Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Tuesday 7th of July 2020, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**20/21/85**	**9:15**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**20/21/86**	**9:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/87**	**9:17**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Monday 22nd June 2020.**	**D**	Read minutes
4.	**20/21/88**	**9:19**	**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: Safe Restart for Alder Hey							
5.	**20/21/89**	**9:20**	**Current Position and Plan:** • **Phase 2 Update** • **Draft Plan for Phase 3.** • **Financial Update.** • **COVID Risk Register:** - **Deep Dive into Safe Waiting Lists.** • **IPC COVID Assurance Framework.**	J. Grinnell/ A. Bateman J. Grinnell/ A. Bateman J. Grinnell J. Grinnell/ A. Bateman N. Murdock	To update the Board on the Trust's short-term plans to increase activity. To update the Board on the work that is taking place to develop Phase 3 of the Trust's plan. To provide an overview of the position for Month 2 and the latest financial guidance. Discuss the current 5 Key Risks. For discussion and to approve the IPC COVID-19 response.	**A** **A** **A** **A** **D**	Presentation Read report Presentation Read report Verbal
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**20/21/90**	**9:50**	**CQC - Final Report.**	E. Saunders	For information.	**A**	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
7.	20/21/91	10:00	**Year-End Quality Assurance:** • **Nurse Staffing Report 2019/20.** • **Q4 Mortality Report.** • **Mental Health Act:** **- Access to Specialist Mental Health Services Improvement Plan 2020.** **- ASD and ADHD Improvement Plan 2020** **- Work of the Youth Forum during Covid-19.**	P. Brown N. Murdock L. Cooper	To provide assurance on safe staffing levels. To present the findings from Q4. To provide an update.	**A** **A** **A**	Read Report Read report Read report/ presentation
8.	20/21/92	10:30	**Cumulative Corporate Report Metrics - Top Line Indicators:** • **Quality** • **Safety**	N. Murdock/ P. Brown	To receive a weekly metrics/monthly report of Trust performance for scrutiny and discussion, highlighting any critical issues.	**A**	Read report
9.	20/21/93	10:40	**Serious Incident Report.**	P. Brown	To provide board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
10.	20/21/94	10:50	**Digital Update**	K. Warriner	To update the Board on the programme.	**A**	Read report
The Best People Doing Their Best Work							
11.	20/21/95	11:00	**Cumulative Corporate Report Metrics - Top Line Indicator:** • **People.**	M. Swindell	To receive a weekly metrics/monthly report of Trust performance for scrutiny and discussion, highlighting any critical issues.	**A**	Read report *(refer to item 8)*
12.	20/21/96	11:10	**Alder Hey People Plan Update:** • **Focus on BMAE.**	M. Swindell	To provide an update.	**A**	Read report
Strategic Update							
13.	20/21/97	11:20	**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
Strong Foundations (Board Assurance)							
14.	20/21/98	11:25	**Reducing the Burden: Board Assurance Committees Re-set**	E. Saunders	To discuss and approve a revised approach.	**D**	Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Proposal.				
15.	**20/21/99**	**11:35**	**Board Assurance Committees; report by exception:** • **Audit Committee:** - **Approved minutes from the 30.4.20.** • **Resources and Business Development Committee:** - **Chair's highlight report from the 24.6.20.** - **Approved minutes from the 27.5.20** • **Clinical Quality Assurance Committee.** • **Workforce and Organisational Development Committee.** • **Integrated Governance Committee.** - **Chair's verbal update from the 15.6.20.** • **Innovation Committee:** - **Chair's verbal update from the meeting that took place on the 6.7.20**	K. Byrne I Quinlan P. Brown M. Swindell K. Byrne S. Arora	To escalate any key risks, receive verbal updates and note approved minutes.	**A**	Verbal/ Read minutes
16.	**20/21/100**	**11:45**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic operational plan are being proactively managed.	**A**	Read report
Items for information							
17.	**20/21/101**	**11:50**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
18.	**20/21/102**	**11:55**	**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: Tuesday 8th September 2020 at 9:00am, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was not used in June 2020:

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Finance Metrics Month 2	**John Grinnell**
Corporate Report Month 2	**Executive Leads**

Alder Hey Children's NHS
NHS Foundation Trust

EXTRAORINDARY PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Tuesday 22nd June 2020 at 9:00am,** via Microsoft Teams

Present:	Dame Jo Williams	Chair /Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Director of Finance/ Deputy Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair	(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)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Director of Medicine	(AH)
	Mrs. D. Jones	Director of Strategyand Partnerships	(DJ)
	Mrs. C. Liddy	Deputy Director of Finance	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
		Committee Administrator (minutes)	(JT)
	Mr. R. Turnock	Interim Deputy Medical Director	(RT)
	Mrs. K. Warriner	Chief Information Officer	(KW)
Apologies	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Ms. P. Brown	Acting Chief Nurse	(PB)
	Miss. J. Minford	Director of Clinical Effectiveness and Service Transformation	
Staff Story	Dr. B. Larru	Consultant in Infectious Diseases	(BL)
	Dr. C. Parry	Consultant in Microbiology	(CP)
	Ms. A. Lupton	Procurement Operational Team Manager	(AML)
Agenda item 5	Mr. H. Rohimun	Ernst and Young	(HR)

Staff Story

The Chair welcomed Beatriz Larru, Chris Parry and Ann-Marie Lupton who had been invited to join June's Extraordinary Board meeting to share their experiences of addressing the issue of PPE from an operational and procurement perspective, and to reflect upon staff testing for Covid-19.

Beatriz provided an overview of the challenges and difficulties experienced by the Trust in respect to addressing the issue of PPE from March 2020 onwards. Beatriz pointed out that as news filtered through about the threat of Covid-19 to the world's population, it became obvious that the Trust needed to take action to protect staff members, patients and families. Work

commenced straight away on acquiring additional PPE via the organisation's supply chain and as PPE became scarce the Trust looked towards alternative solutions to address the national shortages. It was apparent that the Trust needed to implement guidance for PPE to stem the flow of PPE and maintain supplies. Once Public Health England produced guidance the Trust adapted the guidance to meet the needs of the organisation.

In order to support a single approach for the guidance of PPE across the Trust it was agreed to establish a Clinical Advisory Group. It was reported that the group has met with a large number of nurses and clinicians to discuss guidance and agree a way forward.

Beatriz advised that the Trust is continuing to work towards mitigating the risk of Covid-19, acquiring the latest advice on PPE in order to protect staff and patients, and is also trying to help make the lives of people around the world safer for the duration of the pandemic.

Chris informed the Board that the laboratories were asked to commence testing patients admitted from the middle of March, and a further request was made for a quick turnaround of antibody testing across the Trust. Chris pointed out that the logistics for addressing this request have been really challenging. Testing is relatively easy but arranging for people to attend various locations and feeding back results has presented difficulties. It was reported that results are not always accurate and this has been hard to explain to patients and staff.

There has been a big demand for the quick turnaround of results for rapid testing, which again has been challenging. It was pointed out that there is a possibility that asymptomatic testing and saliva testing may also be available soon.

Chris wanted to acknowledge and thank the lab staff, managers, ED staff, volunteers, colleagues, Interserve and the Security Team for their amazing team work and help in ensuring testing took place.

From a personal point of view, Chris reflected that the last five to six months have been reminiscent of being a House Officer again: working long hours, being exhausted, feeling like you have forgotten something and worrying that you are doing the right thing at all times.

Ann-Marie gave an overview of her background in procurement and advised of her involvement in acquiring PPE as the pandemic unfurled and PPE became scarce. Attention was drawn to the work that has taken place with the Innovation Team to look at alternative solutions for visors which were becoming difficult to purchase.

Ann-Marie pointed out that as time went on it became more difficult to procure certain consumables, but even with these constraints the team managed to increase stock levels and therefore were really disheartened when the Trust had to share 7000 of its gowns with other organisations, whilst recognising this needed to be done for the wider benefit of patients.

The team felt that it would have been beneficial to have an understanding of the use of the different types of PPE available, but it was pointed out that the department received great support and guidance from Chris and Beatriz. The team worked long hours with some colleagues working without breaks, which Ann-Marie felt was really admirable. As a Trust we have become inventive, for example, long gloves were out of stock so an alternative solution was devised to address this issue. There is still a major PPE supply issue, FFP3 masks being one of them but it was reported that the organisation was able to purchase power hoods which has alleviated some of the pressure.

Ann-Marie advised the Board that she works with a really good team who have the ability to address the operational PPE issues being experienced by the Trust.

On behalf of the Board, the Chair thanked Beatriz, Chris, Ann-Mare and their teams for the hard work that has been conducted to make the Trust a safer place for patients, families and colleagues.

20/21/76 Welcome and Apologies

The Chair welcomed everyone to June's Extraordinary Trust Board meeting and noted the apologies that were received from Michael Beresford, Pauline Brown and Jo Minford.

20/21/77 Declarations of Interest

The Board noted the declaration received from Fiona Marston in relation to her association with CEIDR.

20/21/78 Minutes of the previous meetings held on Tuesday 2nd of June
Resolved:
The Board received and approved the minutes of the meeting held on the 2.6.20.

20/21/79 Matters Arising

There were none to discuss.

20/21/80 Draft Annual Report and Accounts for 2019/20

The Trust Board received the draft Annual Report and Accounts for 2019/20. Louise Shepherd felt that the report highlights the fabulous work that has taken place across the Trust in 2019/20 and provides the reader with an opportunity to reflect upon the progress that has been made. Louise commented that it had been heartening to be reminded of what a successful year it had been for the Trust prior to the onset of the pandemic. Attention was drawn to a couple of technical issues that are in the process of being addressed to enable the auditors to provide their final audit opinion for 2019/20. Louise Shepherd thanked Erica Saunders for her hard work in producing the Annual Report in unusual circumstances as a result of Covid-19, and commended the Annual Report to the Board.

Louise Shepherd informed the Board that there may be some additional information that will need to be incorporated in the report due to the later than anticipated publication of the Trust's CQC inspection report; a call was to take place later that afternoon to receive notification of the proposed ratings.

Erica Saunders advised the Board that the Trust had fulfilled all of the regulatory obligations that were placed upon the organisation, and in addition the narrative has been overlaid in the report to reference Covid-19 and its impact. Erica Saunders referenced the guidance from the DHSC issued in March with regard to Reducing the Burden and that his had been reflected in the report, including the absence of the Quality Report. For that reason Ernst and Young won't be providing an audit opinion to the Council of Governors on the Trust's 2019/20 Quality Account.

Erica Saunders thanked Jill Preece for her massive input into helping to produce the Annual Report, and drew attention to the window of time between the 22.6.20 and the 24.6.20 for members to feedback comments on the report, prior to its submission to NHSI on 25th June at 12 noon.

John Grinnell presented the Financial Accounts for 2019/20. It was reported that

the Trust's Control Total for 2019/20 was a surplus of £1.7m with £90m cash in the bank. It was pointed out that as a result of two challenges the organisation was initially short on its trajectory for 2019/20. John Grinnell recognised the work of the Divisions on the Recovery Plan along with the work carried out by Claire Liddy and Rachel Lea to close the commissioner contract accounts, which enabled the Trust to achieve a positive outcome under exceptional circumstances due to the impact of Covid-19.

The Board was advised that the Annual Report and Accounts were received by the Audit Committee on the 16.6.20, and following in depth scrutiny were in agreement to recommend the Accounts to the Board, noting the final check that was taking place regarding a technical issue around 'Going Concern'. John Grinnell thanked the E&Y Team for agreeing to conduct the audit remotely in order to provide an external audit opinion for 2019/20.

Resolved:
The Board received and approved the draft Annual Report and Accounts for 2019/20, pending the conclusion of the internal consultation process that E&Y are conducting and receiving the outcome of the CQC's findings of their inspection of the Trust.

Ernst and Young External Audit Year-end Draft Report, 2019/20 – 'ISA260'.

The Board received the External Audit Year-end Draft Report for 2019/20. Hassan Rahimun thanked the Director of Finance and his team for their cooperation with the virtual audit, and drew attention to the following areas in the report:

- Changes to E&Y's risk assessment as a result of Covid-19.
- *Disclosures on Going Concern* – It was reported that financial plans for 2020/21 will need revising for Covid-19. There is no presumption of a going concern for a foundation trust due to the suspension of normal NHS operational planning for 2020/21 and the uncertainties of funding, therefore Alder Hey will need to give some additional consideration around planning for future income flows to ensure the liquidity is sufficient for the purposes of a going concern in 2020/21. E&Y advised that they have done some stress testing on the Trust's liquidity for this period of time and on that basis are satisfied with the outcome.

  It was pointed out that E&Y are in consultation at the present time. The Board was advised that there is a possibility that some of E&Y's decisions may be questioned and therefore until the final process is completed, E&Y are unable to issue the Trust with an overall audit opinion. It was confirmed that the final consultation process closes at the end of the day (22.6.20).

- *Executive Summary* – It was reported that there were a number of items outstanding relating to the completion of audit procedures at the time the report was submitted to the Audit Committee. Since then the Remuneration Report and packages have been completed and E&Y have received responses to all of their enquiry letters. Attention was drawn to the possible impact effect of reporting on the 'Value for Money' conclusion, pending the outcome of the CQC inspection findings.
- There are two areas that E&Y are proposing to refer as an emphasis of matter; property plant and equipment valuations as there are material uncertainties which have been referenced by the Trust's Valuer. The same

may apply to 'Going Concern' in the event there are any issues following the completion of the consultation process that E&Y are participating in.
- There is one uncorrected misstatement which is not material that has been carried forward from 2019/20. This will be corrected by management and included in the 2020/21 financial statements.
- 'Value for Money' conclusion – E&Y are going to issue an unqualified conclusion pending the outcome of the CQC inspection. It was reported that there are no issues with any other reporting responsibilities.
- Control observations are highlighted in section 7 of the report as there are four low risk recommendations that have been raised.

The Chair thanked Hassan Rahimun for providing an overview of the *External Audit Year-end report for 2019/20* and requested clarification that confirmation would be received from E&Y on their overall opinion following the conclusion of the consultation process that they are participating in, and receiving the outcome of CQC's findings of their recent inspection of the Trust. Hassan Rahimun confirmed that this was correct and agreed to liaise with John Grinnell later on in the day to provide an update.

Draft Letter of Representations.

Resolved:
The Board received and noted the draft letter of representations.

20/21/81 Committee Annual Reports

The Board received the following assurance Committee Annual Reports for 2019/20, noting the achievements and future priorities of each Committee:

- Audit Committee.
- Clinical Quality Assurance Committee.
- Resources and Business Development Committee.
- Workforce and Organisational Development Committee.
- Innovation Committee.
- Integrated Governance Committee.

The Chair thanked everyone for contributing in these meetings along with those who provide relevant reports to the Committees.

Resolved:
The Board received and noted the contents of the 2019/20 Annual Reports for each of the Assurance Committees.

20/21/82 Board Self-Certification of Compliance with the Provider Licence

Resolved
The Board received and approved the Self-Certification of Compliance with the Trust's Provider Licence, together with the annual self-assessment as assurance evidence for the Board.

20/21/83 Any Other Business

It was agreed to leave the NEDs briefing session as scheduled for the 23.6.20 in order to provide an update on the outcome of the CQC inspection.

20/21/84 Review of the Meeting

The Chair agreed that the Trust has had an outstanding year and thanked everyone for their effort in helping achieve this outcome.

The Board was informed that an update will be circulated later on in the day to advise of E&Y's overall audit opinion on the Trust's Annual Report and Accounts for 2019/20.

Date and Time of the Next Meeting: 7th July 2020, 900am via Teams.

