also a chance to reinforce messages given throughout the pandemic about self-care.

This can also be a time for recognition. Work in this area can be lead by the Reward & Recognition group among others.

- *Connect*

…with compassion. Reconnecting to others and to the organisation will not be straightforward or positive for everyone so activities should reflect this. We know that for some people there is anxiety associated with resuming social contact, such as those who have been shielding for long periods or those who may be more introvert in nature and who have found elements of the lockdown to be a relief. Also, for some staff who have joined the organisation since Covid, this may be their first "real" connection to the organisation and so they may need to go through adapted induction periods as part of their plan.

For many staff, this period will be one of much anticipated joy and relief. This is where social events and informal opportunities to connect will be key. Our proposal is that there should be a series of social events planned (online initially and moving to more in person events as the restrictions abate). Again, the Reward & Recognition group will be key in planning and developing these events alongside the Communications team and others.

The HWB conversations beginning in April also provide a crucial platform to discussion reconnecting with staff with a focus on what will help them personally. In addition, the Virtual Common Rooms held by the SALS teams and open to all staff will provide another forum for staff to informally connect with each other virtually until more face to face activities are permitted.

Key during this period, and built into the HWB conversation process, will be active monitoring and a particular focus on those staff on the frontline or redeployed to the front line. The work in progress with SALS and the Pastoral Care Volunteer programme will be one means of providing this active monitoring and support to this group. We also plan to work closely with the newly developed Cheshire & Merseyside Resilience hub who can support us to offer:

- Screening surveys to actively monitor trauma
- Self help and trauma focussed resources
- Signposting to trusted organisations and partners for the right support
- Confidential in-house psychological assessment
- Specialist individual and group psychological interventions where there is a need

- Open access resources for managers, leaders and teams to help build resilience and wellbeing in the workplace
- Psychological consultation for teams who are struggling
- Trauma Informed Care training for all levels of staff and leadership

- *Share*

…and learn. When we have rested and connected, we will be ready to make sense of what has happened to us through sharing, reflection and learning. This is a key part of the recovery programme and will enable us to develop meaningful rather than traumatic narrative about what has happened to us.

The debriefing programme will enable all teams to have the opportunity for formal sharing opportunities and learning can be collated and used to continue to adapt and shape the ongoing response to Covid and its aftermath.

However, there will also be a need for more informal space for sharing and reflection. This can include offering Team Time to teams and continuing with monthly Schwartz Rounds for the whole organisation.

Finally, we are proposing that all staff are offered the opportunity to use the Ground TRUTH tool as a means of ongoing sharing and learning from the ground. The tool also helps staff to boost their own healing as demonstrated in the feedback received from its use by the redeployed staff in ICU during the third wave.

The tool was developed as part of Project Ares, part of the University of Liverpool's Psychological Resource Network (PRN). In response to COVID-19, Professor Laurence Alison and his team created Project Ares which brings together professional, clinical and academic expertise from across the globe with extensive experience of dealing with critical incidents to mobilise resources and enhance the provision of existing services currently supporting a range of users. It is a live project, pulling together the experts from the field with the latest research, to create new resources to address the challenges faced by front-line workers (University of Liverpool, 2020).

The Ground TRUTH is an After Action Review tool developed as part of Project ARES – providing resources to assist staff in their psychological preparedness, adaptation and recovery from working in the intense operational environment of COVID-19. Recognising the unprecedented challenges faced by staff in this context, the Ground TRUTH tool aims to: -

1) Provide a platform to register daily challenges and issues in real time, to feed this back up through management structures, and to identify solutions for moving forward.
2) Support staff enduring high levels of stress and ongoing uncertainty, reducing the risk of 'burn-out'. The tool facilitates individual awareness of their own needs and response, whilst monitoring personal and organisational fatigue. Staff reaching 'trauma exposure saturation' can be identified and signposted to additional support.
3) Provide teams the opportunity to develop a shared understanding of challenges, identify lessons learnt, and find ways to cope and adapt in public health emergencies.

The Ground TRUTH tool focuses on five stages: -

**T**alk and log the issue – identifying what was troubling them (negative) or what they felt had gone well (positive).

**R**eview the issue in a bit more detail enabling reflection on why the experience was difficult, what was in their control and what was not, and what the ideal outcome could have been.

**U**nderstand what can be learnt from the event; this should be goal directed and future-leaning – asking why did this happen and what can we learn?

**T**ell others and the organisation about what is needed and what specific things could be done better/differently next time.

**H**eal and move forward – this stage is directed at enabling staff to self-identify, with some guidance from the tool, those things that they can do to support their mental and physical health and boost natural coping.

The tool is based on the following principles: -

- *Non-directive*: the tool is user-led and provides prompts to encourage reflection.
- *User centred*: the user is always the best person to resolve issues, with the tool simply enabling individuals to be specific about their own learning from success and error.
- *Positive*: the notion is that broadly individuals are good at adaptation, innovation and building their own resilience more effectively if they come up with their own solutions.

To overcome logistical challenges at this time, the Ground TRUTH tool exists on an online platform which can be used by individuals alone, in pairs, or in groups. We are proposing that we continue to use the tool to review how staff are feeling and share the summary thoughts back with the staff. We have completed the Ground TRUTH Check Out survey and plan to share this at a Trust briefing in March 2021.

**Next steps**

We propose that the next steps should be as follows:

- Establish Recovery working group (by mid March) - **COMPLETED**
- This group to link with work finalising HWB conversations so that Recovery is central to these conversations
- Focus initially on communication of the Recovery proposal via Briefings and establishing mechanisms for open dialogue with the organisation about what Rest, Connect and Share mean to them
- Reward & Recognition group to develop ideas for ways to recognise staff and also begin planning social events

Alder Hey Children's NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday 25th March 2021**

| | |
|---|---|
| **Report of:** | FTSU Guardian |
| **Paper Prepared by:** | FTSU Guardian |
| **Subject/Title:** | Freedom to Speak Up – Progress Update Report |
| **Background Papers:** | FTSU Board reports from September 2016 onwards |
| **Purpose of Paper:** | To provide the Board with a summary of progress to date to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period |
| **Action/Decision Required:** | The Board is asked to note the progress made to date and to support the further actions outlined |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | **Best people doing their Best Work** |
| **Resource Impact:** | To be identified |

**BOARD OF DIRECTORS**

**FREEDOM TO SPEAK UP QUARTERLY PROGRESS REPORT**

## 1. Purpose

The purpose of this paper is to provide the Board with a summary of the actions taken by the FTSU team in the last quarter and to outline the actions planned for the coming six to twelve month period.

## 2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

## 3. FTSU Champions

Expressions of Interest in joining the FTSU Champions team were advertised to all staff on the 8th February 2021, with further communication on the 5th March 2021. To date there have been 14 requests to become a champion from colleagues in a variety of areas, with representation from a good selection of roles. In order to clearly define this role within the organisation and to be clear on its purpose, a two hour briefing session has been scheduled for 27th May 2021, involving current FTSU Champions and staff who have expressed an interest in the role. The purpose of this is to clearly define the role, the purpose and the structure; the aim is to ensure clarity, promote ownership and help embed the role within the organisation

## 4. Evaluating Guardian Resource

The Freedom to Speak up Guardian role currently has two days' protected time; this time is fully utilized, with some creep into additional time. It is, however, possible that with the expansion of FTSU Champions that this may reduce, without compromise to the service. As indicated, it is intended to increase the number and profile of FTSU Champions and it is anticipated that this role will expand with increased staff exposure, therefore it should be expected that there will be a need to consider protected time for the champions in the future once this becomes clearer.

## 5. Communication Strategy

The FTSU intranet page has recently been revamped, with the introduction of a number of tools that will aid staff who wish to use FTSU as a route to raise concerns; we have also included a link to the new FTSU staff training modules, recently released by the NGO which will be a key focus.
A fundamental part of the role of the FTSU Champion is to actively promote FTSU within the organisation as a route to raise concerns safely; during the session on the 27th May communication will be discussed and Champions will be encouraged to 'keep talking' about FTSU with their colleagues and teams at every opportunity.

Currently we have a range of FTSU communications collateral including pull up banners; these are an effective way of improving visibility. Clearly there will be a benefit of using these additional tools, in order to promote FTSU within the organisation and providing staff with contact details to enable easier access to the service.

## 6. FTSU Connection with our BAME colleagues

Previously the FTSU Guardian has been part of the Trust's BAME Network which supported learning and understanding of the issues that our BAME colleagues face. The Guardian is a member of the BAME Task Force Group which has been established in response to the Black Lives Matter movement. The work of the task force will provide the FTSU service with valuable insight into the concerns felt by our BAME colleagues, helping inform the service on how it can evolve to ensure that this group of staff feel safe to speak up, listened to and their concerns are followed up.

The recent expression of interest for FTSU Champions was communicated trust-wide; however we are looking to send a personal request to our BAME colleagues, as this group is under represented

within the current and new FTSU Champion team. It is hoped that this request will produce a positive response and interest in the role

**7. Triangulating Data**
The triangulation of data relating to staff concerns from across the organisation has been an area that has required development. The importance of this triangulation cannot be undervalued, with it, we will be able to identify any potential 'hotspots' within the organisation, along with this insight, would come the ability to invest in additional support to teams and aid them in making the required change.

Working with the Deputy Director of HR and the SALS team, we have established regular monthly meetings, to triangulate data and intelligence, found within the HR team, SALS and FTSU, this will help in identifying areas of concern and trends and themes within the trust and ensure focus of attention is where it needs to be, it will also shape training and development and policy reviews

There is still a requirement to bring in our Raise It Change It and Ulysses data, including incident reporting; the capability of Ulysses to accomplish this will be complete within this quarter. The FTSU Guardian attends the weekly Patient Safety Meetings which is a further mechanism to aid the monitoring of concerns. Using Ulysses as a central data source will ensure that concerns are acted upon in a timely manner with a robust process for feedback to staff.

**8. FTSU TRAINING**
The National Guardian's Office has recently released a new training programme. There are three modules: the first module, *Speak Up*, is available for all staff via ESR. There have been requests to the NGO to mandate this training, however to date, this has not been agreed, and therefore it does remain a challenge for the FTSU Guardian on how to encourage all staff to complete this first module.

In the recent FTSUG survey, training uptake was identified as a concern for those trusts that did not mandate the training and consequently, uptake was low. The barrier to mandate the training, was identified as being the large amount of mandatory training currently required

There is a link to this training on the FTSU intranet page and our FTSU Champions will be tasked to promote the *Speak Up* module among staff, however we should consider other mechanisms to encourage staff to participate in the training modules, which will not only serve to educate our workforce, but also promote the FTSU service, one consideration would be to include it in PDR's.

The second module*, Listen Up*, is aimed at managers and leaders within the organisation and provides information on how to support staff in raising a concern; this too is accessible on ESR, again the same challenges are faced in terms of uptake, however the recommendation for the inclusion in PDR's should also be considered for this training.

**9. Freedom to Speak Up Guardian Survey 2020**
Following the recent FTSUG Survey 2020, there are a number of recommendations, which relate to: appointment of the FTSUG role, ring-fenced time, feedback of performance, speak up training, groups facing barriers to speaking up, characteristics of FTSU Guardians and detriment. Of these there is ongoing work around training, barriers to speaking up, characteristics of FTSUG's and detriment.

Access to the Chief Executive, Non Executives and reporting to the Board, was also referenced in the survey, however there are no areas of concerns in regard to this that have been identified by the current FTSUG.

**10. FTSU/Raise It Change It/ Ulysses**

Following the disruption caused by the pandemic in the last year, the Guardian will be re-launching FTSU at the same time as the Raise It Change It module goes live on Ulysses, the aim being to publicise to staff the availability of this framework within which to raise concerns of any nature. Staff will still access Raise It Change it, as they currently do, however once in, they will be directed to a simple Ulysses form. This form will still allow anonymity should the user wish; however they will be advised that specific feedback will not be possible should they use this route. Other benefits will include regular requests to the relevant manager for an update on progress, monitoring of lessons learnt, robust feedback process and an ability to produce regular reports, indicating trends and themes.

As in the FTSU Ulysses system, access will be strictly limited, this is to ensure staff, that information relating to concerns raised will be held securely and confidentially.

**11. FTSU INDEX**

The FTSU Index is now in its 3rd year and whilst we had a slight decline in the index last year, the results of the NHS Staff Survey 2020, should indicate an increase in this year's FTSU Index, as the 4 questions used to create this data, 17a, 17b, 18a and 18b have all increased from 2019 NHS Staff Survey results. Importantly, this increase is a positive reflection on the culture of the organisation and its alignment with the principles we promote for a 'Just Culture'

**12. Guardian Report content**

Data submitted to the NGO for Q3 was limited to one case, however after a review of this, it has been identified that some concerns were being raised through our SALS service and not captured under FTSU. This may have occurred due to the FTSUG and a number of FTSU Champions being within the SALS service; this relationship has now been reviewed and the link to FTSU will be via a signposting process from SALS, this will ensure clarity for both services.

It should be noted that concerns raised through Q4 have significantly increased, which would indicate that the proposed changes have been successful.