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
Actions for July 2020							
03.03.20	19/20/350	Board Assurance Framework	To present a paper on the improvement waiting times that is being developed with the commissioners for ADHD patients	Lisa Cooper	07.07.20	Completed	1.7.20 - This item has been included on July's agenda.
02.02.20	20/21/56.1	Financial Update	Link in with Shalni Arora to address a query regarding the financial figures for M1.	John Grinnell	07.07.20	On Track	
02.02.20	20/21/56.2	Covid-19 Programme Update	Link in with respective colleagues to discus the reconvening of Assurance Committees.	Erica Saunders.	07.07.20	Completed	1.7.20 - Meetings have been scheduled with respective colleagues to disscuss the reconvening of Assurance Committees.
Actions for September 2020							
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	07.07.20	On Track	This item has been deffered until further notice due to the Covid-19 crisis.
02.02.20	20/21/60.1	Freedom to Speak Up	Compile a breakdown for the current year of the issues that SALS are addressing.	Kerry Turner	8.9.20	On Track	

Status	
Overdue	(red)
On Track	(green)
Closed	(blue)

Alder Hey Children's NHS
NHS Foundation Trust

Update on Phase 2 COVID-19 Response Plan

7 July 2020, Meeting of the Board of Directors

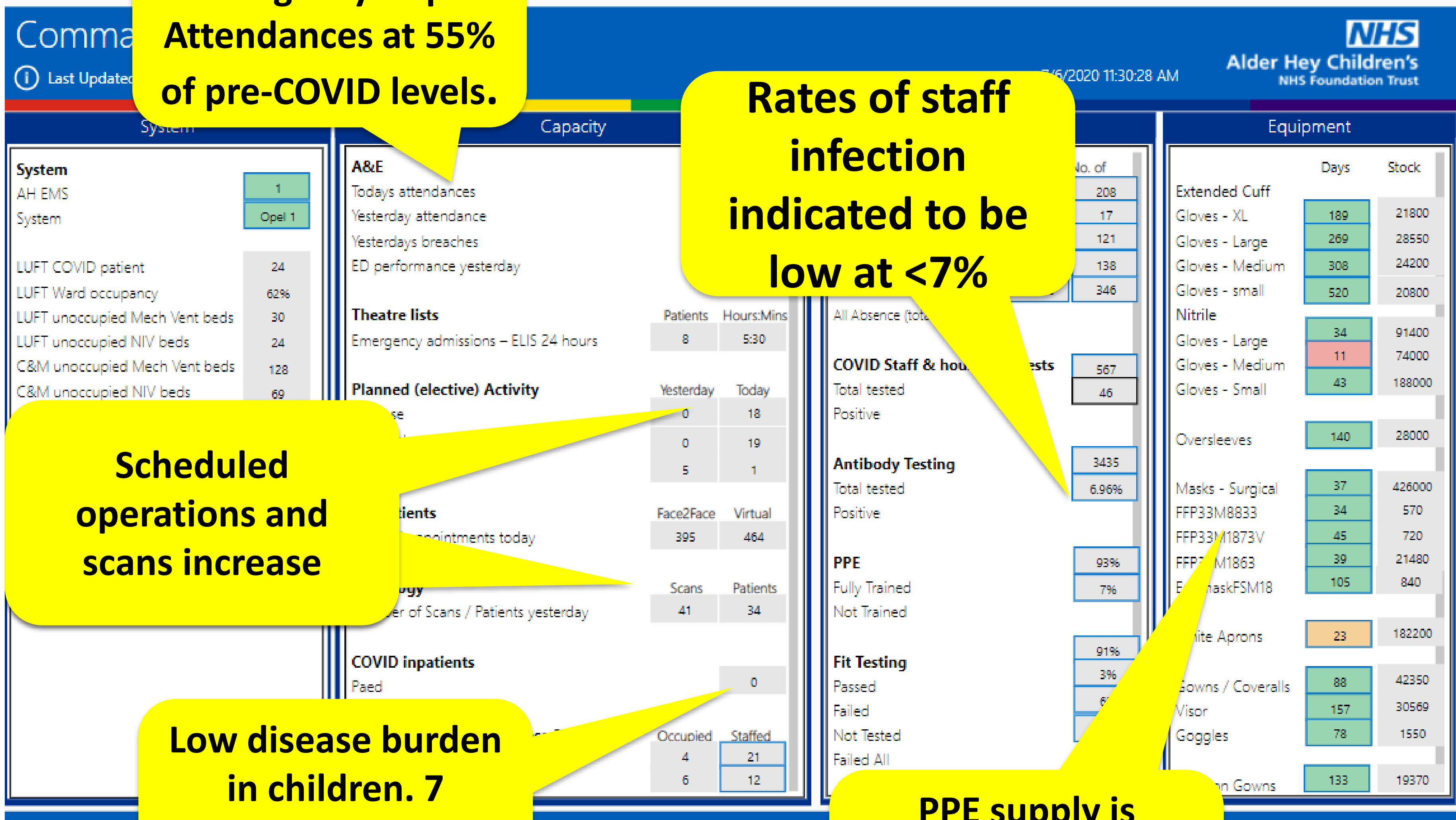
Presentation from Adam Bateman, Chief Operating Officer

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

Purpose

- To highlight the key features that define Alder Hey's delivery of the Phase 2 COVID-19 Response Plan
- To provide an update on the progress made in restoring services to children and young people
- To highlight the key risks and challenges to be addressed and mitigated in Phase 3



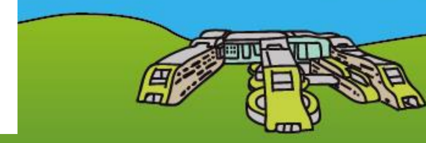
Timely care in the Emergency Dept. Attendances at 55% of pre-COVID levels.
Rates of staff infection indicated to be low at <7%
Scheduled operations and scans increase
Low disease burden in children. 7 inpatients since May.
PPE supply is adequate to support our Phase 2 plan in July
Alder Hey Children's NHS
NHS Foundation Trust
System
Capacity
Equipment
A&E
Todays attendances
Yesterday attendance
Yesterdays breaches
ED performance yesterday
Theatre lists
Emergency admissions – ELIS 24 hours
Planned (elective) Activity
COVID inpatients
Paed
AH EMS
LUFT COVID patient
LUFT Ward occupancy
LUFT unoccupied Mech Vent beds
LUFT unoccupied NIV beds
C&M unoccupied Mech Vent beds
C&M unoccupied NIV beds
COVID Staff & household tests
Total tested
Positive
Antibody Testing
PPE
Fully Trained
Not Trained
Fit Testing
Passed
Failed
Not Tested
Failed All
Extended Cuff
Gloves - XL
Gloves - Large
Gloves - Medium
Gloves - small
Nitrile
Oversleeves
Masks - Surgical
Visor
Goggles

Progress in restoring services

Alder Hey Children's NHS
NHS Foundation Trust

Service area	Measure	Pre-COVID	Phase 2 (June or July snapshot)	Proportion of pre-COVID capacity or activity levels
Radiology	Exams per day	200	143	71%
Emergency Department	Attendances per day	175	95	55%
Theatres	Sessions per week	139	139*	100%
Theatres	Day case operations per working day	40	27**	67%
Theatres	Elective inpatient operations per working day	14	11***	79%

* w/c 13 July 2020
** w/c 29 June 2020
*** w/c 13 June 2020



Progress in restoring services

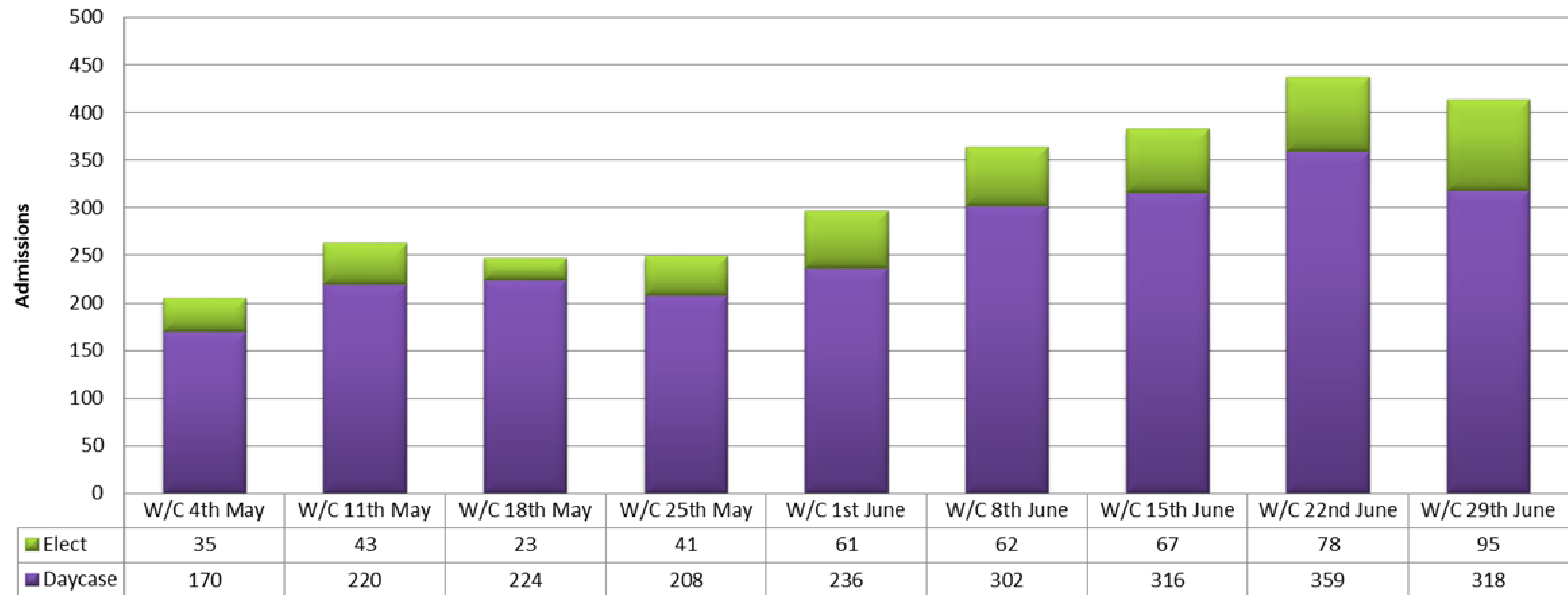
Alder Hey Children's NHS
NHS Foundation Trust

Service area	Measure	Pre-COVID	June-July	Proportion of pre-COVID capacity or activity levels
Outpatients (including Virtual and Face to Face, Offsite Clinics, EMIS, CAMHs and AHP)	Consultations per day	1,048	777	74%
CAMHS	Number of appointments per day	95	91	96%
Community Therapies	Number of appointments per day	108	88	81%

Type of appointment	Measure	Pre-COVID	June-July	Proportion of pre-COVID capacity or activity levels
Face-to-face	Consultation per day	972	381	39%
Virtual	Consultation per day*	76	396	521%

Alder Hey Children's NHS
NHS Foundation Trust

Trend in admissions for planned inpatient and day case treatment



	W/C 4th May	W/C 11th May	W/C 18th May	W/C 25th May	W/C 1st June	W/C 8th June	W/C 15th June	W/C 22nd June	W/C 29th June
Elect	35	43	23	41	61	62	67	78	95
Daycase	170	220	224	208	236	302	316	359	318

Highlights

- **New environments:**

- **Progress in restoring capacity**

- **Innovation in PPE:** e.g. respirator hoods & cloth masks

- **Working with staff side to keep staff protected**: PPE clinical advisory group and PPE Oversight Group

Highlights

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- **Research:** 245 patients recruited to 12 COVID-19 trails.
- **Other research:** 50 clinical trials re-activated
- **Testing:** antigen testing incorporated into emergency and elective pathways
- **CAMHS:** 24/7 crisis line to remain open
- **Virtual medicine:** e.g. Attend Anywhere, community physio at home and remote consultations in neonates

Key risks & challenges

Alder Hey Children's NHS
NHS Foundation Trust

1. Keeping children & young people safe

Increase in waiting times and backlogs; Infection prevention & control; meeting the needs of children and young people who are at-risk and vulnerable

2. Safe staff

Addressing staff fatigue and ensuring staff wellbeing whilst planning for a rise in service capacity; acute pressures on certain teams; supporting staff who are working from home

3. Increasing capacity

Restoring a higher level of face-to-face capacity in outpatients; bottlenecks and pressure points (from anaesthesia to physical space in ED); and financial uncertainties leading to re-purposing and flexible working

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS
Tuesday 7th July 2020

Paper Title:	**Draft - Alder Hey Operational Plan – August 20 to March 21 (Phase 3 COVID response)**
Report of:	**Executive Team**
Paper Prepared by:	Executive Team
Purpose of Paper:	Decision ☐ Assurance ✓ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Revised Draft Operational Plan for the remainder of 20/21 that focusses on COVID recovery in the context of our wider plan. For discussion as document will need updating following release of National Planning Guidance that is expected later in July
Action/Decision Required:	To note ✓ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of outstanding care ☐ The best people doing their best work ☐ Sustainability through external partnerships ☐ Game-changing research and innovation ☐ Strong Foundations ✓
Resource Impact:	

BOARD OF DIRECTORS

Alder Hey Operational Plan – August 20 to March 21 (Phase 3 COVID response)

1.0 Introduction

Alder Hey has been dealing with the COVID-19 pandemic since mid-February which has had a profound effect on the way the Trust operates. The impact of these changes, the system within which we operate and the backlog of CYP needing to access services has meant we have had to fundamentally re-shape our plan for the rest of the year. This document is a first draft of a revised Operating Plan which, as further National Guidance is released, will be finalised through July.

2.0 Current Context

Through the national lens of NHSI/E the pandemic has been dealt with in phases:

	Phase 1	Phase 2	Phase 3	Phase 4
Phase	Covid-19 level 4 incident response	Covid-19 level 4 incident response and critical services switch-on	Ongoing covid-19 management and NHS open for business	New NHS
Timeframe	March 2020 – April 2020	May 2020 – July 2020	August 2020 – March 2021 May need to be broken into shorter periods, or reviewed at the end of the calendar year	April 2021 onwards 1 to ?4 year time horizon for some elements
Purpose	Enable NHS to deal with peak covid-19 demand	Enable NHS to deal with covid-19 demand Start to deliver a range of routine services	Ensure capacity in place for ongoing covid-19 activity Return critical services to agreed standards Begin to address backlog of services Retain changes from pandemic we wish to keep	BaU covid-19 service in place including sufficient critical care Continued action on backlogs and unmet need/ inequalities impacts Resume LTP/ manifesto delivery Inform SR positioning
Planning	CEO/COO letter to NHS issued 17 March 2020	**Letter to NHS planned for issue late April 2020**	**Letter to NHS / light touch planning guidance planned for issue late May 2020**	**Planning guidance planned for issue December 2020**

For Alder Hey **phase 1** saw the Trust focus on managing the pandemic as a critical incident with three key priorities -increasing critical care capacity to support the wider Adult system, continuing to deliver safe care for CYP and their families, and keeping our staff safe. The period saw us reducing elective activity levels to prioritise our limited capacity to maintain access for urgent care.

Phase 2, which we are currently in, is our safe re-start phase. The focus of this phase has been on increasing access to services for CYP, whilst maintaining safe care and being fastidious in protecting our staff from the virus. This has been a very challenging phase. We have needed to increase access to services as continued delays to treatment are of a real

concern, however doing this with constrained levels of PPE and ensuring we can maintain social distancing has meant we have purposefully done this very cautiously.

Through early July our aim is to have all theatres operational again, albeit at a gradually increasing level of utilisation. Our ED Department remains open as usual whilst attendances remain at 60% of previous levels, and we hope to be able to get back to the same levels of outpatient activity as those delivered pre-COVID through face to face and virtual opportunities.

A new system framework has been in place during phase 1 and 2 with leadership and governance being managed through an In-Hospital and Out of Hospital Cell. Commissioner contracts have been suspended as a command and control model has been implemented which is likely to be in place through to the end of the financial year. Temporary regulatory measures were put in place with streamlined governance arrangements, new financial systems and a suspension of many of our usual constitutional access targets.

At the time of writing this draft plan we await the release of the formal DHSC guidance and financial arrangements for the rest of the year. This will undoubtedly shape our thinking further as we gain clarity on the funding available set against the expected pace of any recovery. We felt however at this stage it was important to develop our response to this unique set of challenges to ensure we are ahead of the curve in our response.

This document outlines:

- The wider system update
- The scale of the challenge
- Our draft plan for the remainder of the year, our key areas of focus and activities to support delivery
- Key risks and mitigations
- Financial architecture
- Our revised governance arrangements

Once the national guidance has been received we will adapt the Plan for the Board to consider in late July/early August. To align with this timeframe, a Board strategy time out will be undertaken in September, both to shape plan for remainder of the year, and to look forward in shaping our plan for 2021/22.

2.0 The Wider System

As described the national response to the COVID pandemic was to implement Regional command and control structures, which for each STP/ICS was overseen by an In Hospital and Out of Hospital Cell. The two cells for Cheshire & Merseyside have been responding to the pandemic and are now charged with developing a system wide recovery plan - Phase 3.

Within the recovery work Alder Hey is leading the paediatric services elements of recovery. Louise Shepherd is the Senior Responsible Officer for this chapter of the recovery plan and is being supported by both Cells and PA Consulting who are funded by the system to pulltogether the system plan. This work is due to be completed by the middle of July with Alder Hey taking a key role in ensuring CYP are fairly represented in any system decisions to support recovery. The system aim will be for Alder Hey to play a leadership role in

ensuring there is clear oversight of diagnosis and access for CYP services and in looking to develop new models of care that can be scaled across the C&M footprint.

We also recognise the growing mental health challenges CYP are facing, which in many instances have been exacerbated by the impact of the pandemic. These range from delayed access for already challenged services such as ASD/ADHD, to increased demand for Crisis services and Eating Disorders. Alder Hey's Director of Mental Health and Community represents these critical services through the C&M Mental Health partnership.

Across the North West footprint we are working through our North West Paediatric Partnership with Royal Manchester Children's Hospital to ensure specialist CYP services have a joined up plan across C&M, Greater Manchester and Cumbria and Lancashire. The focus of this collaboration will be to ensure resilience of services and to support the clinical networks to maximise access to services through the winter and the recovery phase.

We continue to advocate for CYP across these varying systems, which is not only imperative to ensure they are not lost in the wider adult NHS/Social Care recovery, but also in ensuring that any resource allocation decisions are appropriately ring-fenced for CYP services.

The Specialist Trust Alliance has also been focussed on how it can help responses to the COVID recovery plan and all 4 hospitals have recommitted to the Alliance. A further exploration of partnership opportunities under the Alliance is under way which is due for consideration with C&M STP in early July. This will include a series of collaborative workstreams and resource plans to move the Alliance forward.

3.0 Scoping the Challenge

Through phase 1 and 2 we have remained committed to increasing capacity, delivering safe care and keeping our staff safe. Those 3 pillars have enabled us to focus on our re-start programme which we set against 4 key tests; having a forward supply of PPE, having appropriate testing capacity in place, having the right staff in place and a safe environment to deliver care.

This re-start has been extremely complex and challenging however from 6th July we will have all our Pre-Covid theatres running, albeit at lower throughput levels and we will be seeing 2/3rds of our outpatient attendances delivered face-to-face or virtually. This has been no small achievement and the clinical teams continue to strive to ensure we can at least deliver our pre-COVID levels of activity by the end of the summer.

Despite this achievement, the slow-down in our elective activity has meant we are seeing a growing number of children waiting longer for services. We are now seeing CYP wait over 52 weeks for treatment and for the first time in years the Trust's 18 week RTT performance has dropped dramatically. Our clinical, operational and business intelligence teams have been working hard to establish the scale of the backlog that has built up and the capacity needs of us managing through the winter period to establish the increase in overall capacity we will need to provide either physically, virtually or though new models of care.

The modelling needs further refinement however it has been developed to allow us to test different scenarios including importantly how long it will take to clear the backlog. On the

basis that we look at what it would take to clear the backlog through to March 2021 and deal with a typical winter the modelling suggests the following scale of capacity gap:

Area	Pre-COVID	Current Daily Activity*	Required capacity**	% Increase from Current Levels	% Increase from Pre-COVID Levels	Comments
Inpatient beds	247	213	261	23%	6%	* 247 commissioned beds excluding EDU * 213 is staffed beds presently. * Additional 14 Surgical beds required for WL Backlog * 11 empty physical beds (7 on crit care) * Required capacity based on 85% occupancy.
Total Elective operations	47	42	67	60%	42%	* additional activity equates to an additional 25 theatre sessions per week (equivalent to an additional 18% increase on the 139 sessions pre-COVID schedule)
Of which, Elective Overnight Stays	12	10	17	70%	42%	
Of which, Elective Daycases	35	32	50	56%	42%	Surgical Day cases only additional 15 required to clear backlog
Outpatients	1,048	777	1,251	61%	19%	* Includes virtual, face-to-face, community clinics, CAMHs and AHP. * Excludes Phlebotomy

* based on last complete/cashed up week in June 2020

** required capacity based on backlog clearance by March 2021

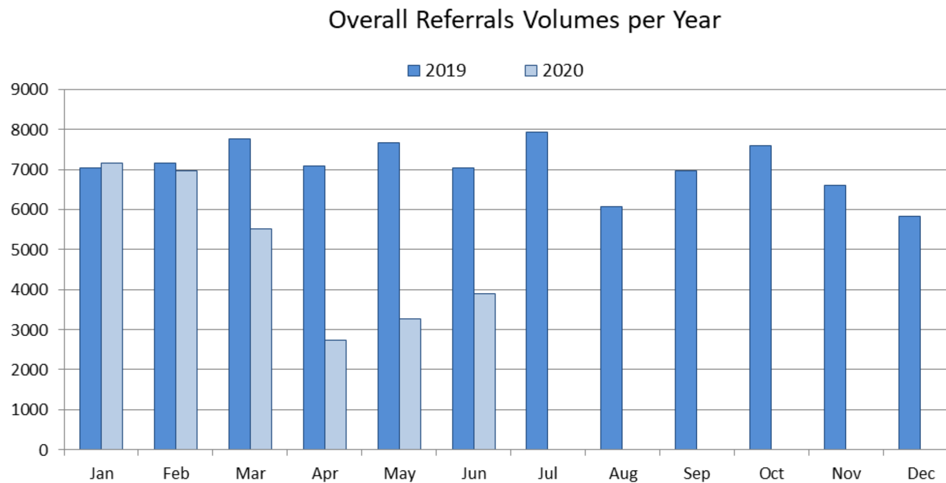
The model is undergoing further validation with individual clinical teams however the high level output is that we would need to increase significantly on our current activity levels, and even assuming we could recover those levels would need to deliver (for example) 21% more theatre operations than we have delivered in the past.

The scale of this capacity gap will vary if we were to extend the recovery period and we will also have to be cognisant of any funding arrangements that follow as the national guidance is published. Nonetheless this type of increase in activity levels is without precedence, and when set against the constraints of safely operating through this pandemic, challenges our whole response effort.

The other unknown we face is the level of demand for services which in all cases has reduced significantly during the pandemic. A summary of the reduction in referrals is summarized below:

Overall Comparisons Referrals Received

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
2019	7031	7173	7754	7080	7672	7041	7933	6061	6973	7606	6615	5840	84779
2020	7160	6963	5510	2742	3273	3900	0	0	0	0	0	0	29548
2019 vs 2020	1.8%	-2.9%	-28.9%	-61.3%	-57.3%	-44.6%							-65.1%



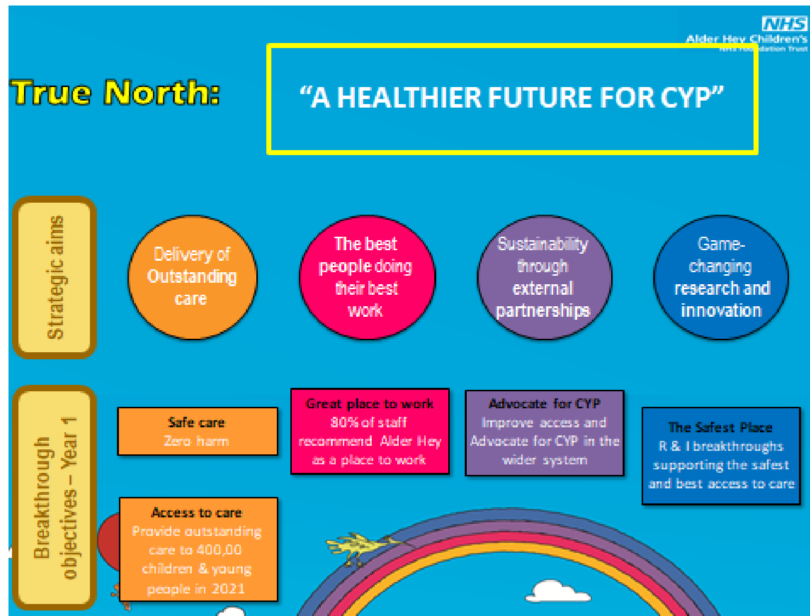
The table and graph demonstrates over a 50% reduction in referrals as the pandemic has evolved. This is common across the wider NHS and in benchmarking with our sister specialist children's hospitals. Drivers for this could be multi-factorial such as the impact of the lockdown on infection and injury, school closures, access to primary care and a general caution from the population accessing health services. Despite ensuring that we give clear messages to the public that we are safe to access, and through working with primary care, the community and education, we are not seeing a return to pre-COVID referral levels. Whilst emergency department attendances have increased since the height of the pandemic, at the current time they still remain at least a 1/3 down on pre-COVID levels.

We have assumed in our modelling that referrals begin to return to their pre-Covid levels however will test this assumption further as we develop a better understanding of the likely trends.

4.0 Our response

Given the unprecedented context we are now operating in we have had to fundamentally assess our operational plan for the rest of the year. We have been cognisant of our strategic objectives in developing this plan and have found not only that many of our already planned objectives align and support recovery, indeed we delivered significant elements of Our Plan rapidly in the opening months of COVID, with huge progress in aspects such as staff advice, support and welfare, digital working etc. We have however had to ensure our response is focussed and necessarily narrower than our original year 1 of 'Our Plan'. We have also wanted to build on our learning from Phase 2 and 3 of dealing with the pandemic in our thinking about how best to tackle the re-start and recovery phase.

To support this we have developed 5 Top Level objectives referred to as our 'Breakthrough Objectives'. These build from our strategic plan however are inevitably bespoke to the COVID response as shown below in the diagram below.



We are re-shaping our delivery programme to achieve these objectives with a focus on ensuring all of our programmes demonstrate their value to these breakthrough objectives. Through our 'Organisational Excellence Programme' we will ensure that all Divisions, Departments, Teams and individuals clearly can align their improvement activities to these objectives.

We will further fine tune our major transformational change programme. The major projects we have prioritised are:

	Safe care	Access to care	Safe staff	Advocate for CYP	Research & Innovation
Transformation programme					
Safety culture	●		●		
Grow our Capacity [safely]	●	●		●	●
Centre for Virtual Medicine	●	●		●	●
New models of care	●	●		●	
Equality, Diversity & Inclusion			●	●	●
Agile			●		
Wellbeing			●		
Role in the system	●	●		●	●
Artificial Intelligence	●	●		●	●

DIGITIAL FUTURES
CAMPUS DEVELOPMENT
FINANCIAL STRATEGY

This transformational programme will only be successful at such a scale and pace by supporting clinical teams in finding the right solutions for them to recover and create a new normal. Through our 'Organisational Excellence' programme, we will support clinical teams with resource and expertise to help them develop Clinical Service Recovery Plans. This support will take the form of teams including digital, change experts, innovation, data

science, HR and Finance. We are assessing our ability to offer this support and may need to bring increase capacity and capability as required.

The individual projects within the transformational programme are being developed and will be finalised through July. Each will have a benefits realisation profile, which quantifies the contribution they will make to the breakthrough objectives. With what we have progressed to date the high impact changes, actions and goals for each project are summarised:

	Safety Culture		
	High impact change	**What will progress look like?**	
		Key actions	**Goal**
1.	**Strengthen our Infection, Prevention & Control resources to respond to changing environment**	Review IPC structure and staffing Advertise DIPC	Safe Patients, Staff and Environment Zero Infections
2.	**Embed Patient Safety and Quality Governance in Divisions – underpinned by a learning culture**	Restructure Quality and Safety governance Identify resources and look at reorganisation/repurposing Human Factors training rolled out	Zero Harm Zero Never Events
3.	**Safe waiting list management**	Maximise capacity, safely Effective clinical review and prioritisation Provide a scorecard with helpful and accurate information against defined clinical and safety standards A single-version of the truth waiting list, with excellent data quality Good administration/ documentation of a patient's pathway Capacity & demand model that projects trends in waiting times	Zero patients wait over 52 weeks for treatment Urgent new patients seen within 6 weeks Cancer patients seen within 2 weeks All patients who are past their latest date receive a clinical review

	Safety Culture - Digital Quality and Safety Improvement		
	High impact change	What will progress look like?	
		Key actions	Goal
1.	**Closed Loop Technologies**	Implementation of closed loop technologies in all in patient areas and the Emergency Department: • Closed Loop Medicines • Closed Loop Blood • Closed Loop Milk	To reduce bedside administration errors relating to medicines, blood and milk
2.	**Alderc@re delivery**	Implementation of upgraded electronic patient record to all staff.	To implement a modern, high quality, safe and effective electronic patient record to all staff
3.	**HIMSS 7**	Delivery of continued technology to improve safety across the Trust in line with international digital maturity standards	To support and enable safe and high quality care and zero harms through technology
4.	**Paperfree**	Scanning of legacy paper medical records, removal of paper notes and implementation of upgraded electronic document management system	To ensure all our records can be accessed digitally, removing paper from care processes

	Grow our capacity (safely)		
	High impact change	What will progress look like?	
		Key actions	Goal
1.	**Growing our Capacity**	▪ Develop our workforce (numbers, new roles and working to boundaries of practice) to achieve the new capacity ▪ Theatre schedule that provides adequate sessions to meet demand ▪ Outpatient schedule provides adequate clinic sessions to meet demand ▪ Physical space plan to provide adequate beds, clinic rooms and theatre sessions ▪ Negotiate extended sessions ▪ Financial analysis of capacity plan ▪ New model of care for step-down & rehab +/- pre-op (explore McHouse & Knotty Ash)	▪ X WTE staff available in clinical services to support growth ▪ 165 staffed theatre sessions per week ▪ Outpatient schedule (F2F & digital) supports 1,150 appointments per day ▪ 273 staffed beds
2.	**GIRFT**	▪ Every specialty receives access to Organisational excellence team supports every specialty with GIRFT and capacity plan ▪ Every specialty has a plan to sustain or achieve the best outcomes amongst peers	▪ Clinical outcomes in the top 10% ▪ Number of cases per list increases from x to y ▪ Number of patients per clinic increases from x to y

	Centre For Virtual Medicine		
	High impact change	What will progress look like?	
		Key actions	Goal
1.	**Virtual Access to Services**	Delivery of: Digital Front Door Virtual Outpatients delivered through Attend Anywhere at scale– including virtual	To enable a Digital First service to support new models of care and access to care through a center of virtual medicine

		chaperoning policy Virtual ED/Front Door Providing a Digital Suite	Every specialty has adopted virtual clinics TBC virtual consultations take place each day
2.	**Virtual Ward Rounds**	Cross site telemedicine for identified services including Neonatal, High Dependency and Major Trauma Implementation of iPads in ward areas to facilitate virtual ward rounds Delivery of Hololense proof of concept to cardiology	To support clinical teams to see in-patients and participate in ward rounds from various locations through a range of technologies

	New Models		
	High impact change	**What will progress look like?**	
		Key actions	**Goal**
1.	Urgent Care	• Virtual ED model • '111 First' (national model developing)	• Meet Demand, within safe footfall • Streamline access
2.	Mental Health	• Mental Health in Schools / Trailblazer • 24/7 Crisis Care (sustain)	• Lead provider for C&YP MH • Meet rising demand (c. 15% increase in referrals) • Growth area – specialist MH
3.	Paeds reach – C&M, N West	• C&M Paeds Capacity model • C&M Paeds Network - resilience • NW Winter Plan and new PIC & SIC network	• Scale the C&YP challenge @ C&M level • System oversight / coordination • Regional Advocacy for C&YP (fair access to limited funding) • Strong clinical relationships to design & facilitate optimal resilience & access • Winter Plan to meet Covid + backlog demand • Resilient services & maximised access (local where possible, with clear plans for specialist across NW)
4.	LTC – New Models of Care	• Centre for Virtual medicine • Remote monitoring • Group models	• 'Home first' – see more C&YP remotely • Promote Self Care (reduce demand) • Manage larger groups of C&YP with same resource levels (increase capacity)
5.	Specialist Trusts	• Secure C&M support • Establish programme & governance • Deliver single procurement / estates / digital etc. plans	• Productivity gains • Cost saving • System strength
6.	Rehab/Reablement	• Develop AH Proposal • Secure C&M support	• Improve C&YP outcomes (across the whole wellbeing, physical & mental spectrum) –and for families • Reduced LOS and Bed days (create capacity) • Reduce readmission (reduce demand)