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**Kerry Turner**
**March 2021**

Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey Children's NHS
NHS Foundation Trust

**Board of Directors**

**Thursday 25th March 2021**

| | |
|---|---|
| **Report of** | Development Director |
| **Paper prepared by** | Associate Development Director- (20/01/2021)<br>Russell Gates |
| **Subject/Title** | Development Directorate<br><br>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:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | ➢ Delivery of outstanding care<br>➢ 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

## March 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 offsite premises (business case submission to the March 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 April 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.<br><br>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.<br><br>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)<br><br>Public perception that the park phase one is not being delivered. | Continued meetings with planners, residents and LCC parks officers to resolve the location.<br><br>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**<br>**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<br>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.<br>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. The decision to seek an offsite solution for offices was accepted, a building has now been found and the business case for taking a lease (rather than purchase) on the building is being put to RABD in March. | Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12) | Take recommendation to lease 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.<br>Oncology, genetics and management blocks have all now been vacated and fully decommissioned this is however slightly behind plan by 1 month.<br>Decommissioning certificates have now been issued. | Asbestos removal cost/time | Complete required works to make the land safe.<br>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.<br><br>Costs for the base works are currently being sought from the market.<br><br>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)<br>Budget for Phases 2 & 3 is inadequate. | Working with landscape designer to reduce costs within the parameters of the Land Exchange Agreement.<br><br>Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress.<br><br>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.<br>A review and report has been commissioned by Curtin's (Traffic management consultants). Initial results of the analysis suggests that no offsite highways work will be required. This will now be incorporated into the design so that budget estimates can be completed. | If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8) | Add to risk register.<br>Continue design work and receive report on advised traffic management from Curtins (due March 2021)<br>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<br>The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments.<br><br>Electricity new supplies;<br>• Now Received an offer from Scottish Power for our HV supply, PO to be raised so that programme can be confirmed<br>• The new energy centre is in design<br>• Tender is slightly delayed which will go out in early April 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 will exceed budget. | Value engineer the proposed plans with the architect.<br>Explore estimated costs and market test/tender.<br><br>Following VE exercise, planning will now be submitted in April 2021 |

## Clinical Hub and Dewi Jones Construction

| Current status | Risks/issues | Actions |
|---|---|---|
| Contract with Galliford Try remains on programme with good visible progress.<br><br>Insurers have requested a change to the roof material/system, due to the timber frame and the insulation material proposed posing a fire risk. This may cause a cost increase to change at such a late stage. | Ongoing design development potentially could raise issues of quality leading to increases on cost. Late change leads to delays and additional costs. Increased costs and delays. | Continue with weekly meetings with Galliford Try and challenge design where necessary.<br><br>Working with insurers and our broker to mitigate additional costs and any delays. |

### 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. Design for a PAU alongside the EDU on the ground floor has commenced.<br><br>Neonatal element of the project on the first floor has completed to stage 3 and will be ready to tender at conclusion of the ground floor reaching the end of stage 3.<br><br>Three parties interested in the construction Interserve, Morgan Sindell and Galliford Try | Project Co engagement extending the programme and increasing costs;<br><br>Planning and any unknown Section.106 or section S.278 costs<br><br>Potential lack of capacity for increased demand for medical oxygen (risk 2353, rating 20) and medical air (risk 2355, rating 16)<br><br>Planning permission fails to be achieved within the timescale of the overall programme delivery. | Continue working with Project Co to mitigate impact.<br><br>Work with LCC planners to minimise impact<br><br>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.<br><br>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<br><br>Cost of providing the developments do not match income from commissioners | Maximise our offering/ support /negotiation on development content and opportunities.<br>Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability.<br><br>Produce robust business cases to highlight any issues/risks.<br><br>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.<br>Fortnightly meetings established to discuss wider campus development progress. | Loss of reputation, locally and regionally.<br>Lack of engagement internally and externally | Maintain links with community and support their development work. |

**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.<br><br>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.<br><br>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.<br><br>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 19th March 2021.

Alder Hey Children's NHS
NHS Foundation Trust

**BOARDS OF DIRECTORS**

**Thursday 25th March 2021**

| | |
|---|---|
| **Paper Title:** | **21/22 Interim Financial Plan** |
| **Report of:** | **Director of Finance** |
| **Paper Prepared by:** | **Rachel Lea**<br>**Deputy Director of Finance** |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☒<br>Assurance ☐<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | Paper provides background reading and key information. |
| **Action/Decision Required:** | To note ☐<br>To approve ☒ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐ |
| **Resource Impact:** | . |

Alder Hey Children's NHS
NHS Foundation Trust

# 21/22 Interim Financial Plan

## Executive Summary

The purpose of this paper is to provide an update to the Trust Board on the 20/21 forecast year end position and to seek approval on the interim 21/22 financial plan for the organisation. The paper will outline the planning principles that underpin the 21/22 plan, noting that the 21/22 national framework and guidance is yet to be released and therefore at this stage the plan is in draft form and will likely change over the coming months once clarity is received.

The key points to highlight from this paper are:

1. The revised forecast for Alder Hey for the 20/21 year end is now a breakeven position.
2. The finance framework for the first 6 months of 21/22 will be a rollover of 20/21 arrangements with the likelihood of a continuation of the current governance arrangements in place being also rolled over.
3. Uncertainty remains on income levels for individual organisations until national guidance is released.
4. An internal interim 21/22 plan has been developed focusing on areas within the Trust control including an expenditure rebase of all divisional budgets and will be updated once clarity is received on current unknowns.
5. Capital spend in 21/22 will be managed through the ICS at system level and create a risk for individual organisations and in particular Alder Hey as it is not yet confirmed how prioritisation of capital spend will be carried out.

The paper will seek the following:

1. Agreement to the revised breakeven position for 20/21
2. Agreement to the interim 21/22 plan including:
    a. Expenditure budgets based on the principles outlined
    b. £6m CIP target for 21/22 and revised distribution across clinical and non-clinical areas.
    c. Overall trust position currently at a £8.5m deficit recognising this will likely change as guidance and allocations are released
3. Agreement to the draft capital plan for 21/22 with further work ongoing to mitigate the system pressures.

## 20/21 Forecast Year End

The February reported overall financial position was a £0.4m deficit and a year to date position of £3.6m deficit. The latest year end plan submitted in January was a £4.5m deficit which was driven by 3 key areas:

1. Shortfall in non-clinical income restoration £2.1m
2. Accrual for carry forward of annual leave for staff £1.2m
3. Increase in capital charges and other investments not funded through top up £1.2m

NHSI/E have confirmed that providers will receive cash funding for the full shortfall in non-clinical income and also cash funding towards the annual leave accrual (maximum 5 days per employee), which for Alder Hey, should result in c£3.1m funding.

In addition, a reforecast has been undertaken based on the improvement in Month 11 and it is expected that subject to the £3.1m funding being received from NHSI/E and excluding any shortfall in

annual leave accrual, the Trust will report a breakeven position at the end of March. The main drivers of this improvement are:

1. Reduction in capital charges due to high cash balances and delays in capital spend - £0.9m
2. Commissioner funding for 20/21 cost pressures - £0.35m

Achievement of a breakeven position will not only meet the required target set by NHSI/E, but with the additional funding due to be received and the reduction in spend, will protect the Trust cash balance to fund the ongoing capital programme.

**National Context**

Given the Wave 3 COVID pressures, NHSI/E confirmed that a full operational planning and contracting round will not be undertaken for 21/22 and there will be no requirement for organisations to submit individual plans or agree contracts with commissioners.

Initially it was suggested that the current financial arrangements that have been in place since 1st October 2020 will be rolled over for Q1 (April-June). However, the latest update is, the rollover will be for at least the 1st 6 months (end September), with uncertainty on what will happen after this period.

The guidance on the rollover arrangement has yet to be released (expected late March) however, a number of key principles and assumptions has been shared with organisations as below:

- Funding envelope for C&M will be based on the income allocated in the last half of year 20/21 and will continue to be paid to providers as a block payment with no tariff-based payments.
- Adjustments will be made for unavoidable inflation, excluding the pay deal as this has not yet been finalised. Back dated funding will be made later in the year for this.
- An efficiency requirement will be included although the % level has not been notified.
- There will remain some out of envelope funding mechanisms e.g. vaccination/testing
- Organisations will be sent indicative financial plans set by NHSI/E for April-September based on actual spend in Q3 20/21. This will not determine income flows as this will be capped at the system envelope funding from 20/21 H2 as point 1 above.
- An expectation remains that at C&M system level, systems achieve financial balance and remain within their allocation.
- Capital spending allocations will be capped at a system level similarly to 20/21 which will provide restraint on individual organisations spend and plans with the C&M ICS providing scrutiny and oversight and ultimately setting the principles of capital spend with the region.
- A separate funding allocation will be created for Activity Recovery and Restoration as per the spending plan, with the metholdogy of how this to be assigned to individual organisation yet to be determined.
- There will be an expectation on activity recovery trajectories as a % of pre Covid levels that will be shared by NHSI/E and will be based on organisations individual start points.
- Independent sector funding from 20/21 will be maintained however distributed to local systems for prioritisation and will not be nationally reimbursed.
- A full planning exercise will be required for Mental Health linked to delivery of the long term plan and Mental Health Investment Standards, the details yet to be confirmed.

Providers are not requested to submit external plans under this interim framework, however it is important to ensure that an appropriate measurable internal budget and plan is set that aligns with the national principles outlined above but also continues to drive future financial sustainability.

Alder Hey Children's NHS
NHS Foundation Trust

**Alder Hey 21/22 Interim Financial Plan**

I&E Plan

An interim plan has been developed for 21/22, using the national principles outlined above and focusing on areas that are within Alder Hey control and that can be influenced. The key principles that has been adopted in the development of the 21/22 interim plan include:

- Fixed block income levels rolled over from Q3/4 of 20/21, with no inflation applied until confirmed by NHSI/E
- Any continued impact of COVID is excluded and assumed to be funded through ongoing COVID allocations.
- CIP target for 21/22 has been set at the previous plan level of 2.2% (£6m), allocated 2% clinical areas and 5% non-clinical areas. The Board had previously signed off a cap on CIP level sat £6m per annum which has at this stage remained a core principle in our planning.
- The cost of activity restoration and growth has not been included and will be subject to funding from the separate central funding.
- Funding has been given to divisions for all business cases approved pre Covid, linked to 19/20 growth where it can be demonstrated that the case of need still remains.
- Clinical Income plans have been removed from divisions with a focus on expenditure.
- The non-recurrent funding allocated in 20/21 to address legacy and historical issues has been made recurrent.
- Financial risks have been quantified by all divisions, however no funding has been allocated in the interim plan, once funding allocations are made clearer if funding is available, an executive prioritisation process will be undertaken.
- Assumption that non-clinical income levels continue to restore to 19/20 levels. Once released, the guidance will confirm the national expectation on this and may provide additional funding whilst recovery is taking place.

The impact of the above is a current forecast overall deficit of £8.5m to March 22 as shown in the bridge below:

| | £ |
|---|---|
| 20/21 Plan pre COVID | -4.30 |
| Unachieved CIP | -6.00 |
| Increase in capital charges | -3.20 |
| Investments pre approved business cases | -1.00 |
| 21/22 assumed CIP | 6.00 |
| **21/22 Interim Plan** | **-8.50** |

Given the uncertainty around the last half of the year it is likely that the forecast this will change as income flows become more certain. There is a level of risk within the planning as it stands currently due to the lack of clarity on funding envelope and the unpredictability of the lockdown restrictions easing and the impact this may have on future COVID demand and NHS capacity. The key risks and opportunities are outlined below:

Risks/Downsides:

- Non clinical income restoration does not reach the 19/20 levels and NHSI/E do not provide additional funding
- Further COVID waves and financial impact of responding not included in interim plan.
- Delivery of the £6m CIP assumed in the plan given organisational readiness coming out of the pandemic.

- Divisional cost pressures/investment plans not fully addressed in the current interim plan

Opportunities/Upsides

- Recognition by NHSI/E of the Complex Paediatric Tariff issues and subsequent funding passed to organisations in the second half of 21/22.
- Further increases to block income for Q1/2 once framework is released.
- Access to central growth/recovery funding to increase income and productivity gains on delivery
- Growth in business development opportunities and increase in overall contribution.

Capital Plan

The Trust submitted a 5 year capital plan in November 19 with 21/22 being year 3 of this programme. A revision to the 21/22 plan has been undertaken taking into account the slippage from 20/21 and updated spend profile for schemes as they now progress.

The latest forecast total capital spend for 21/22 is £29.5m and is broken down in the following table. Further work will be undertaken to confirm the detail within each scheme, ahead of the expected submission to NHSI/E mid April, however the total quantum of spend is unlikely to change.

| | Proposed 21/22 Plan £ |
|---|---|
| ***Estates*** | |
| COMMUNITY CLUSTER / DEWI JONES UNIT | 8,411 |
| NEONATAL | 3,494 |
| PARK DEVELOPMENT | 2,995 |
| RESIDUAL SITE DEVELOPMENT | 2,550 |
| DEVELOPMENT TEAM | 600 |
| INFRASTRUCTURE & DEMOLITION | 1,680 |
| LANDSCAPING | 241 |
| **TOTAL ESTATES** | **19,970** |
| ***IM&T -*** | |
| SERVICE IMPROVEMENT - MICROSOFT REFRESH | 450 |
| SERVICE IMPROVEMENT - DEVICE STRATEGY | 632 |
| SECURITY & RESILIENCE - CYBER DEFENCE | 250 |
| SECURITY & RESILIENCE - NETWORK / TELEPHONY | 250 |
| DIGITAL HOSPITAL - GDE / HIMSS | 650 |
| DIGITAL HOSPITAL - EXPANSE | 957 |
| DIGITAL HOSPITAL - EPR STAFFING | 700 |
| **TOTAL IM&T** | **3,889** |
| ***Medical Equipment -*** | |
| MEDICAL EQUIPMENT - REPLACEMENT | 2,800 |
| **TOTAL MEDICAL EQUIPMENT** | **2,800** |
| BI | 190 |
| AI HQ | 160 |
| STAFF WELFARE | 400 |
| PFI HEALTH & SAFETY VARIATIONS | 300 |
| OTHER | 1,835 |
| **TOTAL OTHER** | **2,885** |
| | |
| **TOTAL SELF-FINANCED CAPITAL SCHEMES** | **29,544** |

**Alder Hey`s Financial Strategy**

***To improve underlying run rate from current deficit to a break even within the next 2 years, and reach a £5m surplus by 2025.***

Alder Hey has achieved financial success over recent years in meeting and overachieving on its control total through one off commercial agreements, allowing us to attract circa £50m in cash through

NHS incentive funds and building up a cash reserve of £100m that has been committed in our 5 year capital development programme.

`Our Plan` financial goal is to move to a £5m surplus, however, despite the recent financial achievements, our underlying position moving into 21/22 is a deficit. This deterioration is largely driven by internal cost pressures such as capital charges and local service investments, set against a baseline which already included a deterioration driven by a reduction in paediatric tariff from 2017/18. If we continue to trade at a deficit position and with the changing national architecture, our cash balances will reduce and our ability to continue to invest in the capital programme will be restricted. We need to be a sustainable organisation, generating cash through our trading performance to allow us to meet our long term financial obligations, whilst also reinvesting in our people and our services.

To achieve our goal and ambition by 2025, will require a fundamental change in our financial operations and a shift in how we continue to grow whilst restricting spend, driving an increase in our EBITDA and overall surplus.

The changes in national financial architecture and continuation of a block and fixed income level, requires a change in the Trust current financial approach and mind set, it will not be credible to assume delivery of the financial strategy through growth and doing more to increase our clinical income. It requires a new radical approach to drive better value from the existing Alder Hey funding envelope, with cost restraint, maximising innovation and transformation opportunities and also leveraging non NHS income opportunities.

In September the Trust Board approved as part of the phase 3 responses, a new financial approach, `Managing the Alder Hey £` with 4 key components:

1. Inclusive Financial Stewardship
2. Organisational Excellence
3. Investment strategy
4. System Working

The last 6 months has been focused on recovery and restoration and delivery of the 20/21 plans, supported by the financial approach above. As we move into 21/22, 6 key principles have been agreed and adopted in developing the 21/22 plan and internal financial strategy. The financial principles are:

1. **Reset of carry forward by 50% CIP targets**
2. **A capped 21/22 CIP of £6m**; allocated 2% clinical (£4m) and 5% non-clinical (£2m)
3. **Updated approach for non-NHS income areas**; including incentivisation and reinvestment and a drive to increase contribution from business development.
4. **Investment strategy focus on benefits realisation and repurpose** to drive productivity gains and reduce overhead cost restraint.
5. **Restoration of activity and backlog recovery** to meet RTT targets
6. **Maximise commissioner income**

<u>CIP Programme</u>

A key driver in becoming sustainable is to maximise the Alder Hey £ and drive efficiency through cost reduction and productivity. It is expected that the 21/22 rollover will include an expected efficiency target for all providers however the % is yet to be confirmed.

Our pre COVID 5-year plan included a 2.2% (£6m) CIP for the next 3 years. Historically Alder Hey has had a distributed target across all divisions, however as outlined above the 21/22 £6m target has been distributed in the 21/22 plan with a higher % target for non-clinical areas.

The Sustainability Delivery Group has been reinstated on a fortnightly basis and will focus on driving the areas of cost reduction and transformation required to deliver the £6m savings target included in the draft plan. At present £2m of savings has been identified through divisional schemes and in addition 8 cross cutting themes have been agreed with identified executive leads:

| Theme | Exec Lead | Areas of Opportunity |
|---|---|---|
| Workforce | M Swindell | • Temporary Staffing<br>• Job Planning |
| Estates | J Grinnell | • Energy<br>• Rationalisation |
| Collaboration | D Jones/J Grinnell | • Specialist Trust<br>• TBC |
| Productivity | A Bateman | • Growth/restoration funding<br>• TBC |
| New Models of Care | N Askew/ N Murdock | TBC |
| Digital & Innovation | K Warriner/ C Liddy | • RPA/Automation<br>• TBC |
| Technical | J Grinnell | • Commissioner risk & opps<br>• Capital charges<br>• Procurement |
| Green | M Flannagan | TBC |

**Conclusion**

The Trust Board are asked to note the contents of this paper and to approve:

1. The 20/21 reforecast plan of a breakeven position.
2. The interim 21/22 plan of a £8.5m deficit and the planning principles adopted, noting the risks and opportunities and that further revisions will be made once national guidance is finalised.
3. Draft 21/22 capital plan with a total spend of £29.5m.

The 21/22 planning will continue over March/April and will align with the business planning underway within the divisions, developing into a further iteration of the 21/22 plan overlaying the base budget above with updated income assumptions aligned to the activity plans for recovery and restoration.

Alder Hey Children's NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday 25th March 2021**

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

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | Monthly BAF Reports |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**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.

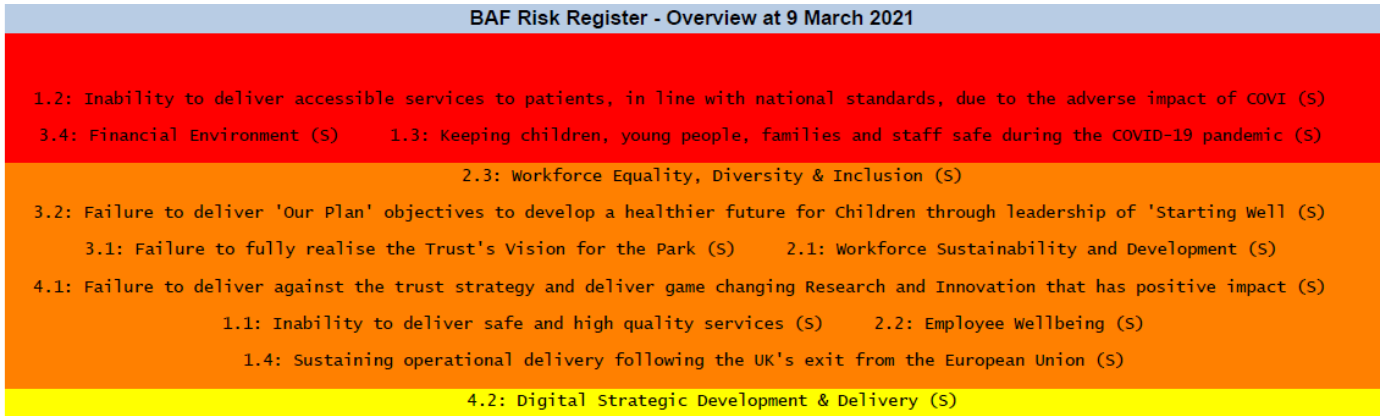
## 2. Review of the BAF

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 10th March 2021

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 10th March 2021

The diagram below shows that all risks remained static in-month.

| 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** | RABD | | 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 | IMPROVED | STATIC |
| **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 February 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 risk rating in month. Progress re-establishment of new C&M CYP Programme, hosted at Alder Hey; evidence attached.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Actions are progressing and an EDI collaborative team is being actively recruited to for specialist trusts.

- ***Sustaining operational delivery following the UK's exit from the European Union (JG)***
  Risk reviewed, no change to score in month. EU Exit Group continues to meet, no major issues identified; frequency of group extended following review of current level of risk. Escalation protocols and pathways remain in place. Daily operational updates still running daily - can escalate issues should they arise.

### 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 size of our backlog of long wait patients increased in February and there are 306 patients waiting over 52 weeks for treatment.

  The increase in the number of patients waiting for treatment is concentrated in admitted care with significant change in ENT and Trauma and Orthopaedics. We have formulated an elective recovery plan and submitted this to the regional cell. This contains a forecast which predicts an increase in the number of patients waiting over 52 weeks for admitted care over the next 6 months. In Q3 and Q4 2021-22 we forecast the backlog will start to reduce with the timescale for complete eradication of the backlog over a 12 month timescale.

  In late February we have delivered a rapid recovery of activity in outpatients (90%) and inpatients (100%) and we expect this to be sustained in March. We have started to utilise additional capacity through the LLP. Through March to June we have significant additional weekend activity scheduled in theatres to alleviate the pressures on the inpatient waiting list.

- ***Keeping children, young people, families and staff safe during COVID-19 (JG)***
  Wave 3 response plan updated at February's Trust Board and signed off. Key ongoing areas of focus are; vaccination programme, staff testing, staff resilience and welfare and restoration and recovery.

- ***Inability to deliver safe and high quality services (NA)***
  The risk has been reviewed and articulated within the context of the current climate. Actions related to work force have been transferred to 2.1. The final gaps in assurance and associated mitigations will be reviewed by the Director of Corporate Affairs, Medical Director and appropriate members of the Executive Team prior to being shared with the Board for approval.

- ***Financial Environment (JG)***
  Risk reviewed, no change to risk score at present as still awaiting confirmed details of 21/22.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  March 2021 – David Powell.
  Prior to March Board.

- ***Digital Strategic Development and Delivery (KW)***
  BAF reviewed, actions on track. Dedicated cyber lead due to commence post April 2021 in collaboration with LHCH. Good progress with training developments and Alderc@re programme on track.

- ***Workforce Sustainability and Development (MS)***
  Some actions on review have slipped slightly - a scheduled meeting 9/8/03/2021 with HRD, deputy HRD and head of L&D to review the recovery plan to achieve 90%compliance on mandatory training

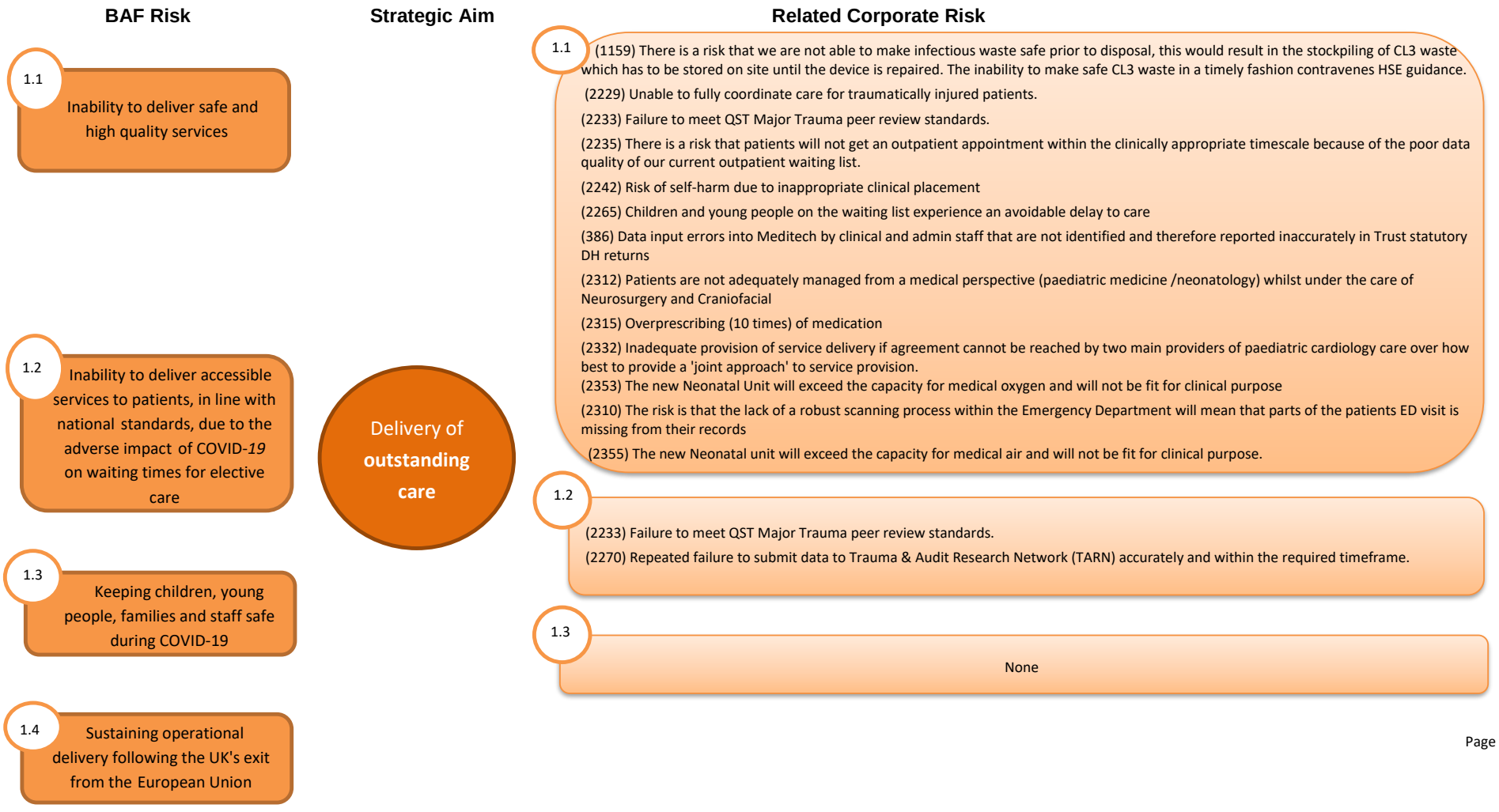
- ***Employee Wellbeing (MS)***
  Risk reviewed. SALS resource action complete. Additional control added following appointment of Wellbeing Guardian. Actions reviewed and progress amended. No change to score.