NHS
Alder Hey Children's
NHS Foundation Trust

	Equality, Diversity and Inclusion		
	High impact change	**What will progress look like?**	
		Key actions	**Goal**
1.	**Establish a Task Force**	• Establish a task force, led by Claire Dove, NED, with a specific focus on supporting black colleagues, in response to the Black Lives Matters campaign • Board level awareness training to be mandatory for all Board members	• Develop a strategic plan to address inequalities and access to opportunities which will include specific actions as listed below:
2.	**Establish a programme of Positive Action**	• Agree a 'contract' with the HEI's to recruit to diversity in the student population • Establish a fast-track leadership programme for under-represented groups, including mentoring support • Develop a 'compact agreement' with a number of local organisations (eg Blackburne House, Greenbank) to support access to opportunity and placements, including apprenticeships, with a particular focus on supporting local black youth and the community	• To reach equality in BAME representation across the workforce pipeline by 2024 • To increase numbers of under-represented groups in Band 7+ positions
3.	**Use of careful listening through networks and specific groups to monitor and challenge progress**	• Review of the BAME, Disability, LGBTQI+ Networks to ensure they are fit for purpose for the communities they serve • Hold specific sessions with black staff to understand specific issues within this staff group • FTSU champions secured from under-represented groups	• To be in the top 20% of Trusts for WRES and WDES metrics • To be in the top 20% of Trusts for Staff Survey Metrics relating to discrimination, reporting concerns and access to opportunities
4.	**Review recruitment practices**	• Review recruitment process and set standards for training, panel composition, support for managers • Review how and where posts are advertised, ensuring access to roles is made available to all groups in the community • All managers to receive awareness training, including unconscious bias training	• To be in the top 20% of Trusts for WRES and WDES metrics • To reach equality in BAME representation across the workforce pipeline by 2024

	Agile Working		
	High impact change	**What will progress look like?**	
		Key actions	**Goal**
1.	**Adopt agile working principles across the Trust**	Clear Guidance for all teams and staff on 'mobile working' User Group established to ensure solutions meet the needs of our staff Working with an expert partner, implement an agile 'change management' programme to support and focus on three separate groups of staff: Individual staff Line Managers Teams Survey staff and teams to collect ongoing feedback and respond to suggestions and concerns	• 100% of staff identified as 'mobile' workers working flexibly by January 2021 • Improved 'health and wellbeing' responses in the staff survey • Reduction in stress related sickness absence • Ensure all staff have the right equipment to do their job well whatever their setting
2.	**Rationalisation of Estates**	Using the data emerging from the agile project, align the resource requirements for desk and office space with the future strategy for the AH estate	• To achieve up to 50% reduction in estates occupancy and requirements • To support the sustainability agenda; to obtain a reduction in car parking requirements in order to manage car parking capacity for families and key onsite workers

	Wellbeing		
	High impact change	**What will progress look like?**	
		Key actions	**Goal**
1.	**Improve health and wellbeing of staff**	1. **Increase awareness** of mental health and wellbeing through psychoeducation and communications (briefings, intranet, trainings). Revive Time to Change campaign. Re-launch Wellbeing Steering Group. 2. **Increase accessibility** of psychosocial support by: **a.** increasing visibility of and connection to staff support available (Staff Advice & Liaison Service (SALS), Clinical Health Psychology, Spiritual Care, Alder Centre, Care First)	1. Increased percentage of staff rating "my organisation takes positive action on health and wellbeing" in the Staff Survey 2. More staff are aware of and accessing the support on offer and more reflective sessions are being offered to all staff.

		b. Providing increased opportunities for reflection through the development of virtual Schwartz Rounds, Team Time sessions, and virtual Staff Common Rooms 3. Ensure **sustainability of support** through: a. Investment in the development of SALS b. Continued investment in staff counselling beyond Covid 4. Embed **active monitoring** of staff wellbeing through: a. Regular measurement and screening b. Regular debriefing c. Implementation of Psychological First Aid Training (Look, Listen, Link)	3. SALS fully operational and launched and ringfenced funding for staff wellbeing and counselling provision in place. 4. Agreed measure of staff wellbeing in place and in regular use across the organisation as part of business as usual. Ground Truth Tool implemented across the organisation. All staff able to access Psychological First Aid training.
2.	**Improve leadership capability**	1. **Strong Foundations revamp and restart.** Develop virtual version of Strong Foundations training. Increase capacity to enable greater reach. Sustain new learning through Leadership Support Circles (based on national model). 2. **Deliver Look, Listen, Link training to all line managers.** Internally developed brief training focussed on supporting managers to identify and manage distress in themselves and their teams and know how to access support when needed. Training will also focus on the skills and practices needed to stay successfully connected to others in a more virtual world. 3. **Embed and extend coaching and mentoring framework.** Finalise current scoping of internal coaches and mentors and identify training gaps. Communicate offer to aspiring and current leaders and managers initially (and connect to Talent Management processes). 4. **Improve information and resources** available to leaders and managers through intranet pages and dedicated leadership	1. Strong Foundations re-launched in September 2020. Improvements seen in organisational culture as measured by the percentage of staff recommending Alder Hey as a place to work (target 80%), increased psychological safety (temperature checks), increase in speaking up (FTSU cases), reductions in bullying and harassment cases and increased and other relevant measures. 2. Training delivered virtually to all leaders and managers by September 2020. More staff feel listened to and understood in relation to their mental health and wellbeing needs. 3. Increased number of coaching sessions available to the organisation with positive feedback about the quality of coaching received. 4. High quality, relevant and up-to-date leadership resource available to all on the intranet.

		development support from leadership experts in the OD team.	Direct access to bespoke and individualised leadership conversations available.
3.	**Reduce sickness absence levels**	1. **Wellbeing Team** now established and supporting managers with the administrative tasks associated with managing absence (including Occupational Health referral, ESR data input, scheduling review and welfare meetings and associated documentation.) 2. **Focus on facilities –** This staff group in the Trust has significantly high and sustained levels of absence. Particular intervention and support will be provided for this staff group.	1. Releasing more time to care as managers not undertaking the administrative processes. 2. Timely referrals and welfare meetings, thus reducing lengths of absence episodes 3. Overall reduction in sickness absence <4%

	Break Through Immersive Medicine – embedding AI		
	High impact change	**What will progress look like?**	
		Key actions	**Goal**
1.	**Reduce harm through using immersive technology to improve systems and processes**	1. Run an AI competition to identify clinicians who would like to use data science to improve safety 2. Facilitate anti-microbial strategy with AI assisted technology a. develop a model to predict where to focus surveillance of Healthcare associated infections (HAI) efforts using artificial intelligence b. Antimicrobial Stewardship programme needs high quality and real-life data to develop data driven interventions, evaluate them and engage all providers in our activities c. aggregate, analyse and display the large amount of data generated by the Microbiology Laboratory into a user-friendly web-based tool to monitor antimicrobial resistance patterns in real time a facilitate clinical decision making 3. Potential areas include: d. Numbers of Medication Errors e. Centralisation and automation of clinical guidelines with a new virtual assistant tool launched. f. Add AI assisted technology to DETECT study to enhance	• Reduce no harm from x to y • Reduce errors from x to y • Improve compliance with national standards • Improve number of up to date guidelines • Improve clinical experience and compliance with guidelines • Improve antimicrobial stewardship • Reduce hospital infection rates • Improve speed of intervention in deteriorating patients • Enhance clinicians ability to utilise real-time monitoring data to guide interventions

		predictive tools g. Explore AI Digital twin in PICU to improve outcomes through predictive prevention	
2.	**Keep more CYP well at home and reduce hospital admissions and visits**	1. Identify 3 clinical teams who want to explore the use of wearable technology 2. Deploy immersive technology to enhance the Virtual ED plan 3. Deploy tele-medicine techniques and technology in at least 3 clinical teams 4. Pilot the deployment across C&M system 5. Identify a research study to measure and evaluate	• Reduce total number of follow-up outpatients • Reduced unplanned emergency admissions • Reduced number of …. • CYP and family feedback positive score (? Develop a PROM) • Reduce travel time for family and reduce carbon footprint
3.	**Improve clinician experience by reduction in unnecessary administrative processing**	1. Use RPA to improve clinical processes and release time to care 2. Use RPA to reduce transaction processing in admin teams and release headcount to repurpose fund 3. Use RPA to improve safety through automated documentation of key alerts	• Reduce time in minutes to process clinical task • Reduce time in minutes to process admin task • Reduce time for communication of key alerts between systems / teams

During July we will refine these projects, ensure they are adding to and aligned to our breakthrough objectives, testing for any overlap and duplication and also whether the scale of the whole programme remains focussed and achievable. The Programme will be overseen by a weekly Strategic Executive Meeting.

5.0 Financial Plan

As a result of the COVID 19 pandemic, in March 2020, the national 20/21 operational and financial planning process was suspended and an interim COVID-19 finance regime, Phase 1, was put in place, primarily to provide stability and also to ensure that organisations focused on responding to the COVID 19 emergency. During this phase, the payment system has been redesigned with a move away from a tariff based payment system (PBR) to a fixed block payment. The Trust has been paid a fixed level of income based on 19/20 activity levels with no growth, no expectation to deliver efficiencies (CIP), and with a retrospective top up payment for any excess costs or COVID 19 expenditure, resulting in a reported breakeven position.

As we are now approaching the end of Phase 1 and also moving away from COVID 19 emergency to delivering COVID recovery, NHSI/E are reviewing the framework in place and although not yet confirmed, have started to outline the anticipated changes to be put in place for Phase 2 from 1st August to 31st October. The expectations are that it will be a continuation of a block/fixed income at similar levels to 19/20, but with a bigger emphasis on financial grip and restraint and a focus on working as a system to achieve financial balance.

What does it mean for Alder Hey?

Alder Hey`s Overarching 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 2024.

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 to invest 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 is a trading deficit; £1.6m deficit in 19/20, increasing to £4m deficit in 20/21. 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 that is expected, 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.
Table 1: Alder Hey underlying financial position:

	17/18 £m	18/19 £m	19/20 £m	TB Approved Plan 20/21 £m
Reported Position Surplus/(Deficit)	1.20	4.40	1.60	**(4.10)**
Remove PSF/STF	(4.40)	(6.20)	(3.30)	0.00
Alder Hey Underlying Position Surplus/(Deficit)	**(3.20)**	**(1.80)**	**(1.70)**	**(4.10)**
CIP included in Plan	7.60	6.90	6.00	4.00
As a %	*3%*	*3%*	*2%*	*1.5%*

The 20/21 plan approved by the Board in April of £4.1m deficit, includes assumed delivery of £4m CIP by the end of March 2021. Although CIP has been paused during COVID, we now need to undertake a review of the schemes already identified and assess what can still be delivered so to not deteriorate the financial plan. The plan was approved by the Board on the basis that we continue to lobby NHSi to ensure we receive an appropriate tariff for complex children's services. This work is ongoing and forms a large part of our underlying financial position.

The expected 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, maximising innovation and transformation opportunities and also leveraging non NHS income opportunities.

Our New Financial Approach: Managing The Alder Hey £

The new approach will consist of 4 key components:

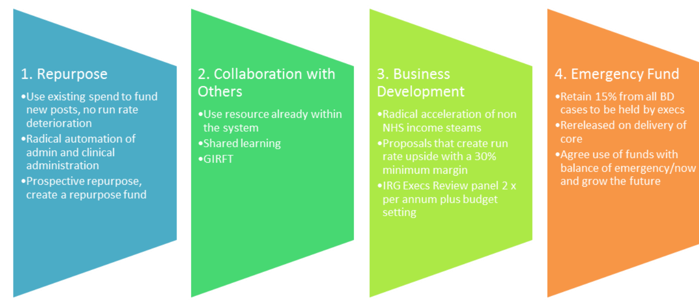
1. **Inclusive Financial Stewardship:**
    - A more collective approach embedded with ownership of money and accountability to drive continuous improvement.

2. **Organisational Excellence:**
    - Devolved accountability for local decision making, making things happen, with a very clear set of parameters on success and failure and clear escalation process. A performance framework focused on improvement of run rate.

3. **Investment Strategy:**
    - A new approach to funding investments which utilises existing funds along with maximising on non NHS income opportunity to allow reinvestment into core services and strategy.
4. **System Working:**
    - A move towards a C&M and North West resource envelope to deliver a paediatric population health approach, which improves outcomes and keeps CYP safe.

What will be different – a 5 point plan

1. A **new addendum** to be made to Trust SFI`s recognising the post COVID framework and changes required
2. A new **code of practice issued to all budget holders** outlining the new regime and expectations around responsibilities, this will be signed by all budget holders
3. A **`toolbox`** put in place to aid with the new way of working. Toolbox to include:
    - Intelligent reporting
    - New set of processes to support agile/quick decision making
    - Mechanism to track benefits for all investments and service changes
    - Clear communication to all employees on the Alder Hey £
4. A drive for **counting and reporting on waste**, applying the Getting it Right First Time to all services with an agreed set of KPIs reported to RABD monthly be each division.
5. A new **investment strategy** with a clear focus on retraction and repurpose, driving better value from the Alder Hey £.



To achieve the ambitions set out in `Our plan` there is going to be a need to invest in services and with a fixed funding envelope, to do this will involve a clear retraction of spend and to repurpose this spend into the investment areas.

]We will make an agreed commitment to retract and reduce spend in the following areas, and an agreed measure, signed off by the Trust Board will be set against them.

- Corporate overhead
- Manual & transaction processing
- Paper
- Rationalisation of the Alder Hey estate
- Premium temporary spend

Whilst we await the formal financial guidance, it seems inevitable that we are moving towards this new NHS finance regime, and if we don't signal a significant shift in managing resources, we will jeopardise our ability to invest in delivering our strategic direction as outlined in `Our Plan`. It is essential that the Board have received the scenarios to present the potential impact on cash and capital of the new regime. On this basis the Executive team will focus on a series of work streams as outlined which will come back through RABD and Trust Board as the operational plan is finalised.

7.0 Key Risks

To support this revised plan a COVID risk register has been developed which is overseen weekly through the Operational Board and monthly at Trust Board. These risks which have evolved as the pandemic has progressed, have fed into a revised Board Assurance Framework and has significantly changed the organisation's risk profile. This strategic COVID risk register has highlighted the following primary risks:

- Risk of patient harm due to delays in treatment and potentially not presenting for treatment:
- Uncertain system environment including, finance, commissioning changes, ICS/Cell etc.
- Increased risk to staff welfare (short and long term, including staff absence, BAME, PTSD etc.
- Risk of infection to CYP, families and our staff.
- Cyber Security threat.

The Trust Board will continue to have oversight of these risks ensuring appropriate mitigations are in place. The risks will be further updated as national guidance emerges as some of our most significant risks relate to the wider system and the future funding arrangements.

8.0 Governance arrangements

The Trust Board approved revised governance arrangements as the COVID incident took hold which was centred on maintaining oversight of delivery and safe care whilst at the same time freeing up time to deal with the situation. This was supported by National Guidance from our regulators which removed certain mandated activities to reduce the burden.

We have continued to work in a more agile governance environment providing detailed updates through Trust Board, having more regular and adapted corporate and risk reporting and through weekly briefing of NEDs by the CEO. As we move into recovery phase we plan to build on this agile governance based upon the following principles:

- Reflects and supports our post Covid-19 plans
- Enabling but safe – maintaining the reduced burden
- 'Form follows function' – risk based approach
- Measure what matters: high level KPI's
- Better alignment with information flows/data driven
- Greater Divisional focus
- Improved accessibility for governors to committees for transparency

Our Director of Corporate Affairs is leading on a review of our governance arrangements to ensure they are fit for purpose. Some of the scope and objectives of this review are:

- Safe re-start requires robust governance and decision-making
- Respond to the emerging NHS landscape
- New organisational shape/revised Plan
- Post COVID ways of working with assurance to reflect this
- Keep pace with DHSC requirements of Boards
- Effective use of management time eg via digital tools
- Opportunity to address issues raised in Well Led reviews e.g. timeliness of information
- Opportunity for NEDs to revisit committee work and agree optimum 'fit'.

The proposed governance arrangements are being discussed at the July Board and can be updated accordingly. The management arrangements for oversight of this plan will be tracked through a weekly Strategic Executive Meeting chaired by the CEO/Deputy CEO. This will oversee the transformational programme and wider progress strategically against 'Our Plan'.

Operational delivery will be overseen by a weekly Operational Board Chaired by the COO. Both the Strategic Executive meeting and the Operational Board have senior Divisional representation as it is key that we continue of our journey of Divisional empowerment and ownership.

As described above, our risk management processes have been developed to meet the needs of the context within which we are operating. There is a proposal that the Board is considering to form an Audit & Risk Committee which will oversee strategic risks with the

Operational and corporate risk reviews being embedded in the Operational Board. The Board will need to keep its overall risk appetite under review as the risk profile linked to the pre-COVID version of 'Our Plan' evolves as set out above.

We have also enhanced and adapted our performance reporting which now includes a daily COVID Sit Rep report, sub Sit Rep reports for key areas such as PPE availability and staffing, a weekly dashboard that is reviewed at Operational Board and by NEDs, and a monthly corporate report that the sub-committees and trust Board receive. We will continue to adapt our reporting arrangements as we progress through the recovery phase aligned to the risks we are managing.

8.0 Next Steps

The Board are asked to:

- Note and discuss the draft Operational plan from July 2020 to March 2021
- Note that the national guidance for phase 3 is yet to be released and that the plan will need to be refined as that is developed
- Note that the associated Financial Plan for the year will also need to be refined once National Guidance released
- Discuss approach to reviewing a final plan late July/early August

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD
7th July 2020

Paper Title:	COVID 19 Risk Register
Report of:	John Grinnell, Deputy Chief Executive/Director of Finance
Paper Prepared by:	Cathy Umbers, Associated Director of Nursing and Governance

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

1. Purpose of the report

The report is presented to the board, to provide assurance of the effective management of COVID 19 operational risks, is in line with national guidance.

2. Summary.

There are currently **42** risks identified on the COVID 19 risk register, compared to **32** identified in the previous report (2nd June 2020).

Appendix 2 shows the current COVID 19 risk profile for this reporting period compared to previous reporting period. Appendix 3 shows the current risk heat map (evaluation of impact x likelihood for risks identified).

There are **7** high risks identified on the register (16.66%), compared to **6** during the previous reporting period. Of the **7** high risks identified, **2** remain at a risk rating of **20** (risk 20178 & risk 2182), the other 5 show a risk rating of 15 **(**risk 2143, risk 2180, risk 2201, risk 1560, risk 2213). Risk 1560 and risk 2213 have recently been added to the COVID risk register, although not new risks, as both were previously identified on the Trust register. However the impact of COVID has seen these risks increase from high moderate (12) to high (15), therefore they has been transferred to the COVID register.

The majority of the risks identified on the register are in the moderate risk category i.e. 26 (61.9%); this is an increase of 6 since the last reporting period. The register shows **4** identified high moderate risks (12), compared to **2** in the last reporting period. Risk 2181 was a high risk (15) during the last reporting period and has since been reduced to 12. In addition, a new high moderate was recently added, risk 2215.

The overview at appendix 3 shows the high and high moderate risk's, including progress with actions and trends. Although there is evidence of actions for all the risks identified, there is slow progress in mitigating most of the risks as identified in the trends. However in some cases mitigations are dependent on external forces, including ongoing developments around the pandemic and in these cases there is certain limitations in what can be achieved to mitigate. In addition, **9** risks were closed during this reporting period (refer to appendix 4).

3. Themes

The primary themes identified on the COVID 19 register are as follows.

Risk of patient harm due to delays in treatment and potentially not presenting for treatment:

There are **3** high COVID 19 related risks within this theme. Firstly a risk around delays in accessing services and the potential short and long term impact this could have on patient safety. *"Risk of not seeing C&YP who need treatment and the associated risk of late or no presentation and associated potential for harm*.(2178).* This is one of two highest scoring risks on the register and remains at a score of 20. There has been progress with action, but this has not yet mitigated the risk.

As highlighted in the previous report the Trust has identified an issue around increased waiting times due to COVID 19 and continues work to enable identification of the specific risks and the profile of those risks. The current risks include, **2** of the other high risks on the register "*Delay in imaging and subsequent delay in treatment*" (risk - 2143), currently scoring 15 , *Risk of patients breaching 18 weeks referral to treatment target (CHAMS) (risk 1560),* currently scoring 15.

A new identified risk currently scoring 9 relates to "Risk *of delay in access to Theatre will result in suboptimal outcome for children and Young people*" (Risk – 2228),

Uncertain system environment including, finance, commissioning changes, ICS/Cell etc.

One of the two highest scoring risks (20) on the COVID 19 register relates to "*Risk of Insufficient financial resource to meet demand". (2182).* As highlighted in previous report, this risk cuts across many of the 'business as usual' risks identified on the Trust risk register, with the potential to increase the level of many of these risks, although this has not been identified so far on operational risk registers

Increased risk to staff welfare (short and long term, including staff absence, BAME, PTSED etc.

There is currently **1** specific risk in this category ""*Risk of short and long term negative effect on staff mental wellbeing",* which was a high risk (15) in the previous reporting period, but as the result of progress with actions to mitigate, this risk has been reduced to high moderate (12). The plan is to identify if there are additional risks within this category, via risk assessments, and this work is currently progressing.

Risk of infection to CYP, families and our staff.

This is clearly a central theme across the COVID 19 risk register. A high risk continues to relate to Personal Protective Equipment (PPE). Although the primary PPE risk *"Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained" remains high (15), risk,* it has continued to be managed effectively in 'real time' to keep both patients and staff safe ", despite some dependency on external forces and the challenges this has presented. The update cited at appendix 3, page 8, outlines progress with actions and ongoing mitigation plans to keep patients staff and visitors safe. The current situation in relation to PPE stocks shows no instances where stockholdings are critically low. The only area that has been a concern is FFP3 Face Masks, but due to the contingency arrangements put in place by introducing 'Powered Respirator Hoods' in Theatres, coupled with the relaxation in guidance related to when FFP3 Masks are required to be used, the risk is currently being mitigated. The Supplies and Innovation Group will continue to monitor progress in relation to the supply and control of PPE stocks and will also review and update the PPE Predictor on a weekly basis to ensure that the return to business as usual activities will be safely and effectively managed.

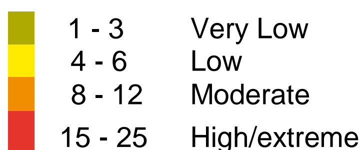
A further theme identified in this category is related to risk of staff contracting COVID 19, due to social distancing issues. The highest risk identified is on the cardiology ward (1c) currently scoring 15 (risk 2201) and serving catering staff, currently scoring 12 (risk – 2142). In addition, there is a new risk identified on the register (Risk – 2215), which is a Trust wide risk currently scoring 12; the plan to mitigate is outline at appendix 3; with a focus on COVID secure risk assessments.

Cyber Security

Risk 2213 "*Risk of Increased exposure to a cyber attack / cyber security incident - which could result in data confidentiality, integrity and availability being compromised*" increased from 12 to 15 during this reporting period. This is not a new risk, but has been added to the COVID 19 register because of the increased risk caused by COVID.

Appendix 1: COVID 19 Risk Register Heat Map

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	0 Risks (5)	6 risks (10)	4 risks (15)	1 risk (20)	0 risks (25)
4 Major	1 risks (4)	0 risks (8)	4 risks (12)	0 risks 16	1 risks (20)
3 Moderate	0 risks (3)	3 risks (6)	12 risks (9)	0 risks (12)	1 risks (15)
2 Minor	0 risks (2)	0 risks (4)	0 risks (6)	9 risks (8)	0 risks (10)
1 Negligible	0 risks(1)	0 risks (2)	0 risks (3)	1 risks (4)	0 risks (5)



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

Appendix 2: COVID Risk Register Profile

1st July 2020 (Total 42)

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**	**1**	**1**	**3**	**5**	**12**	**5**	**4**	**5**	**0**	**2**	**0**	**4**
0 (0%)			**5 (11.9%)**			**26 (61.9%)**				**7(16.66%)**				**4(9.52%)**

28th May 2020 (Total 32)

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**	**3**	**0**	**11**	**6**	**2**	**4**	**0**	**2**	**0**	**3**
0 (0%)			**3 (9.37%)**			**20 (62.5%)**				**6 (18.75%)**				**3(9.37%)**

Appendix 3. SUMMARY COVID 19 RISK REGISTER (20 high – 12 high moderate)

Key	Medical Division		Surgical Division		Community and Mental Health Division		Research Division		Corporate function(s)	

Strategic Objective	CQC Domain	Ulysses Ref.	Risk Description	Current Risk Score CxL	Trend	Target Risk Score CXL	Action plan	Progress update	Risk Owner	Governance
Delivery of Outstanding Care	Safe	2178	Risk of late or no presentation of C&YP who need treatment.	5x4 = 20	⇔	3x3 = 9	Action plan in place	Trust continues to maintain social distancing for staff and families. All visiting parents, outpatient appointments and staff are required to wear a face mask. Staff in office environments required to wear a mask since 15/06/2020. The Environment group continues to maximise use of space available to ensure restoration of services can be delivered within COVID 19 guidelines. This is includes safe distances in waiting areas, ED department and clinical areas. A project group has been established to ensure ED can meet future demand including implementing a virtual ED offer and a proposal to expand the size of ED department. Harms associated with any late presentations to be captured the usual way	Director of Strategy	CQAC

								through Trust's Ulysses system. Safety exec leads progressing an additional approach to capturing intelligence of any further late presentations (i.e. those that may have an impact on C&YP outcomes, but that were not within the Trust's ability to influence directly) Risk reviewed in light of slight lessening of lockdown (i.e. outdoor groups of 6 and small 'bubble's) - rating remains the same given subsequent activity data (i.e. whilst some increase in ED attendance, there remains no significant increase in volumes of referrals overall) Contact made with all relevant AH staff to join the paediatric 111 offer; coordination via C&M Paed. Network, and nationally via 111. Update 26/06/2020		
The Best people doing their best work	Well - Led	2182	Risk of Insufficient financial resource to meet demand	4X5 = 20	⇔	3x3 = 9	Action plan in place	The current financial model as per NHSI/E is in place up to the end of July. Expecting new guidance for financial architecture and framework to be put in place for Phase 2 (up to	Deputy CEO/ Director of Finance	RABD

								end of October). Uncertainty remains on what will be included and what levels of resource restraint will be applied and what activity levels 3X5will be expected to deliver. Existing Set of Controls – still within phase 1 framework with agreement to reimburse costs by NHSI		
Delivery of Outstanding Care	Safe	2213	Risk of Increased exposure to a cyber-attack / cyber security incident - which could result in data confidentiality, integrity and availability being compromised.	5x3 =15	↑	4x2 = 8	Action plan in place	A robust series of phishing campaigns to get data on how our users would respond to an email containing threats. this will allow us to identify gaps in training but also solutions to ensure our systems are as robust as possible, Scope technical solutions to allow a more sophisticated blocking mechanism for online access, e.g. conditional access. Implement SCCM for patch management. Review manual updates to see which systems can be moved to automated patching.	Chief Digital Officer	RABD
Delivery of Outstanding Care	Safe	1560	Risk of patients breaching 18 weeks referral to treatment target (CHAMS) – 50% of children waiting	3x5 = 15	↑	3x1 = 3	Action plan in place	Single-session therapy and VIG intervention for families on the waiting list (research suggests that 40% of those who access these short-term	Director of Community and Mental Health	CQAC

			more than 18 weeks					interventions can be discharged rather than going on for further treatment) Increase partnership capacity by reducing non-clinical time and reducing demand for specific work Demand and capacity modelling to be undertaken for service; to review waiting time improvement plan and trajectory, taking into account likely increase in demand due to covid-19. Report to board 7th July 20202. Increased group interventions - 7 x groups currently available to CYP and parents/carers; will increase to 10 x groups by the end of June 2020.		
Delivery of Outstanding Care	Safe	2143	. Delay in imaging and subsequent delay in treatment.	5x3 =15	⇔	5x1 = 5	Action plan in place	Linking in with all specialties to understand their demand and backlogs. Linking in with the Cheshire and Mersey Imaging Network to scope out help if needed.	Medical Division Director	CQAC
The Best people doing their best work	Safe	2180	Risk of not securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained	5X3 = 15	⇔	2x3 = 6	Action plan in place	Review of PPE Inventory Levels and reporting based on a RAG rating system Updates on sourcing successes and	Chief Operating Officer	CQAC

								Identification of areas of concern in relation to products in short supply Working with the Innovation Team, an “Alternatives” workstream, whereby novel solutions are explored. The potential creation of a Cheshire & Merseyside PPE Manufacturing Hub, led by Alder Hey, working with a local supplier based on the Wirral Use of an App created by the Business Intelligence Team which will be used for daily stocktakes in the Wards to enable greater transparency in relation to stockholdings and usage (burn rates) The use of reusable products (Hoods, Gowns, etc.) will assist in easing the current PPE supply shortages A forward looking PPE Predictor which sets out the increasing PPE requirements as business as usual activities are gradually reintroduced Clinical Product Review		

								Group is being set up to enable rapid review of product samples and certifications Dr. Iain Hennessey is the designated Clinical Lead for the Supplies and Innovation workstream The Supplies and Innovation workstream is one strand of an overarching PPE Programme Board which includes other workstreams i.e. Fit Testing, Capacity & Demand, Clinical Standards, Education & Communication		
Delivery of outstanding care	Safe	2201	Risk of staff contracting COVID 19. (ward 1 c – cardiology)	5X3 = 15	⇔	5X1 = 5	Action plan in place	Initial risk assessment undertaken of work environment. In depth risk assessment planned and assessment of all ward areas (COVID secure)	Head of Nursing Critical Care and Cardiac Surgery	CQAC & WOD
Delivery of outstanding care	Well Lead	2181	Increased risk to staff mental health and emotional wellbeing	4x3 = 12	↓	3x2 = 6	Action plan in place	Additional training for managers via teams immediate counselling service in place to support staff National and local guidelines available via COVID 19 hub. Daily Trust briefs continue. Weekly staff support meeting continues Associate Director OD &	Associate Director OD & CP	WOD

								CP Linking with regional group looking at trauma model including trauma measures and surveys		
Delivery of outstanding Care	Safe	2138	Risk that compliance with national nursing standards for safe staffing levels will not be met	4x3 = 12	⇔	3x2 =6	Action plan in place	Almost all staff required to be redeployed have now returned to their substantive roles at time of reporting. The weekly review of nursing models continues. Safer Staffing Huddles operational and working well with high level of engagement from senior nurses. Rota Hub to co-ordinate the issue of rotas weekly in collaboration with the Ward Managers who own their rota. Staff who would be potentially redeployed will have a clear "stand by" rota	Acting Chief Nurse	WOD
The Best people doing their best work	Safe	2142	Risk that staff contracting COVID 19. (catering staff)	4x3 =12	⇔	3x2 = 6	Action plan in place	Contingency plans progressing to mitigate risk	Facilities Manager	WOD
The Best people doing their best work	Safe		Risk of staff contracting COVID 19 virus Trust wide	4x3 = 12	**new**	4x1 4	Action plan in place	COVID secure risk assessment timetable plan in place. Risk assessments to be completed July/August. Communication to go out to all staff to enable forward planning and preparation. Following completion of risk assessment develop	Associate DIPC	WOD

								action plan outlining actions for staff to achieve and maintain COVID secure status. Monitor via Health and Safety Committee and IPCC Development of COVID-secure guidelines in line with national guidance – now ready for ratification. To develop poster to identify areas that are COVID secure - Stating “this area is COVID secure".		