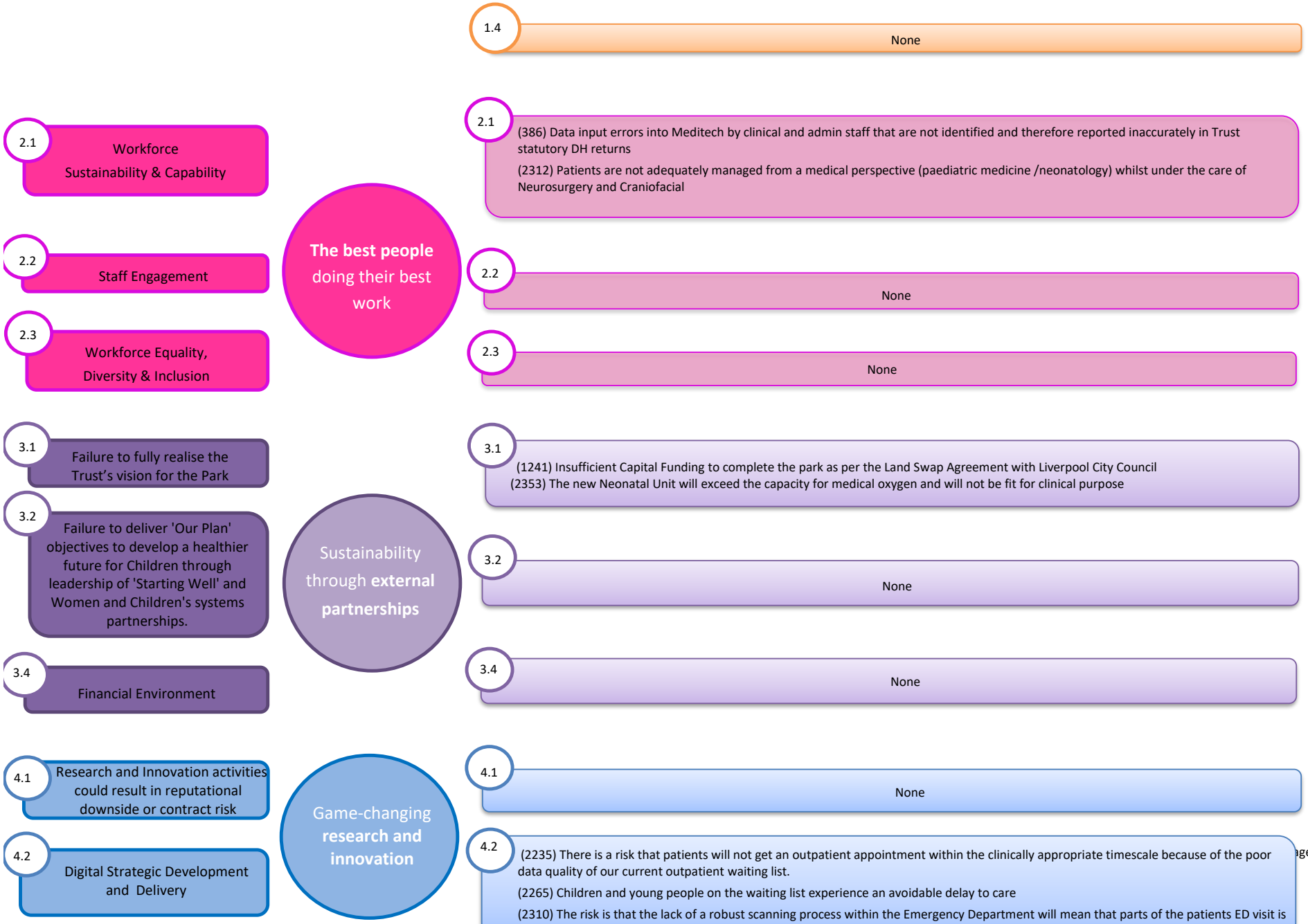
- ***Research and Innovation activities could result in reputational downside or contract risk (CL)***
  Risk reviewed 25/02/21 (FEB21) - no change

**Erica Saunders**
**Director of Corporate Affairs**

## Appendix A

## Links between BAF and high scored risks – as at 1st March 2021




1.4
None
2.1
Workforce Sustainability & Capability
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
2.2
Staff Engagement
2.2
None
2.3
Workforce Equality, Diversity & Inclusion
2.3
None
3.1
Failure to fully realise the Trust's vision for the Park
Sustainability through external partnerships
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
(2353) The new Neonatal Unit will exceed the capacity for medical oxygen and will not be fit for clinical purpose
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.
3.2
None
3.4
Financial Environment
3.4
None
4.1
Research and Innovation activities could result in reputational downside or contract risk
Game-changing research and innovation
4.1
None
4.2
Digital Strategic Development and Delivery
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
(2310) The risk is that the lack of a robust scanning process within the Emergency Department will mean that parts of the patients ED visit is missing from their records

# 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: 2265, 2233, 386, 2312, 2315, 2332, 2235, 1159, 2242, 2310, 2355 | | |
| 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 and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I). | Annual QIA assurance report |
| Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance. | Risk assessments etc. and associated risks monitored via the Care Delivery Board. Trust Board informed vis Audit & Risk Committee minutes. |
| The Quality & Safety sections of the Corporate Report are reviewed and managed through SQAC and reported up to Trust Board | Safety & Quality Committee, Trust Board and Care Delivery Board |
| Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide. | Patient safety meeting actions monitored through CQSG, learning bulletin produced. |
| Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics. | Reports and minutes from Safety & Quality Assurance Committee and Divisional Integrated Governance Committees |
| Under 'Building Brilliant Basics' programme, the Trust will develop three quality priorities and associated improvement programmes to demonstrate increased quality and safety outcomes | Improvement hub to generate monthly reports to SQAC |
| Ward to Board processes are linked to NHSI Oversight Framework | Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care. |
| Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement. | IPC action plan and Trust Board, Safety & Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. |
| The Trust will form a Patient Experience Group which will develop a workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people. | Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. |
| Trust policies and Guidelines will be regularly reviewed, up-to-date and developed in line with best practice evidence | Trust audit committee reports and minutes |
| CQC regulation compliance | Progress against the CQC Action Plan monitoring via Board and sub-committees |
| monthly review meetings with each division will be held with the Medical Director and Chief Nurse to provide assurance relating to the progress of RCA investigations and completion of subsequent action plans. | Monitoring reports will be available from each review meeting |

**Gaps in Controls / Assurance**

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Patients with Mental Health needs are identified, risk assessed and appropriately managed within the organisation
3. Robust reduction programme in the number of medication incidents and near misses

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Alignment of workforce plans across the system | 31/03/2021 | Action captured within BAF risk 2.1 |
| The 72hr review process will be followed for all patients who do not receive their antibiotics within the timeframe to identify themes, trends and any trust wide learning which will lead to improvement in compliance with this standard | 01/07/2021 | |
| The Trust will form a complex children programme board to improve the safety and experience of mental health patients within the Trust. Workstreams will be directed by service need and monitored through CQSG | 02/08/2021 | |
| The Quality Hub will work with the Trust Medication Safety Group to identify areas for improvement across a range of areas relating to prescribing, dispensing and administration of medication | 01/09/2021 | |

**Executive Leads Assessment**

| |
|---|
| February 2021 - Nathan Askew<br>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<br>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<br>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):<br>- Winter Plan with additional staffing and bed capacity<br>- ED Escalation & Surge Procedure<br>- Additional shifts to increase staffing levels to deal with higher demand<br>- Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS) | - Daily reports to NHS England<br>- Daily performance summary<br>- Monthly performance report to Operational Delivery Group<br>- Performance reports to RABD Board Sub-Committee<br>- Bed occupancy is good |
| Controls for referral-to-treatment times for planned care:<br>- Weekly oversight and management of waiting times by specialty<br>- Weekly oversight and management of long wait patients<br>- Use of electronic system, Pathway Manager, to track patient pathways<br>- Additional capacity in challenged specialties<br>- Access to follow-up is prioritised using clinical urgent signified by tolerance for delay | - Corporate report and Divisional Dashboards<br>- Performance reports to RABD Board Sub-Committee<br>- Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame |
| Controls for access to care in Community Paediatrics:<br>- Use of external partner to increase capacity and reduce waiting times for ASD assessments<br>- Investment in additional workforce for Speech & Language service in Sefton<br>- Weekly oversight and management of long wait patients | - Significant decrease in waiting times for Sefton SALT<br>- Corporate report and Divisional Dashboards<br>- Performance reports to RABD Board Sub-Committee |
| Controls for access to care in Specialist Mental Health Services:<br>- Investment in additional workforce in Specialist Mental Health Services<br>- Extension of crisis service to 7 days<br>- Weekly oversight and management of long wait patients | - Monthly performance report to Operational Delivery Group<br>- 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:<br>- SAFER<br>- Best in Acute Care<br>- Best in Outpatient Care<br>- Best in Mental Health care | - Monthly oversight of project delivery at Programme Board<br>- 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<br>- Weekly 'Executive Comm Cell' meeting held<br>- 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

March 2021 - Adam Bateman
The size of our backlog of long wait patients increased in February and there are 306 patients waiting over 52 weeks for treatment.

The increase in the number of patients waiting for treatment is concentrated in admitted care with significant change in ENT and Trauma and Orthopaedics. We have formulated an elective recovery plan and submitted this to the regional cell. This contains a forecast which predicts an increase in the number of patients waiting over 52 weeks for admitted care over the next 6 months. In Q3 and Q4 2021-22 we forecast the backlog will start to reduce with the timescale for complete eradication of the backlog over a 12 months timescale.

In late February we have delivered a rapid recovery of activity in outpatients (90%) and inpatients (100%) and we expect this to be sustained in March. We have started to utilise additional capacity through the LLP. Through March to June we have significant additional weekend activity scheduled in theatres to alleviate the pressures on the inpatient waiting list.

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 for outpatients. In ENT we are forecasting to go from > 60 patients waiting 52 weeks for an OP appointment to less than 5. However, for inpatients the backlog of long wait patients is increasing caused by a contraction in inpatient theatre capacity during wave 3.

# 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 | Winter 2020 Plans |
| 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 | https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Staff-Testing.aspx |
| Covid-19 test and trace policy | 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 | https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Covid-Vaccine.aspx |
| Enhanced staff welfare programme | https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Support%20%26%20Well-Being.aspx |

**Gaps in Controls / Assurance**

| 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. |
| Oversight Group initiated focussing on redeployment, temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment | 31/03/2021 | |
| 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** |
|---|
| March 2021 - John Grinnell<br>Wave 3 response plan updated at February's Trust Board and signed off. Key ongoing areas of focus are vaccination programme, staff testing, staff resilience and welfare and restoration and recovery. |
| February 2021 - John Grinnell<br>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<br>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. |

# 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<br>K drive<br>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 every three weeks. | 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<br>To feedback formally to the group<br>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**

March 2021 - Lachlan Stark
Risk reviewed, no change to score in month. EU Exit Group continues to meet, no major issues identified; frequency of group extended following review of current level of risk. Escalation protocols and pathways remain in place. Daily operational updates still running daily - can escalate issues should they arise.

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.

# 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 | | |
| 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<br>-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<br>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 | 31/03/2021 | Full review of recovery plan scheduled with HRD and HR deputy 9/03/2021 |
| 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 | Progress against the plan was slower than hoped however this was impacted be pandemic 3rd Wave in Jan 2021. Task and finish group meetings back in the diary to progress action plans. |
| 2. HR/Managers/SALS and Wellbeing officers are working together to wrap around and effectively support all 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. | 31/01/2021 | HR/Managers/SALS and Wellbeing officers are working together to wrap around and effectively support all 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. |

| | | |
|---|---|---|
| | | |

| **Executive Leads Assessment** |
|---|
| March 2021 - Sharon Owen<br>some actions on review have slipped slightly - a scheduled meeting 98/0/03/2021 with HRD, deputy HRD and head of L&D to review the recovery plan to achieve 90%compliance on mandatory training |
| February 2021 - Sharon Owen<br>Actions reviewed and on track against plan |
| January 2021 - Sharon Owen<br>Actions reviewed and on track against plan |

# 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 |
| Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work | Report in development to assess progress against 9 WB principles outlined in national guidance document |

**Gaps in Controls / Assurance**

1. Need to review staff counselling provision and ensure fit for purpose, coordinated with SALS and sufficient to meet demand going forward

| 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 | Meeting arranged with Alder Centre Manager and Director of HR/OD to discuss current staff counselling provision and explore options for future delivery of the service |
| 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 | Meeting to be arranged with Resilience Hub within the next month to explore support they can offer to us in delivery of the Recovery plan for staff (in development and being presented to execs on 2.3.21) |

| | | |
|---|---|---|
| Fixed term part time psychology post to be made permanent | 05/02/2021 | Job now advertised internally and interview date set for 5th February. |
| Paper to be presented on 2.3.21 to execs outlining proposal for helping staff with their Recovery from impacts of Covid. Proposal to develop Recovery working group to develop and monitor action plan to include whole organisation debriefing programme | 31/03/2021 | |
| **Executive Leads Assessment** | | |
| March 2021 - Jo Potier<br>Risk reviewed. SALS resource action complete. Additional control added following appointment of Wellbeing Guardian. Actions reviewed and progress amended. No change to score. | | |
| January 2021 - Jo Potier<br>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<br>Risk reviewed in month. Score reduced and additional actions identified. | | |

# 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<br>- 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<br>- EDS Publication |
| Equality, Diversity & Human Rights Policy | - Equality Impact Assessments undertaken for every policy & project<br>- 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<br>-Workforce Race Equality Standards<br>- 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<br>- Workforce Disability Equality Standards<br>- 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. | 31/03/2021 | The collaborative with specialists trust has now be agreed. We are actively recruiting to an EDI team to support the specialists Trusts. |

## Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

| Executive Leads Assessment |
| --- |
| March 2021 - Sharon Owen<br>Actions are progressing and EDI collaborative team being actively recruited to for the specialists trusts. |
| February 2021 - Sharon Owen<br>Actions reviewed and progressing. |
| January 2021 - Sharon Owen<br>Actions reviewed and progressing against plan. |

# 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<br>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<br>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 | 08/04/2021 | |

| | | |
|---|---|---|
| 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** | | |
| March 2021 - David Powell<br>Prior to March Board | | |
| February 2021 - David Powell<br>Prior to Feb Board | | |
| January 2021 - David Powell<br>Prior to January 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. Hosted ODN Assurance reporting to RABD (2 x per year) |
| 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 | Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) |

**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 |
|---|
| March 2021 - Dani Jones<br>Risk reviewed; no change to risk rating in month. Progress re establishment of new C&M CYP Programme, hosted at Alder Hey; evidence attached. |
| February 2021 - Dani Jones<br>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<br>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. |

# Board Assurance Framework 2020-21

NHS 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: No Risks Linked | | |
| Exec Lead: John Grinnell | Type: Internal, Known | Current IxL: 4x4 | Target IxL: 4x3 | Trend: STATIC |

**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<br>- Full electronic access to budgets & specialty performance results<br>- Financial in-month and forecast position reported through SDG, Exec Team, RABD Ops Board and Trust Board<br>- Financial recovery plans reported through SDG and RABD<br>- 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**

March 2021 - Rachel Lea
Risk reviewed, no change to risk score at present as still awaiting confirmed details of 21/22.

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<br>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.<br><br>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<br>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<br>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: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People. | | |
|---|---|---|---|---|---|
| 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**

The trust strategy requires the growth of game changing research and innovation activities to enable an increase in R&D investment levels and generate commercial opportunity. The failure to deliver R&I strategies could result in an inability to achieve growth and new partnerships plans which will limit R&D investments and delay new discoveries.