Appendix 4. Closed risks

Risk reference	Risk description	Target
2124	Risk of insufficient transport media to test COVID samples	4x1 = 4
2133	Risk to Sustainability of CAMHS Services (Dewi Jones Unit and CAMHS Crisis Care)	4x1 = 4
2148	Temporary closure of the EDU	1x1 = 1
2158	Unable to access regular theatre lists to undertake diagnostic and therapeutic endoscopy (reduced theatre capacity due to COVID-19 except for 'urgent' patients)	3x1 = 3
2163	Risk of insufficient scrubs being available for all staff that need to wear them	3X1 = 3
2179	Risk to ability to cope with the increasing demands of COVID testing, leading to delays in sample processing and results delays.	3x1 = 3
2208	Risk of Covid 19 confirmed, suspected, general anaesthetic or emergency patients unable to be scanned	4x1 = 4
2144	Inability to adequately protect staff and public the consequence of which is spreading the virus (ED)	3X1 = 3
2151	Health and Safety risk to staff due to COVID 19	4 X 1 = 4

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th July 2020

Report of:	Chief Nurse
Paper Prepared By:	Acting Chief Nurse
Subject/Title:	Nursing Workforce Report
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Hard Truths: The Journey to Putting Patients First: Department of Health, 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Safe staffing for nursing in adult inpatient wards in acute hospitals: National Institute for Clinical Excellence July 2014 • Safer Staffing: A Guide to Care Contact Time: NHS England 2014 • Single Oversight Framework: NHS Improvement September 2016 • Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals: Department of Health and Social Care, February 2016 • Standards of Proficiency for Registered Nurses: Nursing and Midwifery Council, May 2018 • Supporting Nurses, Midwives and Nursing Associates (England) in the event of a COVID-19 epidemic in the UK, March 2020
Purpose of Paper:	This paper provides the required assurance that Alder Hey Children's Hospital has safe nurse staffing levels across all in-patient and day case wards and appropriate systems in place to manage the demand for nursing staff To inform the Trust Board of proposed workforce improvements in 2020/21
Action/Decision Required:	The Trust Board is asked to note:

	• The content of the report and assurance that appropriate information is being provided to meet national and local requirements • The information on safe staffing and the impact on quality of care
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	

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1. EXECUTIVE SUMMARY

The aim of this paper is to provide assurance to the Trust Board of Directors that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff.

Since the previous annual Nurse Staffing Board report for 2018/19, the senior nursing leadership team have continued to work on the recommendations that were agreed. This report contains an updated position with regard to the nursing workforce and makes further recommendations for continued improvement.

The recruitment action plan has continued in order to maintain safe staffing levels. Alder Hey has demonstrated continued success in this highly competitive regional and national market, and the attrition rate of nurses offered employment at Alder Hey has reduced from 30-35% to 23%. However the number of newly qualified nurses available to be recruited has reduced, and is understood to relate to a decreased number of nursing students completing their nurse training. As such, the Trust supported and approved an international nurse recruitment campaign which proved highly successful. As such, in the last financial year of 2019/20, 100.5 WTE Band 5 Registered Nurses have been recruited through local, national and international campaigns. In addition, the Trust has successfully externally recruited to key senior nursing leadership posts: Associate Chief Nurse for Community Division, and a new role of Matron for Research; and internal partnership recruitment to the Head of Neonatal nursing and Matron for Neonates.

The senior nursing team have worked closely with the Finance team to devise a more exact nurse availability predictor tool in order to more accurately predict staffing pressures and vacancies. There were 18 staff in the Pool at March 2020 although with continuing high levels of maternity leave and sickness, there is no additional resilience in the Nurse Pool. However 23 WTE Band 5 nurses were successfully recruited and commenced in the Trust in April 2020 and 40 WTE were successfully recruited in June 2020 and will commence in post by September 2020. The average number of front line staff leaving the organisation remains consistent at 5.6 WTE.

To assist with winter pressures and ensure bed availability for sick children admitted through the Emergency Department, 4 additional beds were open on Ward 3C, 4 additional beds on Ward 4B, and 3 additional beds in EDU from October 2019 in line with the Winter Plan.

An audit against the RCN standards was repeated as part of ward establishment reviews which although has not changed the overall RAG rated position from 2018/19 (14 standards fully compliant; 2 standards partial compliance) has demonstrated further improvement.

The Trust's mandated monthly submission of staffing levels to NHS website presented was consistently higher than 90% throughout the year against the nationally accepted level of 90%. However significant frontline staffing pressures were experienced on Ward 4A resulting in the closure of 4 beds for 2 weeks in October-November 2019. The causes were multi factorial and due to an accumulative effect of staff leavers in September and October, high maternity and sick leave, locally supported secondments to other roles in the Trust, and fewer new staff commencing in post in line with higher attrition rates during nurse training. The risk (risk 1904 initially rated 16; now closed) was escalated to the executive team and appropriate short term mitigation and long term action was put in place to re-open the closed beds in a safe and timely manner.

Towards the end of 2019/20, the consequences and impact of the Covid-19 pandemic became apparent. In response to the national crisis, a temporary model of nursing was devised for the Trust in March 2019 for the emergency period. The staffing guidelines devised at the time of the crisis (Amber and Red staffing levels) were for that point in time and have since been stood down back to the usual Green staffing levels in line with national guidance. It is important to note that at no time

during the Covid crisis period were either the Amber or Red staffing levels invoked and staffing remained at Green and in line with national standards at all times.

A significant training and redeployment process was established and implemented in recognition of the anticipated spike in patients requiring critical care and up to 20% staff absence for Covid related reasons. Staff from across the Trust, came together and worked collaboratively to set up and implement a successful process which saw a large number of staff trained and available to be redeployed to critical care, wards and as health care support workers.

2. NATIONAL CONTEXT AND REGULATION

There are a number of tools available to determine safe staffing levels. The tools currently used at Alder Hey are Royal College of Nursing standards, nurse to patient ratio, skill mix review, patient acuity, Safer Nursing Care Tool, professional judgement and triangulation with nurse sensitive indicators.

Specific guidance for safe staffing levels in neonatal and paediatric settings is set in the main by the Royal College of Nursing (2013). An audit of the Trust's compliance against the 16 core standards conducted between Q2 to Q4 of 2019/20 can be found in section 4.3, with the Trust fully compliant with 14 standards and partially compliant with 2 standards. Although this is the same position as reported in 2018/19, there have been improvements within Green and Amber standards as highlighted in section 4.3.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine lay out standards for care of neonates (BAPM, 2011).

In November 2017, the National Quality Board (NQB) published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care. The improvement resources are based on the NQB's expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time. The Trust undertook an annual review of the majority of ward establishments during Q2 to Q4 of 2019/20. Due to a high number of Business Continuity Incidents during the summer of 2019, during which establishment reviews are routinely scheduled, a number were rearranged to be undertaken following winter pressures, however the advent of the Covid-19 pandemic unfortunately resulted in the reviews being postponed. The results of the 2019/20 review are detailed in section 4.1 and 4.3. Reviews not undertaken in 2019/20 will be prioritised for 2020/21, with all other reviews also being repeated.

In line with Department of Health Hard Truths Commitments (2013), all Trusts are required to submit monthly staffing data. The Trust is compliant with submitting data to the public through NHS website and on the Alder Hey website (Section 4.2 and Appendix 1)

In 2000, the Department of Health proposed that every hospital should have Matrons who are accountable for a group of wards and are easily identifiable to patients, in order to improve the delivery of patient care and patient experience, and to provide strong clinical leadership and authority at ward and departmental level. In 2019, a new role for a Research Matron was established and appointed to in order to strengthen the nursing leadership in the Research Division. Senior nursing roles were also established as part of the neonatal single service with LWH, and a Head of Neonatal Nursing and Matron for Neonatal Nursing were successfully appointed to working across both sites and providing key clinical leadership and expertise.

The Nursing and Midwifery Council (NMC) implemented Nurse Revalidation from April 2016, which requires all registered nurses to revalidate every 3 years to maintain their professional registration.

The purpose of revalidation is to improve public protection ensuring nurses remain fit to practise throughout their careers. To date, all registered nurses due to revalidate have done so successfully.

The RCN's Principles of Nursing Practice states that 'Nurses and nursing staff must have up to date knowledge and skills and use these with intelligence, insight and understanding in line with the needs of each individual in their care'. In May 2018, the Nursing and Midwifery Council (NMC) launched new standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. The Standards of Proficiency for Registered Nurses represents the skills, knowledge and attributes all nurses must demonstrate. Practice Educators play an essential role in the development of a workforce that is able to deliver high quality, effective and safe care. The clinical education team, expanded in 2018/19, has proved invaluable in supporting students, new registered nurses and existing staff with support and education throughout the year and more recently as part of the Trust response to the Covid-19 pandemic, providing induction to new staff and PPE training throughout the Trust.

In July 2017, the Cheshire and Mersey (CM) Director's of Nursing presented a paper entitled 'Maximising the Collective Impact of Nurse Directors and Nursing within Cheshire and Merseyside' to the Local Workforce Advisory Board to consider and support a proposed programme of work to address some critical nursing workforce issues within CM. The intention and scope of the programme is designed to mobilise and maximise nursing leadership across CM and provide a platform for action which should align and deliver outcomes which will help support the ambitions of the CM STP and directly impact on the attraction and retention of a talented nursing workforce and safeguard future supply. The original five areas of focus have been consolidated into two workstreams focusing on recruitment and retention, and education. The Chief Nurse, Director of Nursing and Deputy Director of Nursing have been actively involved in this project.

Towards the end of 2019/20, the consequences and impact of the Covid-19 pandemic became apparent and as such a multitude of associated new national guidance has been set out since then. In a letter sent out in March 2020, the Chief Nurse (CNO) for England recognised that the pandemic would require temporary changes to practice, requiring health and care professionals to be flexible, working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole whilst practicing in line with the NMC code and using judgement in applying the principles to situations that you may face, and using professional judgement to assess risk and to make sure people receive safe care. The CNO acknowledged this included a rational approach to varying practice in an emergency as part of that professional response. In response to the national crisis, a temporary model of nursing was devised for the Trust in March 2019 for the emergency period. The staffing guidelines devised at the time of the crisis (Amber and Red staffing levels) were for that point in time and have since been stood down back to the usual Green staffing levels in line with national guidance. It is important to note that at no time during the Covid crisis period were either the Amber or Red staffing levels invoked and staffing remained at Green and in line with national standards at all times. The Director of Nursing worked in collaboration locally with the Ward Managers, Matrons and Associate Chief Nurses; and at regional and national level with the Association of Chief Children's Nurses, the RCN and the C&M Director's of Nursing in order to ensure safe staffing levels were set to cope with the Covid crisis. The risk was recorded on the Risk Register (risk 2138) and has subsequently been closed. The Covid staffing plan devised for the emergency period can be found in Appendix 8.

3. SUMMARY OF ACHIEVEMENTS

The overall impact of the success of the recruitment, reduction in vacancies and other developments to support safe nurse staffing is as follows:

3.1: Recruitment

i. 100.5 WTE front line nursing staff recruited in 2019/20.
ii. 1 WTE Nurse Associate graduated and appointed in the last 12 months following internal support.
iii. The development of a responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days and a comprehensive induction and preceptorship programme for new nursing staff.
iv. Successful international recruitment programme with 105 nurses given conditional offers for over a period of 18 months in line with the nurse predictor tool. 25 nurses have successfully commenced employment at Alder Hey in February 2020.

3.2: Safe staffing levels

i. Staffing levels consistently higher than 90% throughout the year although adjustments to bed availability was required on Ward 4A in order to maintain safe staffing levels as reported in section xxx.
ii. Safer Staffing Huddle implemented.
iii. Covid-19 staffing plan set out for the emergency covid period as reported in section 5.9.

3.3: Strong and effective leadership structure

i. External recruitment to the new Research Matron in the Research Division.
ii. External recruitment to the Associate Chief Nurse for Community Head following retirement of the previous post holder.
iii. Internal partnership recruitment to the Head of Neonatal Nursing and Matron for Neonates.
iv. Internal promotion to Band 6 Ward Sister / Charge Nurse positions.
v. Safer Staffing Huddle Chaired by a senior nurse
vi. Senior nurse oversight and involvement at all stages of the redeployment process due to Covid-19 pandemic.

3.4: Educational developments

i. Continued to support senior nurses and aspiring nurse leaders to undertake the MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles. Maintained and supported 3 senior nurses per year to participate.
ii. The establishment of a nurse education team, led by the Head of Nurse Education, including 3 Practice Education facilitators and 21 clinical practice educators continues to address organisational education requirements and provides a streamlined approach to a wide variety of staff development opportunities.
iii. The ongoing opportunity of a Staff Nurse Rotation programme for all newly qualified nurses: Facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields.
iv. Maintained and recruited to the increased number of places of trainee Advanced Nurse Practitioners to enhance nursing practice and assist in the reduction of Junior Doctors.
v. We continue support of trainee nurse associates to meet the workforce need, and offer a development opportunity for our healthcare support worker workforce.
vi. In response to the Covid-19 pandemic, in March 2019 a significant training and redeployment process was set up by staff from across the Trust to address anticipated staffing challenges. This saw a large number of staff trained and available to be redeployed:
    a. Critical care orientation training: 246
    b. Ward orientation training: 121
    c. HCA orientation training: 112

3.5: Quality metrics

i. Implementation of the Perfect Ward quality audit tool across all wards. Further work underway to expand audits more widely within the Community Division. Collaborative work between Perfect Ward company and the Ward Managers, Matrons and senior nurses in setting the metrics appropriately for Alder Hey.
ii. With the support and expertise of the IT team and the Communication team, we have improved the electronic safety screens outside all wards to include public facing information regarding cleanliness scores, hand hygiene compliance, medication errors, and complaints.
iii. Collaborative working with the IT team and Pharmacy to roll out Bedside Medication Verification to enhance and improve the safety of medicines administration.
iv. Collaborative working with the Research Team, IT and ward teams to commence the DETECT study.

4. HOSPITAL NURSE STAFFING MODEL

4.1: Ward establishments

The staffing model is fundamentally based on achieving compliance with the national requirements as described in section 2. A review of the majority of ward establishments (10 of 16) was undertaken in Q2-Q4 2019/20 and will be repeated in 2020/21.

Due to a high number of Business Continuity Incidents during the summer of 2019, during which establishment reviews are routinely scheduled, a number were rearranged to be undertaken following winter pressures, however the advent of the Covid-19 pandemic unfortunately resulted in the reviews being postponed. The results of the 2019/20 review are detailed in section 4.3. Reviews not undertaken in 2019/20 will be prioritised for 2020/21, with all other reviews also being repeated.

Professional judgement regarding increasing patient acuity provided by Ward Managers, together with information from the DETECT study indicating where the sickest patients and highest numbers of sick patients outside of critical care, has been a critical factor in reviewing ward establishments.

4.2: Safer staffing levels

In line with Department of Health Hard Truths Commitments (2013), all Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level and make the information available to the public. The Trust is compliant with submitting data to the public through NHS website, the Alder Hey website, and at ward level. The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2019/20 demonstrated that the overall staffing level was consistently higher than 90% throughout the year, however in order to achieve safe staffing levels on Ward 4A this resulted in the closure of 4 beds for two weeks in October to November 2019. Where patients have required specialling due to higher acuity, the overall fill rates for Health Care Assistants will be higher than 100% (as per section 5.7).

In 2019/20 there were occasions where the average fill rate for registered nurses was 87% to 89% fill rate, and one occasion where the fill rate was 84%. The wards were supported by Matrons, Ward Managers, Clinical Educators, and additional Health Care Assistants during these times as required. The bed occupancy during those months was between 71-86%, ensuring safe quality care and appropriate nurse to patient ratios in line with national standards.

The frontline staffing pressures experienced, particularly on Ward 4A resulting in the closure of 4 beds, in October-November 2019 was multi factorial and due to an accumulative effect of staff leavers in September and October, high maternity and sick leave, locally supported secondments to other roles in the Trust, and fewer new staff commencing in post in line with higher attrition rates during nurse training. The risk (risk 1904 initially rated 16; now closed) was escalated to the executive team and appropriate short term mitigation and long term action was put in place to re-open the closed beds in a safe and timely manner. International recruitment has been an integral strategy to increase nurse recruitment numbers for the next 2 years.

Appendix 1 provides a full break down of staffing levels by ward for 2018/19.

4.3: Compliance with RCN guidelines

To continue to monitor and improve staffing levels, an audit against the RCN standards has been repeated in Q2 to Q4 2019/20 during establishment reviews involving the Ward Managers, Matrons and Associate Chief Nurses across in patient and day case wards.

4.3.1: RCN Core Standards

The thermometer below demonstrates year on year improvements against the RCN core standards since the first audit was undertaken in 2014.