The delivery of the R&I activities may also expose the Trust to contractual and reputation risks due to the need to enter into legal agreements with academia, large corporate's, SMEs and investors.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| R&I: RABD review of commercial issues per Corporate governance manuals, oversight of Innovation Ltd Corporate governance manual and oversight of deal diligence (commercial and reputational) . Trust Board oversight of shareholding and equity investments and intellectual property. | Reports to RABD / Trust Board and associated minutes |
| R: Establishment of Research Management Board | Research Management Board papers. |
| I: Innovation Committee and RABD Committee | Committee oversight of Innovation strategy with NED expertise |
| I: Clear Management Structure and accountability within Innovation Division | ESR Divisional Hierarchies |
| Alder Hey Innovation LTD governance manual established | |
| R&I: Plans for joint research & innovation clinical leadership | Job Description and Hierarchy |
| R: Clinical trials Covid recovery plan operational. | Trust Board papers |
| R: research division monthly focus on research at Care Delivery Board to support strategy deliver. | Care Delivery Board papers |
| I: Clear Management Structure and accountability within Innovation Division | |
| I: Legal Partner now in contract to advise on partnership structure and intellectual property | Letter of engagement |
| R&I: Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.) | Trust Policies and digital audit trail to audit committee |
| R&I: Formal Press Releases and external communications facilitated through communications department | Communications Strategy and Brand Guide |

**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.<br>Reactivated 38.9% of Suspended CRN studies.<br>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: 2265, 2143, 2235, 2310 | | |
| 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<br>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**

March 2021 - Kate Warriner
BAF reviewed, actions on track. Dedicated cyber lead due to commence in post April 2021 in collaboration with LHCH. Good progress with training developments and Alderc@re programme on track.

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

Alder Hey Children's NHS
NHS Foundation Trust

**Resources and Business Development Committee**
**Approved Minutes of the meeting held on Monday 25th January 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:** | Russell Gates | Associate Commercial Director Development | (RG) |
| | Dani Jones | Director of Strategy & Partnerships | (DJ) |
| | Ken Jones | Associate Director Financial Control & Assurance | (KJ) |
| | Cath Kilcoyne | Deputy Director, Business Development | (CK) |
| | Rachel Lea | Acting Deputy Director of Finance | (RL) |
| | Claire Liddy | Director of Innovation | (CL) |
| | Angie May | Head of Clinical Partnerships | (AM) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Amanda Graham | Committee Administrator (*minutes*) | (AG) |

**20/21/143** **Apologies:**

| | | |
|---|---|---|
| Shalni Arora | Non-Executive Director | (SA) |
| Sue Brown | Associate Development Director | (SB) |

**20/21/144** **Minutes from the meeting held on 14th December 2020.**
**Resolved:**
The minutes of the last meeting were approved as an accurate record.

**20/21/145** **Matters Arising and Action log**
Capita - MS has not yet had a response from Capita and will update at the February meeting.
Handrail - RG is awaiting meetings with the current RFID manufacturer, an update will be given when available.

**20/21/146** **Declarations of Interest**
There were no declarations of interest.

**20/21/147** **Finance Report**
**Month 9**
KJ presented the Month 9 Finance Report with a reforecast figure of £4m deficit, which is being reported against for Month 9.

The in-month position is a deficit of £0.3m, with a year to date of £2.4m deficit. This is in line with the reforecast figure, however £700k ahead of the original plan. There has been further capital slippage of £1.6m with £10.9m slippage year to date which is to be recovered by the end of the year.

Income & Activity have remained in line with NHSI requirements. There has been some spend on temporary spend including Waiting List Initiatives in order to support the delivery of the restoration targets.

The £4m deficit includes £2.1m relating to the loss of non-clinical income. It has been indicated that some further funding will be provided to compensate this loss, however this has not yet been confirmed.

Annual leave accrual is currently estimated at £0.7m, reduced from £1.2m following the issue of a revised annual leave policy. NHSI have indicated that this will be an acceptable deficit to record going through to year end.

CD questioned whether the NHS would consider paying some staff's leave. MS advised that there has been a change to legislation relating to Statutory leave following Covid in that any employee who was unable to take leave due to Covid is now able to carry up to 20 days Statutory leave over into the next two leave years. Alder Hey now has a number of areas where staff are unable to take leave due to service pressures; staff can now carry over in excess of 5 days with senior management sign-off & demonstrable evidence of Covid / service pressures.

IQ noted the divisional analysis improvements for both Community and Medicine, however highlighted the challenging position within Surgery. It was requested that the Surgery division attend the next RABD committee to present an update on the financial positon.

**Resolved:**
RABD received and noted the M9 Finance report.

**20/21/148** **2020/21 Framework**

RL shared an update on the 20/21 framework and the key messages & principles for 2021/22 framework. Q1 of 21/22 will be a rollover of the existing block arrangements, with full contracts with commissioners expected to be in place from July 2021.

The importance of 21/22 planning was made and a range of principles was presented to the committee following a finance workshop held at care board.

The 21/22 financial budget setting process is underway, with a focus on expenditure and further review of Income once NHSI guidance has been made available.

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

**20/21/149** **Business Development**

CL gave an overview presentation on the first iteration of plans for future business development.

IQ requested when the detailed financial figures will be ready to be shared to RABD. CL noted that full plans are emerging and will be further developed over the next 3-6 months.
CD questioned what impact Covid will have had on the expected figures and whether these plans will be feasible. CL replied that it is felt that these activities can be progressed in the current Covid scenario, as most are not impacted by the current pressures.
JG commented that previous attempts have been restricted by having no physical space to undertake private work which it is hoped will be resolved soon and this is supported by clinicians. There are potentially opportunities for international work as

a result of Covid and there needs to be a continued look at these opportunities as public sector funding changes.
IQ noted his agreement to the lack of physical space. CL noted that there are plans for building or repurposing a physical space for this work, but also to develop an international remote platform to open new business opportunities.

AM gave a brief presentation on Telemedicine. ES noted that there may be data protection aspects which need to be approached carefully and further discussions will take place with ES/AM.

**Resolved:**
RABD received an update on Business Development.

**20/21/150** **Productivity**

**Community** – Data presented showing increased activity in line with restoration plans and improved waiting times. It was noted there has been a significant number of new referrals, particularly in mental health and planning is ongoing to manage the increase.
**Medicine** – Data presented showing an increase in the numbers of patients treated per clinical session due to improvements to theatre start times. Discharges before noon are down slightly partly due to acuity and more complex discharges. Restoration sits between 97-100% which is reflected in the improvement in access times.
**Surgery** – Data presented showing a small increase to numbers of children treated per theatre session and per clinical session. The division are looking to measure individual start time by speciality and also to adjust the metric for start times appropriately to take account of administering any pre-medications.

**Corporate Office Paper**
A update was provided to the committee on the ongoing work to look at the future location of the corporate departments. It was noted that there is a future shortfall of c200-220 desks, assuming flexible working, by January 2022 following demolitions. The development team are seeking options for purchase of a building to address this shortfall and have secured additional capital funding to enable this. The chair gave agreement for this to proceed.

**Resolved:**
RABD noted and received the M9 Productivity report.

**20/21/151** **Month 9 Corporate Report**

AB presented the Month 9 Corporate Report, noting great performance in Access to Cancer Care and timeliness of care in the Emergency Department. There are two main challenges impacting on the number of children waiting over 52 weeks from referral to treatment time, being an acute issue within ENT which is undergoing daily scrutiny and root causes to the safe waiting issues. It is hoped that increased activity within surgical specialities will be sought from the independent sector to support and further reduce the waiting times.

**Resolved:**
RABD noted and received the M9 Corporate report.

**20/21/152** **Safe Waiting**

AB gave a brief presentation on the Safe Waiting List Management program, updating on progress with validation work. Governance has been defined and there

continues to be a weekly internal Executive Oversight Group meeting and monthly Assurance meeting with the CCG.

AB noted two points: there had been a newspaper headline originating from the minutes of a CCG governance meeting, which may have reputational impact; and that details of investment will be brought to the Committee in more detail.

**Resolved:**
RABD received an update on Safe Waiting List Management.

**20/21/153** **PFI Report**
It was agreed to defer the PFI report until next month.

**20/21/154** **Procurement Report**
It was agreed to defer the Procurement report until next month.

**20/21/155** **Communications Strategy**
It was agreed to defer the Communications Strategy presentation until next month.

**20/21/156** **Board Assurance Framework**
The Board Assurance Framework paper was noted as being within the meeting pack for information.

**Resolved:**
RABD received the BAF update paper within the meeting pack.

**20/21/157** **Any Other Business**
No other business was received.

**20/21/158** **Review of Meeting**
Key points: Progression of purchase of 410 East Prescot Road; progress of work on safe waiting lists.

**Date and Times of Next Meeting: Monday 22nd February 2021, 10:00, via Teams.**

Alder Hey Children's NHS
NHS Foundation Trust

**Resources and Business Development Committee**
**Confirmed Minutes of the meeting held on Monday 22nd February at 10:00am, via Teams**

| | | | |
|---|---|---|---|
| **Present:** | Ian Quinlan (Chair) | Non-Executive Director | (IQ) |
| | Shalni Arora | Non-Executive Director | (SA) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Claire Dove | Non-Executive Director | (CD) |
| | Dani Jones | Director of Strategy & Partnerships | (DJ) |
| | John Grinnell | Director of Finance | (JG) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Kate Warriner | Chief Digital & Information Officer | (KW) |
| **In attendance:** | Sue Brown | Associate Development Director | (SB) |
| | Ken Jones | Associate Director Financial Control & Assurance | (KJ) |
| | Cath Kilcoyne | Deputy Director, Business Development | (CK) |
| | Rachel Lea | Acting Deputy Director of Finance | (RL) |
| | Claire Liddy | Director of Innovation | (CL) |
| | Amanda Graham | Committee Administrator (*minutes*) | (AG) |

**20/21/159** **Apologies:**

| | | |
|---|---|---|
| Erica Saunders | Director of Corporate Affairs | (ES) |

**20/21/160** **Minutes from the meeting held on 22nd February 2021.**
**Resolved:**
The minutes of the last meeting were approved as an accurate record.

**20/21/161** **Matters Arising and Action log**
Handrail - JG advised that this is now incorporated into the Children with Complex Behaviours work and the Chief Nurse is also reviewing this. An update will be given next month.
Capacity Lab – RL to discuss with RG.

**20/21/162** **Declarations of Interest**
There were no declarations of interest.

**20/21/163** **Finance Report**
**Month 10**
KJ presented the Month 10 Finance Report.

The in-month position is a deficit of £0.8m, which is £0.2m better than plan. Annual leave accrual has been put back to £1.2m following Covid Wave 3 and the additional lockdown which have impacted on the taking of leave, but there is a possibility that this may be funded by NHSI. The forecast for the year is a £4.5m deficit.

Capital spend has increased in the month, a spend of £6.1m in M10 and forecast to meet the plan as submitted with NHSI.

There are strong indications that there will be repayment for the loss of non-clinical income which will improve the year-end position.

For information, there has been further information received regarding the cost of reinstatement of the Park for Stages 2 & 3 and these proposed costs are now undergoing negotiation.

IQ asked for an update paper on the Park to be brought to the next RABD.

**Resolved:**
RABD received and noted the M10 Finance report.

**20/21/164** **2020/21 Financial Strategy**
RL shared an update on the 20/21 Financial Strategy, in that subject to audit evidence, the shortfall of non-clinical income should be paid by NHSI with the first instalment by end of February. It is expected that the annual leave accrual will be offset by an allowable overspend rather than cash payment. This would leave the deficit amount signalled at the last meeting; however, NHSI are pushing for all providers to be as close to break-even as possible given the extra funding that is being provided. Options to improve this are being explored through slippage on capital charges and non-block income.

There have been no changes to the expected timetable as presented last month and Q1 Rollover guidance has not yet been received.

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

**20/21/165** **Write-offs**
Agreement was given to progress with the write-offs listed.

IQ asked whether there were any lessons to be learnt. KJ commented that there are particular issues relating to the private patient case and that maybe there should be an assessment of the likelihood of collecting any outstanding monies when engaging in private work, or perhaps taking payment or part payment in advance. In relation to non-commercial debts and training courses pre-payment could be an answer.

**20/21/166** **Business Development**
CL gave an overview of the paper detailing plans to position Alder Hey as a global leader in the use of Immersive Technology, funding achieved and partnership arrangements.

SA asked whether there is any content from educational pieces that may need to be protected. CL responded that there may well be some intellectual property and future work that will need to be copyrighted, but as yet there is not a large portfolio of work.
CD asked whether the University will be working up that work. CL commented that as it is clinical skills that is owned by Alder Hey, and there may be some joint projects with the Universities in the future.
MF proposed bringing a paper on sponsorships and partnerships agreement to a future RABD meeting, in development with the Corporate Governance Handbook.

CL gave an overview of the paper detailing the commercial agreements which are to sit within the remit of RABD and be brought as updates in a Commercial Schedule, including their impact both financially or brand / image.

IQ suggested the use of a dashboard demonstrating impacts & progress.
CD asked whether an impact review for the Kidzania collaboration was received prior to extension of the contract; CL noted that contract extension took place in the early Covid wave and that an impact report will be requested.

**Action:** Formal transfer of items from Innovation Committee to RABD (ES/AG)
**Action:** Terms of Reference to be adjusted for both Innovation Committee and RABD (ES/AG)

**Resolved:**
RABD received an update on future Business Development plans around immersive technology and the commercial schedule.

**20/21/167** **Key Risks**

**Surgery** – JF & AM presented an update on the Division of Surgery and its financial position detailing the drivers behind its projected overspend. Plans are in place to control temporary nursing & bank spend where possible, bearing in mind additional shifts in areas of work for reducing the backlogs. An increase in scrutiny is required to ensure all the associated costs of waiting list initiatives as an example are taken into account.

KW asked whether this may get worse before it gets better, noting that there has been spend where there is no budget; AM responded that there is a need to change and manage expenditure and not to expect generated income to cover any overspend. It is expected that critical care overtime costs can now reduce following recent closure of the Adult ICU beds.
AB suggested that pay controls be weekly and that consideration is given to caps of some sort being brought in on temp spend allocation.
AB also asked for re-evaluation of the financial risk-sharing approach for the Congenital Heart Disease partnership as that has been a large cause of adverse variance.
CL asked for update on the E-Roster project; MS updated that a full implementation plan and team are in place and the programme is on track for roll-out. CL asked for visibility on the project as a control measure.
CD asked for consideration for a plan to be prepared for future nursing staff requirements, including succession planning for those who will retire, training and recruitment.
IQ noted that it may be better to sign off future spend rather than retrospective spend; RL commented that would be part of the weekly pay controls, to sign off costs in advance of them being incurred.

**Action:** An action plan is to be brought back to the next meeting detailing (AMc/JF)

**Research** – JRT presented an update on the current position within the Division of Research, noting that capacity for leading & supporting research activity is reduced and an increasing backlog of studies to be set up and delivered. There has been recognition by NIHR CRN for Alder Hey for its outstanding Covid-19 research, and Alder Hey has also been selected for the 12-17 years old vaccine trial.

JG asked what plans are in place for the next steps in restoration of research studies. JRT noted that some capacity is being held back for emergency redeployment purposes which impacts on safety studies that cannot be paused once in progress; once the pressure is off redeployment then steps can be taken to open up again but there is no timeline as yet.

**Cash** (by exception) – KJ noted that once detail is available on the financial trajectory and framework for 21/22, implications for the cash position and the capital programme can be built in.

**Capital** (by exception) – KJ noted work is ongoing to ensure the capital programme remains on plan by the end of the year. JG noted that an update on the current status of hosted services will be brought to RABD and to Audit Committee in coming months.

**Action:** An update paper to be brought on hosted schemes. (JG/RL)

**Capital** (by exception) – SB noted that the park costs are an ongoing concern and a paper will be brought to the next meeting of RABD with more detail on this.
CL noted that there will also be a future paper on progress of the science & technology building opportunity.

**Resolved:**
RABD received and noted the updates on current risks.

**20/21/168 Alder Hey Workspace Proposal**

MS gave an overview of the proposal for flexible working and workspace requirements. There was discussion around collaborative workspace zones, staff health & wellbeing and whether the affected teams have been identified. SB noted that there has been considerable work with teams but final sign-off will be required from the Executive team and Associate COOs for those areas. RL noted there is time-limited funding available to create urgent on-site capacity for Mental Health teams by enabling off-site flexible working for other teams.

SB gave a brief overview of an approximate number of staff affected and sites that have been considered. CD expressed some concern of lack of clarity and being under pressure to spend the allocated funds. JG noted that these extra funds enable proper understanding to be gained of needs across the whole site for the whole workforce, perhaps involving a larger piece of work than that outlined in phase two of the paper.

IQ proposed that the request for the supplementary spend commitment of £300k is approved and that the strategy is refined before being brought back to RABD. CD noted agreement of this.

**Resolved:**
RABD received and noted the Workspace proposal and agreed supplementary spend of £300k.

**20/21/169 Month 10 Corporate Report**
AB presented the Month 10 Corporate Report, noting great performance in Access to Cancer Care, timeliness of care in the Emergency Department and low numbers of operations cancelled on the day.
There are two main challenges impacting on the number of children waiting over 52 weeks from referral to treatment time, namely the adjustment made to theatre schedules to take in adults and the safe waiting list work. There has been an increase in outpatient capacity and is hoped that increased activity within surgical specialities sought from the independent sector will support and further reduce the waiting times alongside the aim for every speciality to have a capacity plan that reduces waiting times by working in different ways.
IQ asked why the ENT wait times are so long; AB responded that ENT pathways often involve several steps of outpatients, diagnostics and surgery, and also some procedures require air filtration which has significantly reduced the throughput of patients.

**Resolved:**
RABD noted and received the M10 Corporate report.

**20/21/170** **Safe Waiting**
AB gave a brief presentation on the Safe Waiting List Management program, updating on progress with validation work. Governance has been defined, the corporate risk register is regularly updated and there continue to be fortnightly internal Executive Oversight Group meetings and monthly Assurance meetings with the CCG.

**Resolved:**
RABD received an update on Safe Waiting List Management.

**20/21/171** **PFI Report**
GD gave a brief overview of the PFI report, noting 98% performance and high energy consumption due to increased use of the ventilation system to ensure patient and staff safety and to increase patient throughput. Pipework replacements continue, along with planned replacement of the autoclave and the aseptic isolator.

**Resolved:**
RABD noted and received the M10 PFI report.

**20/21/172** **Procurement Report**
SB gave a brief overview of the procurement report including an update on the collaboration work with specialist trusts.

CL asked for assurance that the collaboration will ensure continuation of the support and advice given by the Procurement team on commercial activities and the risk of losing that expertise. SB noted that there will be a formal MOU KW noted that from experience of the Digital collaboration which is road-testing the process, the MOU is overarching with specific SLAs for each service & associated governance and a paper will be brought to the next RABD on this. RL noted the points raised and undertook to ensure these are considered.

SB noted that there are no concerns with PPE stocks or availability. Brexit appears to have had little impact to date with all deliveries being made on time with no issues. Consideration is being given to future security arrangements and whether to bring this in-house.

**Action** Paper on Digital Collaboration work to be brought to next RABD (KW/RC)

**Resolved:**
RABD noted and received the Procurement report and thanks were given to Steve Begley ahead of his retirement.

**20/21/173** **Independent Sector Proposal**
AB gave an overview on the paper, noting the guiding points set out, that it was: value for money; delivering an improvement in access to care; equitable in terms of pay & being non-discriminatory; and not having any unintended consequences. RL confirmed that procurement due diligence has been undertaken and legal & financial / audit advice has been obtained from the Trust's professional advisers.

**Resolved:**
RABD noted and received the independent sector proposal.

**20/21/174** **Communications Strategy**

MF gave a brief overview of the forthcoming Communications Strategy. IQ asked that Marketing is higher on the agenda in future.
KW asked whether the internal communications strategy will be included; MF noted that there are elements within the document but there is a lot of work still to be done.
DJ noted that there is also a need to understand what other people say and think about the Alder Hey brand; MF responded that there is not the resource available to undertake a full interrogation but that will be broken down and done in parts.

**Action**: Communications Strategy to be brought back to RABD in May (MF)

**Resolved:**
RABD noted and received the Communications Strategy.

**20/21/175** **Board Assurance Framework**

The Board Assurance Framework paper was noted as being within the meeting pack for information. JG noted that there has been some work done to slightly readjust the financial risk for year-end.

**Resolved:**
RABD received the BAF update paper within the meeting pack.

**20/21/176** **Any Other Business**

No other business was received.

**20/21/177** **Review of Meeting**

Key points:

**Date and Times of Next Meeting: Monday 22nd March 2021, 10:00, via Teams.**

Alder Hey Children's NHS Foundation Trust

# Confirmed Safety and Quality Assurance Committee
## Minutes of the meeting held on
## Wednesday 17th February 2021
## Via Microsoft Teams

| | | | |
|---|---|---|---|
| **Present:** | Fiona Beveridge | (Chair) Non-Executive Director | (FB) |
| | Nathan Askew | Chief Nursing Officer | (NA) |
| | Pauline Brown | Director of Nursing | (PB) |
| | Kerry Byrne | Non-Executive Director | (KB) |
| | Lisa Cooper | Director - Community & Mental Health Division | (LC) |
| | John Grinnell | Director of Finance/Deputy Chief Executive | (JG) |
| | Dani Jones | Director of Strategy & Partnerships | (DJ) |
| | Beatrice Larru | Consultant, Infectious Diseases | (BL) |
| | Jacqui Pointon | Associate Chief Nurse/Safety Lead for Community | (JP) |
| | Phil O'Connor | Deputy Director of Nursing | (POC) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Robin Clout (on behalf of KW) | Interim Deputy CIO | (RC) |
| **In attendance:** | | | |
| | Raman Chhokar | Chief Operating Officer, Medicine Division | (RC) |
| | Adrian Hughes | Deputy Medical Director | (AH) |
| | Jill Preece | Governance Manager | (JP) |
| | Julie Creevy | Executive Assistant (Minutes) | (JC) |
| | Cathy Umbers | Associate Director of Nursing & Governance | (CU) |
| Agenda item: 20/21/103 | Liz Edwards | Head of Clinical Audit & NICE Guidance | (LE) |

**20/21/98 Apologies:**

| | | |
|---|---|---|
| Anita Marsland | Non-Executive Director | (AM) |
| Alfie Bass | Divisional Director, Division of Surgery | (AB) |
| Adam Bateman | Chief Operating Officer | (AB) |
| Urmi Das | Interim Divisional Director for Medicine | (UD) |
| Nicki Murdock | Medical Director | (NM) |
| Erica Saunders | Director of Corporate Affairs | (ES) |
| Cathy Wardell | Associate Chief Nurse, Medicine Division | (CW) |
| Kate Warriner | Chief Digital & Information Officer | (KW) |
| Christopher Talbot | Safety Lead, Surgery Division | (CT) |
| Cathy Umbers | Associate Director of Nursing & Governance | (CU) |

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

**20/21/99 Declarations of Interest**

SQAC noted that there were no items to declare.

**20/21/100 Minutes of the previous meeting held on 20th January 2021 –**

**Resolved:** committee members were content to **APPROVE** the minutes of the meeting held on 20th January 2021.

**20/21/101 Matters Arising and Action Log**

**Action Log**

The action log was updated accordingly.

**Matters Arising**

**CQSG Quality Metrics –** NA advised that a meeting had taken place with Karl Edwardson in order to review the actions and thresholds relating to the quality metrics, following that meeting some thresholds would change. NA advised that the proposed quality metrics plan would be submitted to March SQAC for approval.

**HCAI Code of Practice Compliance –** SQAC **NOTED** that this update would be deferred until March 2021 meeting.

**Was Not Brought rate** – SQAC **NOTED** that this update would be deferred until March 2021 meeting.

**Delivery of Outstanding Care - Safe**

**20/21/102 CQC Action Plan**

NA presented the CQC Action Plan update to January 2021, which continued to progress at a good pace and remained on track in all areas. Continued focus on surgery, and electronic E Consent pilot for Surgery is in development and is progressing as planned.

KB queried whether consent should be included in a future internal audit or clinical audit, and whether there should be a wider look back/review at previous audits to identify themes. NA agreed that consent should be included in the internal audit plan for this coming year and agreed it would be helpful for ES to review the overall plan with the closed actions, in order to establish whether there are any other themes.

**Action: ES to review overall action plan, to establish whether there any other themes.**

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

**20/21/103 NICE Compliance Report**

LE presented the NICE Compliance Report which provided an overview of the impact of Covid 19 on clinical audit activity, Trust wide clinical audit plans, local audit plans and audit registers, together with details regarding dissemination of clinical audit findings and NICE guidance, and actions required as outlined in the paper.

- 83 local audits registered, 14 audits had been completed during this period, with 68 ongoing audits, of which 3 remain outside the estimated completion date, this is a significant improved within the last 12 month period. 1 audit had not commenced; however, an amended start date had been confirmed.
- The COVID pandemic had continued to cause disruption to delivery of Trust clinical audit plan, with many audits remaining suspended, and there had been a lack of clarification in terms of what is required to fulfil the programme for the Trust Quality Contract. The Divisions continue to collect and submit data for many of the national and regional audits.
- The development of local plans for 2021-2022 had been suspended due to continuing COVID pandemic. Discussions with the Divisions are planned to resume

in April 2021, or as advised by Divisional Triumvirate and executive team.

- 2 Clinical Guidelines published during the Quarter NG184 – Human & Animal Bites –Antimicrobial Prescribing – published in November 2020 and NG18 Diabetes in Children & Young People – Diganogis & Management – updated in December 2020, both within the Division of Medicine.
- LE advised that record keeping audits across the Trust needed to be reviewed, and that a complaint process audit would be proposed over the coming months.
- Consent Audit - within medicine and community divisions there would be procedures that require parent or family consent that require consent, this would need incorporating into the medicine and community divisions.
- CQC action plan and any associated actions would require incorporating into either Divisional or Trust wide consent audit.
- Discussions had taken place whether NICE should be included within the dashboard and further thought required regarding how NICE is managed going forward.

FB echoed LE comments regarding consent issues and clinical audit. FB stated that SQAC had also discussed the CQC action plan and had acknowledged that some of the actions needed to incorporate into the clinical audit action plan, this would be addressed over the coming months. KB stated that the Clinical Audit Report had been shared at the previous Audit & Risk Committee meeting in January 2021, and that KB had no objections in the Clinical Audit Report being shared with March SQAC meeting pack, FB welcomed this.

NA advised that there is a need to review and include additional additional audits to the programme such as complaints.

**Action: NA would follow up offline with LE for discussion offline**

LC proposed that as a minimum the Trust should have an Annual Record Keeping Audit, and that this shouldn't be held by LE, with conversations with Divisional Directors and Associate Chief Nurses to discuss further. LC would undertake an offline discussion with NA with regards to progressing this further.

**Action:** Offline discussion to take place with NA, Associate Chief Nurses, LE and FB & KB if required regarding clinical audit.

**Action:** Offline discussion to take place with LC & NA.

SQAC **RECEIVED** and **NOTED** the NICE Compliance report and noted the Actions required.within the update.

**20/21/104 Progress update regarding CQC Section 31 Actions**

NA advised that the Action Plan had been completed and submitted to CQC in January 2021. CQC had written to the Trust to advise that they are assured that the appropriate actions had been completed, the Trust had since written to CQC to accept the process in order to lift the actions. Next steps are to ensure that all the actions are fully embedded within the governance process, either through audit or the reporting cycle and including on CQSG or SQAC workplan. JG there is a growing understanding that similar issues are being experienced across the Country, with some system related issues that underpin this.

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

FB thanked NA for update.

**20/21/105 Quarter 3 DIPC Report/DIPC Exception Report**

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

- Ongoing work to change target, ongoing process, biggest health associated infection CLABSI will be communicated in future report, in the process of arranging a meeting to prevent CLABSI's.
- No new Cdiff cases to report.
- Covid Vaccination – 80% completion –3119 staff had received first dose, no waste of doses.
- Fit testing – increased capacity within the team – this had achieved fit testing compliance to be 91% as at the end of January 2021.
- Self-testing – Lateral Flow testing continued to be successful with more than 3,000 kits distributed to staff, with the intention to move to LAMP testing within the next 2-3-week period.
- COVID-19 Outbreaks – (four outbreaks in total – two in December 2020, and two in January 2021). No impact to service provision, with bespoke training regarding PPE provide to staff within the said areas, with no further outbreaks to date.