July 2014	2	4	6	7	8	10	11	15	16	1	3	5	9	12	13	14
Feb 2017	2	4	6	7	8	9	10	11	12	13	15	16	1	3	5	14
Feb 2018	2	3	4	6	7	8	9	10	11	12	13	15	16	1	5	14
Mar 2019	2	3	4	5↑	6	7	8	9	10	11	12	13	15	16	1↑	14↑
Mar 2020	2	3	4	5	6	7	8	9	10	11	12↑	13↑	15	16	1	14↑

The audit last year demonstrated the Trust was Green (full compliance) with 14 standards and Amber (partial compliance) with 2 standards.

The recent audit has demonstrated a further improvement within 3 of the standards although they have remained at the same RAG rating.

Although 2 standards have remained at Amber (partially compliant), there has been significant improvement in standard 14 as detailed in Table 1 and a plan to address gaps in standard 1. Appendix 3 demonstrates improved position across two Green rated standards.

Table 1 below provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to improve compliance:

Table 1: Core standards to be applied in services providing health care for children and young people		
Standard		**Compliance**
1	The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff	**Partial**
	10 out of 15 areas have a supranumery clinical co-ordinator Gaps exist on Wards 3C, 4B (nights), Burns Unit, EDU and Medical Day Case.	

	However, all Ward Managers are supernumery; all wards benefit from presence of a supernumery Matron; and all wards benefit from the presence of a Clinical Educator introduced in Q3 2018/19. A significant number of wards benefit from a supernumery Advanced Nurse Practitioner (ANP) and / or Trainee ANP (see core standard 2) and whilst ANP's should not be counted in the bedside establishment, they provide key clinical leadership, skill, experience and knowledge that benefit the ward teams All wards allocate a nurse to take charge and co-ordinate the shift. This model requires nurses on the shift to increase the number of patients they care for to facilitate a supernumery co-ordinator, or the co-ordinator cares for patients as well as taking charge of the ward Review of this standard is a key component within the establishment reviews and ED / EDU have since submitted a business case to address	
2	Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff	**Compliant**
	Fully compliant In March 2020 in response to the Covid-19 pandemic, a significant training and redeployment process was undertaken which saw a large number of Clinical Nurse Specialists undertake training and redeployment to wards and departments. This was very successful and forms a key part of the wider Training Needs Analysis and education strategy going forward to build on the skill set and ensure a flexible workforce as required	
3	At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need	**Compliant**
	100% compliance with the Trust resuscitation policy for areas identified to have APLS or PLS trained staff on each shift	
4	There will be a minimum of 70:30 per cent registered to unregistered staff	**Compliant**
	Fully compliant. Ward 4B has a ratio of 50: 50 however that is a deliberate workforce configuration as the support staff are trained to care for children requiring long term ventilation	
5	A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave	**Compliant**
	The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE rotational Band 5 nurses achieving the full uplift and as such increasing the availability, resilience and support to the front line nursing workforce. In addition, 6 WTE nurse Clinical Educator's in post	
6	There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas	**Compliant**
	Fully compliant	
7	Nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles	**Compliant**

	Fully compliant	
8	Seventy per cent of nurses should have the specific training required for the speciality, for example, children's intensive care, children's oncology, children's neurosurgery	**Compliant**
	Fully compliant. Specialist wards have locally or regionally delivered programmes to support staff development and expertise in their field as identified in their local Training Needs Analysis	
9	Support roles should be used to ensure that registered nurses are used effectively. Support roles are defined in the standards as a minimum of the following:	**Compliant**
	Supernumery Ward Manager: Fully compliant	
	Ward receptionist / ward clerk / admin support for ward staff: Fully compliant	
	Play Specialist: Fully compliant apart from PICU however they can make a referral to the Play Specialists as required which will then be reviewed and actioned appropriately. Prior to Covid restrictions, all areas had access to the significant Arts for Health programme which includes musicians attending the wards and departments	
	Housekeeper: Fully compliant. Burns Unit access PICU / HDU housekeeper	
10	Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks	**Compliant**
	All new Health Care Assistants signed up to NHSP undertake Advanced Clinical Skills training. All HCA's on wards have assessment of competency in assigned skills. Review of Band 2 and Band 3 roles forms part of annual establishment review	
11	The number of students on a shift should not exceed that agreed with the university for individual clinical areas	**Compliant**
	Fully compliant	
12	Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels	**Compliant ↑**
	SCAMPS tool in place Workstream established pre Covid pandemic to review the tool and will now be progressed further. Workstream led by a Ward Manager	
13	Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.	**Compliant ↑**
	Ward Managers / Senior Nurses attend new daily Safer Staffing Huddle to inform of ward level patient acuity and requirement for additional staff; staffing plan is agreed, implemented and reported in to the Bed Meeting Monthly Safety Thermometer and Infection Control audit regularly conducted and ward dashboards completed. New audit called Perfect Ward introduced widely and plan to enhance further in collaboration with the senior nursing team. Ward Accreditation process embedded which incorporates all ward quality indicators.	

	In line with Hard Truths Commitments daily staffing information displayed electronically to the public via screens. Screens updated and improved with grateful thanks to the IT team	
14	Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification	**Partial ↑**
	Improved compliance to partial compliance in 2019/20 following recruitment to the Acute Care Team (ACT) to support staff 24 hours per day and respond to patients showing early signs of deterioration. Band 8a ANP posts recruited to commence in August 2020 upon which time the Trust will achieve full compliance	
15	All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day	**Compliant**
	Fully compliant. Nursing and Medical staff on call	
16	Children, young people and young adults must receive age appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs	**Compliant**
	Appropriately trained workforce and specially designed Children's Hospital Clinical educators have played a key and essential role in supporting newly qualified staff, internationally recruited staff, redeployed staff, and providing PPE training	

4.3.2: RCN Specific Guidance

Analysis has taken place to audit front line staffing against the relevant specific staffing guidance sections of the RCN guidelines not captured within the core principles.

The audit demonstrated that the Trust remains fully compliant with 2 standards and partially compliant with 2 standards, with an improved position in standard 5. Majority of wards (12 out of 15 for standard 7; 6 out of 9 for standard 8) are fully compliant in the standards rated Amber and a staffing plan is in place to mitigate any gaps as outlined in Table 2 below and Appendix 2.

The thermometer below demonstrates sustained improvements against the relevant RCN specific standards since the first audit was undertaken in 2017.

Feb 2017	5	6	7	8
Feb 2018	5	6	7	8
Mar 2019	5	6	7↑	8↑
Mar 2020	5↑	6	7	8

Table 2 below provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to mitigate and improve compliance:

Table 2: Staffing principles within "Defining staffing levels for children and young people's services"		
Section		**Compliance**
Section 5: Neonatal services	Bedside, deliverable hands-on care: Special care 1:4 nurse: infant High dependency care 1:2 nurse: infant Intensive care 1:1 nurse: infant	**Compliant ↑**
	Fully compliant. Neonates requiring intensive care are nursed on PICU, surgical and cardiac neonates requiring high dependency care are nursed on Ward 1C. Neonates on other wards are nursed 1:3 in line with standards in Section 7 below Significant work has been undertaken in line with the neonatal Single Service with LWH. Both a Head Nurse for Neonates and a Matron have been successfully appointed across the partnership. Rotation of ANPs and nursing staff in place	
Section 6: Designated children's intensive care and children's high dependency services	PICU 6.7-7.06 WTE per bed dependent upon maternity leave included in calculation Bedside, deliverable hands-on care: Level 1: HDU 1:2 nurse: child Level 2: PICU or HDU cubicle patient: 1:1 nurse: child Level 3: PICU: 1:1.5 nurse: patient Level 4: 2:1 PICU: nurse: patient (ECMO)	**Compliant**
	Current ratio now at 6.6 WTE per PICU bed compared to 6.4 WTE in 2016. HDU compliant with 4.4 WTE per bed Full nursing ECMO team established in PICU All patients are nursed as per ratios set above unless not required for example a patient who is being transferred from PICU to a ward HDU care provided on general HDU, Ward 4A and Ward 1C Cardiac all provide 1:2 care	
Section 7: General children's wards	Bedside, deliverable hands-on care: Children < 2 years of age 1:3 registered nurse: child, day and night Children > 2 years of age 1:4 registered nurse: child, day and night	**Partial**
	12 out of 15 areas fully compliant: All wards compliant except Wards 3B, 4B, 4C and EDU on night duty however additional temporary staff are sourced where acuity is high and necessitates the need to increase the night nurse to patient ratio This staffing plan continues to be monitored and evaluated and all wards have annual establishment review undertaken as per best practice guidelines.	

Section 8: Specialist children's wards	At least a third of patients on specialist wards (such as oncology, cardiac, neurosurgery) should be classed as requiring high dependency care, although in some ward areas this may be as high as 50 per cent. The relevant standards must be followed (1:2 registered nurse: child). The minimum standard for other children being 1:3 registered nurse: child	**Partial**
	6 out of 9 areas fully complaint There is a case to say that almost all of the in-patient wards at Alder Hey are specialist in nature Wards with dedicated HDU beds (Ward 1C and Ward 4A) are established for 1:2 ratio for commissioned HDU beds, and in addition Ward 4A provides 1:2 ratio for orthopaedic patients requiring a higher intensity of care Ward 3C regularly has high acuity patients requiring a HCA 1:1 and this is always supported and facilitated through temporary staffing as required Wards are not established for 1:3 ratio for remainder of patients. Achieving compliance with this standard would require significant additional financial investment	

4.4: Recruitment and Resilience

The senior nursing team have continued to undertake recruitment activities throughout 2019/20 and have recruited 100.53 WTE front line registered nurses. However there has been a reduced number of nurses available to recruit at the point of qualification as it is understood that the attrition rate occurring during nurse training has increased significantly to 30% from our main HEI's.

As such, the Trust was on track to only recruit 75 WTE nurses in 2019/20. As a result, a proposal was taken to and approved by the Trust Operational Board in October 2019 to undertake national recruitment in India. A highly successful recruitment campaign was undertaken in November 2019 and the Trust welcomed the first cohort of highly skilled and experienced nurses from India at the end of February 2020. A comprehensive induction and OSCE programme was put in place however in response to the Covid-19 pandemic, the national guidance regarding overseas nurses changed to enable the staff to join a temporary register sooner with the NMC to then work at Band 5 rather than the intended six month Band 4 period. Thirteen of the nurses are working in critical care and are progressing well with the critical care foundation programme. A further cohort of 10 nurses were expected to commence in April 2020 however this was postponed due to Covid-19 restrictive interventions.

The Trust has also supported the training of a further 2 WTE Nurse Associates.

Table 3 shows actual number of starters per quarter in 2018/19 in comparison to the previous 2 financial years.

Table 3: Front line registered nurses recruited in WTE												
Q1 2016/17			Q2 2016/17			Q3 2016/17			Q4 2016/17			Total
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
	25	5.8	6		65.6		2		5.45	12.22	2.8	124.87

Q1 2017/18			Q2 2017/18			Q3 2017/18			Q4 2017/18			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
2	22.35	2.61	2.51	1	49.67	10.15	3.92	0	5.96	3.46	1	104.63

Q1 2018/19			Q2 2018/19			Q3 2018/19			Q4 2018/19			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
4	26.21	3	1.22	0.76	4	48.53	2.22	0	1.31	0	1.39	92.64

Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
0.92	16.9	5.41	1.61	1	2	34.75	1.5	0.43	6.5	3.51	26	100.53

There has been a recognised reduction in the number of staff who have commenced employment in the Trust since 2016/17, addressed this year through international recruitment.

During 2018, the senior nurse leadership team undertook a listening event with the Universities, student nurses and newly qualified Staff Nurses in order to better understand their requirements with the aim of recruiting and retaining nursing staff. The student nurses advised us that they were not comfortable with the term of "Nurse Pool" as they did not understand what the term meant, they did not feel the term conveyed the permanence of a substantive position, and the term did not foster a feeling of being part of a team. Newly recruited Staff Nurses staff fed back that there was inconsistent preceptorship across Trust. The senior nursing leadership team also recognised that we were unable to clearly articulate our "offer".

Therefore, as a result of the review, the senior nursing leadership team identified opportunities and implemented improvements in the recruitment of registered nurses through a formalised corporate process, including a "One Stop Shop" recruitment day, incorporating a clearly articulated offer to new staff, and the development of the Staff Nurse Rotation Programme (see section 4.5 iii and section 5.1). This has now been in place for a full year and is proving successful.

The senior nursing team have worked closely with the Finance team to devise a more accurate frontline nurse availability predictor tool in order to more accurately predict staffing pressures and vacancies. There were 18 staff in the Pool at March 2020 although with continuing high levels of maternity leave and sickness, there is no additional resilience in the Nurse Pool. However 23 WTE Band 5 nurses were successfully recruited and commenced in the Trust in April 2020 and 40 WTE were successfully recruited in June 2020 and will commence in post by September 2020.

The senior nursing team have supported the opening of an additional 11 beds as part of the Winter Plan through the Staff Nurse Rotation Programme, and these were open over the winter although as previously reported there was a 2 week period where beds were closed on Ward 4A due to staffing levels.

A full break down by ward is provided in Appendix 3 and Appendix 4 provides analysis of all new starters in 2019/20 by ward.

4.5: Workforce developments in 2019/20

i. **Training and Redeployment process and RotAHub:** In response to the Covid-19 pandemic, in March 2019 a significant training and redeployment process was established and implemented in recognition of the anticipated spike in patients requiring critical care and up to 20% staff absence for Covid related reasons. Staff from across the Trust, including (but not exhaustive to) Critical Care, Finance, HR, OD, IT, DMO, Nurse Education, Divisions came together and worked collaboratively to set up and implement a successful process which saw a large number of staff trained and available to be redeployed:

   a. Critical care orientation training: 246 (104 ward staff / 108 Theatre staff / 34 Nurse Specialists)
   b. Ward orientation training: 121
   c. HCA orientation training: 112

   A RotAHub was set up to assist in the co-ordination of ward rotas.
   On behalf of the Trust, the senior nursing team would like to express their gratitude to all of the staff involved in the organisation of these processes and to all of the staff who demonstrated professionalism, commitment, flexibility and courage during the training and redeployment phase.

ii. **Safer Staffing Huddle:** A Safer Staffing Huddle has been implemented and takes place every day before the Bed Meeting. The huddle is Chaired by a senior nurse and there is representation from the Divisions. Staffing is reviewed for the day and the next 24-48 hours and a plan is put in place which is then shared at the Bed Meeting. This has resulted in shared and agreed oversight of the Trust staffing position and increased efficiency within the Bed Meeting.

iii. **Acute Care Team (ACT):** In 2018/19, a business case was devised and approved to establish an ACT team to support staff 24 hours per day in responding to patients showing early signs of deterioration. This is a significant and vital development in ensuring the safety of our patients 24 hours a day. All Band 7 and Band 6 posts have been recruited both externally and internally and have commenced in post. The Band 8A Advanced Nurse Practitioners have been recruited to and commence in post in August 2020 at which time the ACT team will be fully operational.

iv. **Senior Nurse Bleep Rota:** The implementation of the ACT team has released the Ward Managers from their previous time spent on the senior nurse bleep rota (approximately a shift every 2 weeks) enabling them to provide full time leadership and support in their ward. The Ward Managers have provided exemplary clinical and professional leadership to the Trust as part of the bleep rota for very many years and the senior leadership team wish to take this opportunity to acknowledge and thank them for providing this service.

v. **Clinical Educators:** In May 2018, the Nursing and Midwifery Council (NMC) launched new NMC standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. A business case was devised, approved and implemented to introduce and successfully recruit a Head of Nurse Education to the Trust, supported by 6 WTE ward based Clinical Educators and an additional PEF, to facilitate the advancement of nurse education in the Trust. This has had a significant impact on the provision of education, training and support to new and existing staff.

vi. **Staff Nurse Rotation Programme:** Developed in 2018 following a collaborative review involving local Higher Education Institutions, student nurses, and new Staff Nurses. The programme is a standardised approach to staff working and gaining a wider experience in

different areas of the Trust, developing their knowledge and skills, and helping to retain our valued nursing workforce. During the first year of employment at Alder Hey, the nurse is allocated to a medical or surgical ward in line with their preference. In the second year, the nurse transfers to a specialist ward. All new nurses have a standardised and protected induction and preceptorship period. The programme also incorporates a formal standardised approach to staff movement within the Trust via a Transfer Window if the nurse is not happy on the allocated ward and considering leaving the Trust. The first cohort of the new Staff Nurse Rotation Programme commenced in October 2018 and has been positively evaluated thus far. The senior nursing leadership team will continue to monitor, evaluate and refine the programme based on feedback, results and audit.

vii. **Research Matron:** In 2019, a new role for a Research Matron was established and appointed to in order to strengthen the nursing leadership in the Research Division.

viii. **Head of Neonatal Nursing and Matron for Neonates:** In 2019, new roles were successfully appointed to across the neonatal single service with LWH.