**Resolved**: SQAC received and **NOTED** the assurance provided by the DIPC Exception Report and agreed that good progress continued to be made.

SQAC **NOTED** ongoing energy from IPC team, with good progress to date and that the document review is ongoing. IPC team would escalate any issues requiring SQAC attention as appropriate.

FB thanked BL for DIPC update.

**20/21/106 Quarter 3 Mental Health Attendances at ED**

LC presented the Quarter 3 ED Attendance Report, the report detailed mental health attendance at the Trust Emergency Department for the reporting period 1st October 2020-31st March 2020. The report detailed actions required for Quarter 4, and details regarding Next Steps. 158 Children and young people had attended the Trusts Emergency Department. Over the course of Quarter 3 there had been an improvement in the use of the crisis pathway by AED.

Actions required for Quarter 4 as follows:-

- Monthly meetings with Trusts ED are scheduled to review the current pathway share monthly audit findings.
- Continued attendance at the Trusts ED daily huddles by Crisis Care services to ensure good communication and allow any issues regarding presentation of and young people in mental health crisis are identified in a timely manner
- A monthly audit of 10 randomly selected cases to be undertaken, to review the Pathway and this to be presented as part of quarterly presentation to Divisional Board.
- Development of a digital dashboard to support regular audit and monitoring and to supporting sharing of information across the organisation.

**Resolved:** SQAC **RECEIVED** and **NOTED** the contents of the Quarter 3 ED Attendances Report and the improvement actions identified within the report.

SQAC **NOTED** that all future reports would be submitted to the Community & Mental Health Divisions Internal Business and Performance meetings, with

escalation of any areas of concern via the Community & Mental Health Divisional Board to Safety, Quality and Assurance Committee (SQAC).

FB sought clarity on the purpose of the update/report and future reporting. LC suggested that the future report should be a joint report with Community & Mental Health Division and Medicine Division, in order to identify any issues, and ensure correct pathways, & correct services are included.

**Action: offline discussion with RC/UD regarding progressing a future joint report with Community & Mental Health with regards to providing assurance for acute mental health attendances at ED.**

NA stated that future reports required Board oversight,until such time as an appropriate dashboard is created.

SQAC **NOTED** that ongoing work would progress over the coming weeks and months

SQAC would continue to receive the Quarterly report until the dashboard is in place.

FB thanked LC for informative update.

**20/21/107 Safe Waiting List Management Update**

RC presented the Safe Waiting List Management Update, which provided a comprehensive update on the in-patient and outpatient dashboard. Inpatient validation - 4062 records had been validated, of those, 719 patients should have been on an active pathway, 66 patients had been waiting over 52 weeks, all had received a clinical review, and clinicians had agreed that none of these children require a face to face harm review, with no harm review identified. 48 of these patients had been treated, with 18 remaining outstanding patients.

Outpatients - 13,891 records had been validated, 84% of patients, 'the clock had Stopped'. 3% are RTT active patients (416 patients),1875 patients require a further operational review, of which 15 patients had been identified as 52 weeks breaches, 6 had been treated, 9 patients remain outstanding. Clinical reviews had been undertaken for 13 patients, with 2 clinical reviews yet to take place shortly, no harm had been identified. 7 patients identified from the active patients, 2 patients had been converted to in-patient treatment, with 5 awaiting an appointment.

Work is continuing regarding data quality and pathway errors, with regards to active RTT's, team are reviewing data, and aligning with national codes.

Outpatient trajectory is on plan, with the support of MBI.

SQAC **RECEIVED** and **NOTED** Safe Waiting List update.

***Effective***

**20/21/108 CQSG Key Issues Report**

NA provided a verbal CQSG update as follows:-

- NA advised that CQSG had been cancelled for the last two months period, a small oversight group had met. NA informed SQAC regarding a new document management system which had been launched across the Trust, which identified that 200 policies and guidelines are past the review date. A small task and finish group had been established and would meet biweekly for 4-6 weeks in order to

address this issue, due to capacity issue of CDEG, in order to approve the out of date policies, an extra ordinary CDEG meeting would be convened, to review policies by exception. Moving forward there is assurance that the document management system alerts the policy owner and policy author who would receive 6 month advanced notification that the policy is required for renewal, this would ensure improved oversight in the future.

- NA reported that Sepsis compliance is noted as vastly improved this month, with both inpatients and ED demonstrating an improved position. NA advised that the plan from March 2021, is to introduce a 72-hour review for inpatients of every patient who does not receive antibiotics within 60 minutes, in order to identify any themes or trends. ED pathway is more complex with the team reviewing any additional measures or monitoring to enhance.
- NA advised that it is the first time that the satisfaction for education has reached a score of over 90%, which is extremely positive and that the targeted approach of ongoing work with the school Headmaster had resulted in an improved position.

**Resolved**: SQAC **NOTED** verbal CQSG update.

FB thanked NA for CQSG update.

**20/21/109 SQAC Terms of Reference**

NA presented SQAC Terms of Reference, NA advised that there had been minor amendments to the structure and processes within the Terms of Reference. SQAC were content with the amendments to the Terms of Reference.

SQAC received, **NOTED** and **APPROVED** the SQAC Terms of Reference.

***Well Led***

**20/21/110 Board Assurance Framework**

NA presented the Board Assurance Framework detailing updates to the end of January 2021, NA highlighted that focus had been made regarding issues in terms of COVID, delivery of services, restoration of services, financial stability of the organisation. NA advised that both he and ES had previously discussed BAF risk 1.1, and following discussion, both had agreed that this risk needed to be significantly Reviewed. NA would provide a further update at March 2021 meeting, prior to receiving an update at Trust Board in April 2021.

FB questioned whether LLP Service Provider is on trajectory, RC confirmed that the Trust have approval, LLP had reached a point for final sign off, however formal sign off had not yet taken place and is envisaged imminently.

**Resolved**: SQAC received and **NOTED** the BAF update and **NOTED** that an update on rearticulated risk 1.1. would be provided at March 2021 meeting, ahead of the Board of Directors receiving an update at Board.

FM thanked NA for update.

**20/21/111 Divisional Reports by exception**

***Division of Community & Mental Health***

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

**Safe**

- 1 incident of restrictive intervention within Tier 4 inpatient unit which related to a physical assault on a member of staff by a child, parents had been informed and the incident reported and appropriately managed.
- The Division had an increase in incidents reported – 137, 50 of which related to non clinical incidents. There had been several information governance data protection incidents, LC had requested a formal review across the Division, and is awaiting an update at Divisional Board meeting.

**Caring**

- Reduction in PALS from 17, to currently 15 in December 2020.
- Division received 6 formal complaints in January 2021
- Division had received 18 excellence reports, and over 90% positive Family & Friends scores.

**Effective**

- Booking and scheduling turnaround time had continued to decrease, and is now 8 days above target as at January 2021
- Division had no breaches in the eating disorder pathway for January 2021 and continued reduction in pre-April 2020 cohort for ASD and ADHD Children and Young People.

FB alluded to the Information Governance Data breaches and queried whether there were any emerging themes, LC confirmed that the breaches related to several emails, when staff had been contacting parents by email. Learning had been provided to cohorts of staff within the division.

***Division of Medicine***

RC, Chief Operating Officer for Medicine Division, presented the Quality Metrics Divisional update; key issues as follows:-

**Safe**

- Zero Never Events
- 1 clinical incident resulting in severe, moderate or permanent harm related to the review and treatment of a neurology patient. An RCA is planned to be initiated, with support from Neurologist at Manchester Children's Hospital, in order to ensure objectivity, as this is an incident between two organisations.
- Challenges with regards to sepsis compliance, the division had undertaken a very detailed review at Divisional performance meeting, with further work to do in this area. A Working Group had been established in ED.

**Caring**

- Division had seen a small reduction in complaints; however, the Division continue to receive complaints regarding Tics and Tourette's service and neurology service.

**Effective**

- ED performance continued to meet the national standard. The Division are seeing a very low number of attendances compared to the same time in the previous year, there are several improvements within the ED department regarding process.
- Challenges remain regarding the 'was not brought rate', with further work to do regarding notice to patients in terms of booking appointments, and how much advance notice patients are being booked in, which is broadly in line with other organisations.

- There had been 1, 28-day cancellation breach, with regards to reduced theatre schedule within Gastro Department.

**Responsive**

- RTT compliance continued to improve with strong performance, currently at 89.5%, against the 92% national standard, with month on month improvement.
- Ongoing challenges regarding capacity, with the Division remaining focussed on challenges within Radiology reporting.

**Well Led**

- Division remain committed to addressing and improving Mandatory training and sickness rates.

***Division of Surgery***

RH, Associate Chief Nurse for Surgery presented key issues update; key issues as follows:-

**Safe**

- The Division had no Never Events, (this had continued for over 1 year)
- The Division had no Category 3 or 4 pressure ulcers.
- The Division had 1 catastrophic incident which related to an 8-day old baby who was transferred from Warrington Hospital, this case was an unexpected death. RH had liaised with the family and agreed a cross organisational review at the request of the parents, the team plan to liaise with colleagues from Warrington.
- The Division had 1 incident relating to moderate harm, incident relating to a query extravasation, with the Division liaising with colleagues at Liverpool Women's Foundation Trust, with regards to a review for this neonatal patient in terms of arterial lines and excavations for neonates.

**Caring**

- Management of formal complaints within the Division had been a challenge since December 2020. This issue had now been appropriately managed and had resulted in good oversight within the Division. Division are currently on plan, with substantive staff member overseeing management of complaints returning in March 2021.
- 2 formal complaints reported in January 2021, which are on trajectory for completion.
- PALS had significantly reduced in January 2021, with all PALS being appropately managed to date.

**Effective**

- The Division had commenced risk reviews, in order to review risk compliance on a weekly basis, currently 70% within review compliance for the week. The Division had undertaken a significant review of the risk register, ensuring actions contained on the Risk Register are achievable, and are in date, whilst also reviewing longstanding risks in order to establish whether they are still current.

SQAC **NOTED** issue regarding complaints within the Division and **NOTED** that this had now been resolved and is on plan.

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

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

KB referred to information governance breaches and queried going forward, whether any reports should be provided to relevant sub committees, KB advised that she would take a personal action to follow this up offline with ES in order to establish whether a regular update should be provided to ARC committee.

**Resolved**: KB to follow up offline with ES

**20/21/112 Any other business**

None

**20/21/113 Review of meeting**

- SQAC welcomed the comprehensive update regarding the progress regarding Safe waiting list management
- SQAC welcomed CQC Action plan update, and that the action plan was reaching completion, with agreement that prior action plans would be reviewed in order to identify and themes and would be followed up through the audit process.
- SQAC welcomed the Section 31 update
- SQAC welcomed ongoing collaborative liaison with Community & Mental Health with regards to ongoing work required regarding presentation of patients with MH concerns in ED/Acute Trust ED attendance and compiling future joint report
- SQAC APPROVED the SQAC Terms of Reference
- FB looking forward to receiving update on Deep Dive of Risk 1.1.

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

**20/21/114 Date and Time of Next meeting**

24th March 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 25th January 2021
## Via Microsoft Teams

| | | |
|---|---|---|
| **Present:** | Claire Dove | Non-Executive Director (Chair) |
| | Melissa Swindell | Director of HR & OD |
| | Ian Quinlan | Non-Executive Director |
| | Mark Flannagan | Director of Communications & Marketing |
| | Pauline Brown | Director of Nursing |
| | Erica Saunders | Director of Corporate Affairs |
| | Nathan Askew | Chief Nurse |
| **In attendance:** | | |
| | Sharon Owen | Deputy Director of HR&OD |
| | Darren Shaw | Head of Learning & Development |
| | Cath Wardell | Associate Chief Nurse – Medicine |
| | Dot Brannigan | Public Governor (Observing – Part Attendance) |
| | Jackie Friday | Executive Assistant (Minutes) |
| **Apologies:** | Fiona Beveridge | Non-Executive Director |
| | Nicki Murdock | Medical Director |
| | Jacqui Pointon | Associate Chief Nurse – Community |
| | Adam Bateman | Chief Operating Officer |
| | Rachel Greer | Associate COO – Community |
| | Raman Chhokar | Associate COO – Medicine |
| | Jo Potier | Associate Director of Organisational Dev |
| | Tony Johnson | Staff Side Chair |

**21/66** **Declarations of Interest**

None.

**21/67** **Minutes of the previous meeting held on 17th November 2020**

**Resolved:** The minutes of the last meeting were approved as an accurate record.

**21/68** **Matters Arising and Action Log**

**Action Log**

20/44 - Sickness rate comparisons with other Children's Hospitals (Manchester/Sheffield/Birmingham) – MKS advised an update will be brought to the Committee in March 2021. MKS advised the Trust sickness rates has seen an increase and is reported via agenda item People Plan.

**Equality, Diversity & Inclusion**

20/29 - Share highlights of EDS2 & Workforce EDI Annual Report with BAME Task Force – MKS advised this had been shared. **Noted as complete**.

20/42 – Present at future Board the Government Framework for Social Value – It was acknowledged this impacts on recruitment and MKS sought clarity - **CD/MKS to progress this piece of work outside of the Committee.**

20/20, 17/13, 19/68 – MKS confirmed that the actions relating to EDI are picked up by the BAME Task Group. An update on the objectives of the EDI report to be shared with a future Board. MKS and JF to review PAWC action log and update at the next Committee in March

**Action: 21/68 - MKS & JF to review PAWC action log for update for March Committee.**

**Governance**
20/30 – Work through a couple of cycles with the new streamlined agenda and workplan – take feedback from Chair/NEDS to guage how it's working. – MKS confirmed that once 'normal Committee business' resumes we can revisit that. **Noted as closed.**

**Assurance on Key Risks**

**21/69** **To agree top 5 Risks**
The Committee received an update on the Top 5 risks for approval. MKS noted that following discussion at the last Committee, the risks have been grouped together as follows:

**Staff Availability** – focus on sickness absence (covid and ongoing sickness absence).

**Staff Wellbeing** – focus on making sure that we keep addressing what we are doing to support staff (phsychological/mental health and physical going forward – SALS/Ader Centre). Evidence is also showing this is linked to Staff Availability, i.e. staff being in work then taking taking time off work due to illness.

**Workforce Planning** –recruitment specifically in relation to BAME and increasing diversity of our workforce; new ways of working and development of new roles are linked. MKS advised that good discussions have taken place at recent Executive Committee about new ways of working and development of new roles being linked, look to focus on this going forward as there is a real nead to look at this in a different way, whilst being mindful of the financial constraints – recent events have shown there are different roles that can pick up different kinds of work.

**Flexible Working** –Coming up to 12 months of staff working from home; we need to look at the estate requirements and having the right accommodation for staff going forward and also how we embed and promote flexible working

**Quality of education** – need to ensure we have a robust approach to education governance and ensuring high quality of experience/placement for all trainess/students and staff.

Comments/feedback raised:
- CD – quality of education should it be widened, not just about education, but to include staff development and training, ensuring all people to reach their potential (particularly level 2 skills for maths, English etc.).

- ES flagged that at the last Audit & Risk Committee discussions took place re BAF risk 2.1 – gap around robust workforce planning. Links into the above risks, the Chair of ARK asked that it be shared with PAWC (from one committe to another). ES was mindful about that broader discussions that had commenced about the top 5 risks and suggested that an offline conversation be had outside of Committee with ES/MKS, in relation to BAF risk 2.1 to enable ES to report outcome to ARK, to ensure linkage is there from an assurance perspective.

- **Action: 21/69 - (raised under Assurance of Key Risks) MKS/ES to discuss BAF risk 2.1, gap in workforce planning offline and ES to report outcome to next ARK.**

- CD – staff holiday carryover – what impact would that have on the Trust. MKS advised that we do not have a full picture as yet as only approved the previous week (i.e. how many staff will request holidays to be carried over). Discussions have taken place and it has been suggested this could be monitored at Divisional level (1 of the 3 at the top in each Division approval required).

**PAWC discussed and approved the Top 5 Risks.**

**Trust People Plan 2019-2024**

**21/70** **People Plan Report**
MKS paid particular attention to the 3 big projects to focus on in terms of the plan going forward for Health & Wellbeing, Flexible Working and BAME Task Force. MKS advised we are on track for those pieces of work and shared the following:

**21/71** **Health & Wellbeing**
A lot of activity has taken place with wellbeing, some specific work with a plan of action SALS/OD and the Clinical Health Psychologists in ICU. Expanded the SALS operation, approx 700 contacts have been responded to. Sickness is hovering about 9-9 ½%, just before Xmas that was about 6-6 ½%, so an increase of 3% due to covid.

**21/72** **Flexible working**
A lot of work has taken place with managers (sessions have taken place with managers, re managing remote teams effectively). During December staff were asked their individual feelings about working from home and what they would like to see in a new working environment (some sessions with staff to feedback the results of the surveys have taken place). This will help us to think about what the future of work will look like and if we start to do something different with the accommodation that we have, what this will be. The biggest challenge for the Trust is flexible working, a commitment had been made to start bringing staff back around April 2021 and given what is happening with the national lockdown (ever changing), this may be causing staff anxiety, need to keep this in our sights.

**21/73** **BAME Task Force**
Following the update outlined in the paper CD advised it is going well, still got a bit to cover but all going in the right direction.

Comments/feedback received on the People Plan:

- CD referred to the 700 contacts made to SALS and acknowledged it was an amazing achievement but noted as we haven't used this provision in the past we have no comparisons as to what the metrics should be (is it all Covid related?). The more it gets more embedded into the Trust and people are more aware of it, will the system be able to cope. MKS advised that we have committed to keeping the SALS resource going. MKS referred to a recent conversation she and the SALS lead had with the head of NHS Leadership Academy Team in London (who was impressed by what the SALS Team had achieved and their approach), the outcome being that SALS Team have been offered funding for a 12 month period for Psychologist. A good structure is in place, but also good that it has been recognised nationally. MKS added we are seeing some cases whee individuals need intense support, so having that psychological support is vital. MF shared that the SALS Team have been nominated for a HSJ award.
- CD asked where are we up to with the vaccine rollout – as this will impact on staff being able to return to work in April. MKS confirmed that as of today 79% of staff have been vaccinated and the Team has done an amazing job. The offer is still available to those who haven't had it yet and is monitored on a daily basis. 75% of BAME colleagues and 85% of doctors have received the vaccine. Will continue to monitor and the 2nd vaccination roll-out will commence mid to end of March.
- IQ – referred to Mandatory Training and highlighted the low completion rates for Estates and Facilities and asked for the reasons why. MKS advised that this is because these departments rely on face to face training (as don't usually access IT) and face to face training has been hugely impacted by Covid. The Learning & Development Manager is looking to introduce alternative methods for this. On top of which, due to a whole host of regulatory reasons, further topics have been added to the list of mandatory training, so the L&D manager has put a plan in place but it has been a challenge. CD acknowledged we have work to do relation to digital inclusion as everybody needs to have the rudimentary knowledge of being able to access information on-line.

CD asked MKS to pass on her congratulations/thanks for the work completed by both the SALS & Vaccination Teams.

PAWC **received and noted** the content of the People Plan.

**Governance**

**21/74** **Corporate Report Metrics – December 2020**

The paper is noted as read and includes an overview of workforce KPI's that we report and also includes divisional updates.

MKS confirmed we have talked about sickness, the sickness on the corporate report is reflective of last month, and it does not show the sickness absence as we had separated earlier, hovering at about 9% to 9.5% mark with roughly 3.5% of that covid related. Slight slip in appraisals, to be expected in current circumstances, 74% compliance at the moment. Will start the new round again in April and the Organisational Development Team are thinking about the most pragmatic way to take forward operationally, just working through this at the moment (the simplified paperwork last year was welcomed by staff).

CD felt that the appraisal process was important, especially at this time, with people working from home and the possibility of staff feeling isolated, especially if you live by yourself and this formulated into the plan going forward.

**Resolved:**
The Committee **received and noted the update** on the content of the Corporate Report.

**20/74** **Board Assurance Framework – October 2020**

The Committee received a full BAF report. ES referred to the locally determined areas as MKS alluded to earlier and the requirement of capturing some of that in the documentation along with catching up with some of the outstanding actions (that may have slipped due to the pandemic and operational pressures). ES confirmed that risks are scruitinised very well in this Committee. CD concurred.

**Resolved:**
PAWC **received and noted** the latest position of the Board Assurance Framework.

**21/75** **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:

ES advised that ED training of staff was remitted to this Committee, but falls to the Division of Medicine and should sit under individual governance arrangements. ES recommended that PAWC track it through one or two more cycles, as is an ongoing task and to ensure compliance does not fall behind. ES confirmed we are getting to the point were we will be signing off the whole of this action plan in a future CQC engagement meeting.

**Resolved:**
PAWC **received and noted** the content of the CQC Action Plan

**21/76** **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 referred to the detailed papers (included for completeness – HEE letter and detailed report) received by the Committee. At the interim virtual quality review in November 2020 by HEE, they reviewed a number of paediatric trainees and interviewed some of them as well. It was hopeful we were going to be taken off enhanced measures at that point because there had been a significant amount of work done with the Medical Education/Clinicians leading on this. Unfortunately there was still some information about 1st on call handover that was received that didn't give HEE full assurance, which meant the HEE team were unable to recommend the removal of enhanced measures, although they recognised significant areas of great practice and real progress so this was a disappointing outcome. We have to submit another action plan by end of March 2021 specifally about improving 1st on-call and maintaining the successes of the 2nd on-call handover.

To support improvements a new process will be implemented in January, this will be audited with the trainees and the consultants. We are also looking at learning from other Trust's who have received a green rag rating to see what they can share. The

consultants and trainees have a Task & Finish group to review. HEE have indicated that a formal review will take place in May 21.

IQ asked if we go direct to junior doctors to ask how this can be fixed. MKS advised that there is so much work that has taken place, that is why it has been so disappointing. The lead consultants have had regular conversations with trainees along with Task & Finish group.

CD expressed concern, particularly as new groups of junior doctors are joining the training and are in place for just a period of time, so it is not a permanent group being reviewed. As advised by MKS/IQ looking at other Trusts for good practice and working with junior doctors to guage what they think.

MKS to bring regular updates back to PAWC and ensure the Board are sited on it as well.

**Resolved:**
The Committee received and noted the content .

**21/77** **Policies**

The Committee received the following policies and Equality Assessments for formal ratification/approval. The Deputy Director of HR outlined high level changes (if any) and advised all policies had previously been approved at either the Policy Review Group or HSC with the support of Staff Side colleagues.

**Mandatory Training Policy & Equality Assessment**
MKS advised of some small changes re changing training needs analysis (the amount of training the professions need to complete), this is agreed at the Education Governance Committee so the policy has updated that. Referenced Covid 19 in terms of training access. Updated some terminology in terms of job titles. No fundamental changes.

**Security**
MKS advised that this has come to us following approval at the Health & Safety Committee. Authored by our local Security Management Specialist. Some changes around organisation and who does what in terms of functions on the Security side. Some changes relating to risk assessments. A section added on counter terrorism and some clarification on CCTV, confidentiality and training included in the work plan that links back to the mandatory training policy.

Questions raised/Discussion:
IQ referred to recent events in Washington. In light of the world being a violent place, does Alder Hey have the trigger points to deal with this kind of scenario. MKS advised that this is a question she would need to ask Security management and referred to an experience in recent years (approx. 3 years ago) and felt we would have had significant learning from that situation (work took place with the police). ES also advised that policy wise this would sit in the Emergency Planning Framework, rather than the standard Security policy, but the two things are linked.

MF highlighted a discussion point – relating to volunteers and the requirement to stop and challenge visitors/staff for not wearing a mast (mask abuse). Volunteers have limited powers or receive limited training to deal with mask abuse.

CD asked how often does the Trust receive advice on Security measures (should be part of Risk Assessments at the Trust). MKS to ask Security and Emergency Planning how often the Trust receives advice on security measures.

**Action: 21/77 – MKS to ask Security/Emergency Planning how often the Trust receives advice on security measures.**

**Resolved:**
The Committee **ratified the policies** and the equality analysis for the above were approved.

**21/78** **Board of Directors Summary**

Assurance - Key risks at todays Committee to be noted:

- Wellbeing & SALS
- Education/Training/Security Issues
- Agreement of top 5 Key Risks

**Resolved:**
The Committee agreed the Board of Directors Summary.

**Sub Committee/ Working Groups reporting to Committee**

**21/79** The Committee received the minutes for the following for information.

- LNC – 22.09.20
- Health & Safety Committee – 14.10.20
- JCNC – 22.10.20

No questions raised.

**Resolved:**
The Committee **noted** the content of LNC, JCNC, Health & Safety.

**21/80** **Any other business**

None.

**21/81** **Review of Meeting**

The Committee noted the pared down agenda, due to current pressures, to ensure that Committee business can be addressed quickly and efficiently. CD thanked the Committee.

**21/82** **Date and Time of Next meeting**

23rd March 2021, 10am-12noon, via Teams

| Minute Reference | Action | Who | When | Status |
|---|---|---|---|---|
| **Matters Arising and Action Log** | | | | |
| **21/68** | • Review PAWC action log and update for March Committee | **JF/MKS** | March 2021 | Completed |
| **Assurance on Key Risks** | | | | |
| **20/43** | • Top 5 Risks – receive an update for approval – noted as approved 25.01.2021 | MKS | January 2021 | Complete |
| **21/69** | • To discuss offline BAF Risk 2.1 – Gap in workforce planning and ES to report outcome to the next ARK. | MKS/ES | March 2021 | Complete |
| **Trust People Plan 2019-24** | | | | |
| **20/44** | • Sickness rate comparisons with other Children's Hospitals (Manchester/Sheffield/Birmingham) | MKS | March 2021 | |
| **Health & Wellbeing** | | | | |
| 20/28 | Sickness Absence/Shielding/Agile Working<br>• Working from home – update on review<br>• Winter plan update – workforce monitoring | <br>MKS<br>MKS | <br>March 2020<br>November 2020 | |
| **Equality, Diversity & Inclusion** | | | | |
| 20/29 | EDS2 & Workforce EDI Annual Report<br>• Share Procurement strategic government guidelines for sourcing suppliers/services with ES/MKS<br>• Revisit Procurement statement to get a sense of what further action is required.<br>• Share highlights of EDS2 & Workforce EDI Annual Report to BAME Task Force – Noted on 25.01.2021 this action complete. | <br>CD/MKS<br>ES/MKS<br>SO | <br>November 2020<br>November 2020<br>November 2020 | <br><br><br>Complete |
| 20/42 | • 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. Noted on 25.01.2021 to be progressed outside of this Committee | CD/MKS | January 2021 | Noted on 25.01.2021 CD/MKS to be progressed outside of this Committee. |
| **Governance** | | | | |
| 21/77 | Policies to Review & Ratify | MKS | March 2021 | |

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|---|---|---|---|---|
| | • Security Policy – MKS to ask Security/Emergency Planning how often the Trust received advice on security measures. | | | |
| 20/30 | Terms of Reference / Workplan<br>• Work through a couple of cycles with the new streamlined agenda and workplan – take feedback from Chair/NEDs to guage how its working. Noted on 25th January 2021, to be resumed when normal business allows. | ES/MKS | 2021 | Closed |
| 20/34 | **HEE NW Annual Assessment Visit 2015-19**<br>• Prepare assurance report for CQC | ES/MKS | January 2021 | Closed |
| 20/52 | **Corporate Report Metrics**<br>• Move this section on agenda to earlier to support attendance at Committee of Divisions. | MKS | January 2021 | Closed |
| **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<br>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<br><br>17/13<br><br><br>19/68 | • Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place<br>• Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months<br>• Equality Metrics Report to be brought back to next Committee<br>• WRES/WDES Updated Plan | MKS/CD<br><br><br><br>SM | TBC<br><br>1/4ly Update<br>6 monthly Review | |
| **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 | Closed |
| **Nurse Associate Recruitment** | | | | |
| 19/69 | Develop a wider plan – to be reviewed | Vikki Hughes | April 2020 | |