4.6: Proposed workforce developments for 2019/20 to 2021/22

i. **E-rostering:** 2019/20 has seen significant progress made towards implementing a Trust wide Rostering system. A robust procurement process was followed which identified a preferred provider and the Trust are in discussions regarding the implementation phase. We were also successful in a bid to NHSI for the funding of our new system. As part of the development of our E Rostering team a new implementation Manager has been appointed and work is ongoing to appoint the wider team. COVID 19 provided us with the opportunity to start to develop our roster options and the Rota Hub now coordinates electronic ward rosters across the organisation allowing us to test some of our rostering options and assumptions.

ii. **Education strategy:** Continue to build on the education strategy and maximise and include the notable awareness training and front line experience gained during redeployment in response to the Covid-19 pandemic. This will form part of a longer term Training Needs Analysis to ensure a flexible workforce in the event of future short or long term staffing pressures such as winter, a second spike in Covid-19 or any other business continuity incident affecting staffing.

iii. **Appropriate nursing workforce to meet demand:** Review roles and nursing workforce demand appropriately in order to safely support Phase 3 of the Trust Covid-19 operational response to enable children and young people to be cared for in a timely manner whilst ensuring and maintaining safe high quality care.

iv. **Research strategy:** Facilitate, enhance and maximise the full potential of the nursing workforce who have a wealth of ideas, innovative solutions and experience to further shape and develop evidence based practice.

v. **Neonatal Single Service Workforce:** Continue to work in partnership with Liverpool Women's Hospital to plan, develop and recruit to the Single Neonatal Service in line with British Association of Perinatal Medicine (BAPM) standards.

vi. **Nurse Associates and Pharmacy Technicians:** The long term plan is to train and recruit an appropriate number of Nurse Associates to support each shift on each ward. The benefits realisation from this change in workforce configuration would enable a Pharmacy Technician to be introduced on each ward to support the nurses with medicines administration. This follows the successful research project in 2017 which demonstrated the positive impact of the role on patient experience, medication safety, and releasing nursing time to care.

vii. **Patient Acuity Tool:** Professional judgement has been provided regarding increasing patient acuity provided by Ward Managers, together with information from the DETECT study indicating where the sickest patients and highest numbers of sick patients outside of critical care. As a result feedback by Ward Managers regarding acuity, a workstream has been set up to review the STAMP acuity tool, led by a Ward Manager. Although the work has been delayed due to the challenge of the Covid-19 pandemic, this is a key priority for 2019/20.

5. WORKFORCE CHALLENGES

5.1: Leavers

The average leaver rate per month in 2019/20 was 5.6 WTE per month, a lower leaver rate sustained from 5.7 WTE per month in the previous year. The data collected over the last four years demonstrates a fairly static annual leaver rate.

Following an analysis of exit interviews, the senior nursing leadership team identified that there was no agreed process for staff to move wards if they were unhappy: the process was mostly reactive and often relied on senior nurses having to intervene to enable a nurse to transfer between wards and departments. This may have resulted in nurses leaving the Trust to gain a different experience at another organisation rather than retaining the nurse at Alder Hey.

Therefore, in line with the development of the Staff Nurse Rotation Programme, a proactive retention methodology has been introduced, incorporating a formal standardised approach to staff movement within the Trust via a Transfer Window where a nurse is not happy on their ward and considering leaving the Trust. The Transfer Window is open to all nursing staff, not only newly recruited staff and has been in effect for 12 months. It is anticipated that this strategy will improve the retention of our valuable nursing workforce and the senior nursing leadership team will monitor the effect of this process on the leaver rate.

Appendix 5 provides analysis of all leavers in 2019/20 by ward. Table 5 shows actual leavers by Quarter demonstrating the improved position since 2016/17:

Table 5: Actual and average leavers in WTE per Quarter

	Q1		Q2		Q3		Q4		Total	
Year	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Total**	**Mean for year**
2016/17	**20.6**	(6.8)	**12.3**	(4.1)	**22.5**	(7.5)	**19.2**	(6.6)	**75.4**	(6.2)
2017/18	**20.5**	(6.8)	**14.5**	(4.8)	**24.7**	(8.2)	**18**	(6)	**78.4**	(6.5)
2018/19	**10.9**	(3.6)	**21**	(7)	**15**	(5)	**22.4**	(7.4)	**69.4**	(5.7)
2019/20	**15.7**	(5.2)	**13.9**	(4.6)	**15.6**	(5.2)	**21.9**	(7.3)	**67.2**	(5.6)

5.2: Age profile of nursing staff

Age profiling and the potential for retirement is an integral part of effective workforce planning, thus enabling predicted future requirements to be identified and factored into the Trust's recruitment strategy.

Any registered nurse in the pre-1995 NHS pension scheme is eligible for full retirement at the age of 55 and actuarially reduced retirement from the age of 50. The nursing age profile in Table 6 identifies 72 WTE front line nursing staff aged 55 and over who could retire with immediate effect. There are a further 77 WTE (aged 51-55) achieving retirement age in the next 5 years. Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years.

Table 6: Age profile of front line nursing staff in WTE										
Age range	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**
WTE 2019/20	124	178	150	135	91	68	77	43	25	4

Effective succession planning is key, and there has been successful internal promotion to front line Band 6 and Band 7 nursing roles, including Ward Manager and Matron roles.

5.3: Maternity leave

Maternity leave cover is not currently included within the calculated ward establishments for any of the wards. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the funded nursing pool to 40 WTE in order to further improve resilience and optimise bed occupancy.

It is clearly evidenced in Table 7 that an average number of around 40 WTE represents a "normal" level of maternity leave year on year across the ward nursing teams. 60% of costs are recovered from central government across the duration of a period of maternity leave absence, the remaining 40% is the Trust's internal challenge, which is valued in the region of £480,000 per annum. Appendix 7 provides analysis of all maternity leave in 2019/20 by ward.

Table 7: Average maternity leave in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average in year**
2016/17	42.6	41.6	44.3	45	43.3
2017/18	36.8	35	31	35.6	34.6
2018/19	36.4	36.6	39.6	38.4	37.7
2019/20	27	26.8	30	29	28.2

5.4: Sickness

Long term sickness (LTS) has remained high, however there is a significant reduction compared to the previous year when the average was 27.5 WTE off on LTS compared to 19.6 WTE in 2019/20. Ward Managers are supported by the HR team to ensure all staff on LTS are appropriately supported and managed.

Short term sickness has reduced slightly from last year however remains high. Ward Managers are working in collaboration with HR to support the physical and mental health and wellbeing of staff, and manage sickness. The senior nursing leadership team are engaged with the Trust Staff Wellbeing Committee to understand the top reasons for sickness absence and to support strategies

to help staff stay well and in work. The implementation of the Staff Advice and Liaison Service (SALS) has been welcome and now forms part of the signpost offer of support to staff from managers, in addition to staff able to access support directly.

Table 8a: Average LTS in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
2016/17	30.9	21	27	24.6	25.8
2017/18	15.7	14.7	24.4	29.4	21
2018/19	22.5	30.5	25	32	27.5
2019/20	22.2	17.2	18.5	20.5	19.6

Table 8b: Average STS in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
2016/17	20.8	12.5	14.2	10.8	14.5
2017/18	6.8	8	13	15.7	10.8
2018/19	14	15	18.9	21.7	17.4
2019/20	13.7	13	17.4	20.5	16.1

Staff health and wellbeing will continue to be an area of support and focus in 2019/20.

5.5: Attrition rates of recruited staff

The Trust continues to experience an attrition rate amongst new recruits with appointed nurses subsequently taking up employment elsewhere. This has previously been 30-35% however dropped to 23% attrition rate overall last year. This attrition rate compares favourably with a reported figure of 50% attrition as the national average. However the intelligence demonstrates the need to recruit over and above the number of staff known to be required at any given time.

5.6: Increasing patient acuity

Specialling refers to patients' acuity requiring 1:1 nurse to patient ratio of care, which is over and above all acute inpatient ward normal rostered shift pattern and funded establishment (excluding PICU and HDU). The vast majority of special shifts are utilised on surgical wards (3A and 4A), and medical wards (3C and 4B). An example of a typical patient requiring "special" 1:1 care for a period of time would be a child requiring non invasive ventilation stepping down from HDU to Ward 4B.

Professional judgement has been provided regarding increasing patient acuity provided by Ward Managers, together with information from the DETECT study indicating where the sickest patients and highest numbers of sick patients outside of critical care. As a result feedback by Ward Managers regarding acuity, a workstream has been set up to review the STAMP acuity tool, led by a Ward Manager. Although the work has been delayed due to the challenge of the Covid-19 pandemic, this is a key priority for 2019/20.

5.7: Change to student nurse funding

In July 2016, the Government put in place student loans to replace NHS bursaries, and student nurses were charged tuition fees from August 2017. The RCN report a drop of 25% in applications for nurse training across England. However in December 2019 the Government confirmed that from September 2020, all nursing students in England will receive at least £5,000 a year to help with

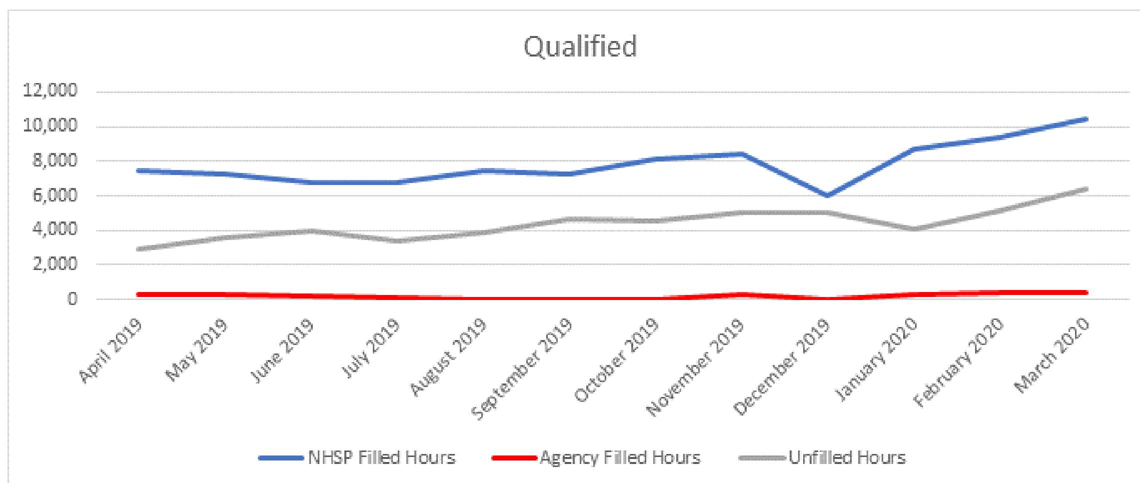
living costs and the grant will not need to be repaid. For students entering specialities that struggle to recruit, areas which have seen a decrease in those accepted onto nursing degree courses, or to help students cover the costs of childcare, there may be a supplement of up to £3,000. This move has been widely welcomed within the nursing profession.

Whilst the number of entrants to children's nurse training has not reduced locally, the number of nurses not completing their training has increased significantly which has had a negative effect on our recruitment pipeline. It is hoped that the new funding arrangement will have a positive impact on nurses completing their training and this situation will continue to be monitored in collaboration with our HEI partners and the CM regional workstreams.

5.8: Temporary staffing: NHSP and agency

There has been a continued drive to reduce the use of bank and agency staff, which in addition to reducing expenditure, also provides safer nursing care with staff employed directly by the Trust.

There was a temporary requirement for the use of front-line nurse agency staff to predominantly support Ward 4A although agency usage has remained very low.



5.9: Covid-19 pandemic

The importance and guidance surrounding safe and sustainable staffing levels is enshrined in national professional nursing and regulatory standards. At Alder Hey, the senior nursing team have worked tirelessly to ensure compliance with national standards (RCN / BAPM / PICS / QNIC / NQB / Hard Truths). However with the advent of COVID-19, and the predicted rate of 20% of staff across all groups being unable to work, this presented a significant impact on the ability of the Trust and the UK to be able to comply with these standards. Coupled with this, was the intention to significantly increase the number of critical care beds available which further significantly challenge the Trust's ability to meet and maintain national staffing standards.

In response to the national crisis, a temporary model of nursing was devised in March 2019 for the emergency period. The staffing guidelines devised at the time of the crisis (Amber and Red staffing levels) were for that point in time and have since been stood down back to the usual Green staffing levels in line with national guidance. It is important to note that at no time during the Covid crisis period were either the Amber or Red staffing levels invoked and staffing remained at Green and in line with national standards at all times. The Director of Nursing worked in collaboration locally with

the Ward Managers, Matrons and Associate Chief Nurses; and at regional and national level with the Association of Chief Children's Nurses, the RCN and the C&M Director's of Nursing in order to ensure safe staffing levels were set to cope with the Covid crisis. The risk was recorded on the Risk Register (risk 2138) and has subsequently been closed. The Covid staffing plan devised for the emergency period can be found in Appendix 8.

5.10: Staffing risks and incidents reported

There were a total of 125 staffing related incidents and near misses reported in 2019/20. Where staffing related incidents were a theme within a week, this was reported to and discussed at the weekly Patient Safety Meeting. Staff are actively encouraged to report incidents, concerns and near misses via the Ulysses Incident reporting system and a high level of reporting is a positive indicator of a Trust with an open, transparent and learning culture. The main themes relate to staffing issues due to sickness and concerns regarding skill mix. All incidents are investigated by the relevant Division and escalated appropriately. Examples of action taken are as follows:

- The Safer Staffing Huddle has been introduced to ensure a clear and agreed daily staffing plan each day; appropriate redeployment of staff from other areas following assessment and review
- Use of temporary staffing including agreement for agency nurses
- Weekly staffing overview meeting overseen by Associate Chief Nurse
- Weekly forward look of TCIs to plan staffing requirement
- Clinical Educator working alongside new nurses and student nurses
- Recruitment strategy
- Retention strategy in collaboration with HR
- Education strategy for nursing staff including induction, preceptorship, clinical supervision, CPD. Clinical Educator on ward

There are currently 11 open risks on the Risk Register relating to staffing (not all associated with wards) with risk scores in the main ranging from 4 to 9 and one risk scored at 12. All have appropriate control measures and associated actions. 12 risks were closed on the Risk register in 2019/20; 4 related to the Diabetes team.

As previously outlines in the report, Ward 4A experienced significant staffing challenges in October and November 2019 which were mitigated and actioned appropriately.

The Safer Staffing Huddle has been implemented and is proving to be effective in setting out the daily staffing plan.

6. RECOMMENDATIONS

A positive foundation has been built to support ongoing workforce management and further development. The senior nursing team will continue to implement planned developments, recruitment strategies, workforce reviews, and educational strategies. In addition, the team will respond to national and local developments and changes, and identify opportunities to transform and enable effective new ways of working.

The Trust Board of Directors is asked to support the following recommendations for further development:

a) Support the improvements and developments as detailed in section 4.6.

b) Continue to monitor and evaluate staffing levels and review safety and effectiveness, with specific emphasis on night staffing levels and staffing levels in specialist areas as outlined in section 4.2.

c) Continue to work in partnership with HEI's in the evaluation and further development of new nursing and support roles including through the apprenticeship route.

d) Continue to work with HEI's to promote nursing as a career choice with young people from all backgrounds and ethnic groups.

e) Continue recruitment activities to ensure low levels of nursing vacancies.

Appendix 1: Staffing Availability Report 2019/20

Ward Safer Staffing 2018/19	Day registered	Day HCA	Night registered	Night HCA	Overall staffing	Overall Bed Occupancy
April	92%	105%	90%	107%	94%	76%
May	92%	105%	91%	110%	94%	83%
June	89%	94%	87%	92%	90%	77%
July	89%	100%	88%	113%	91%	79%
August	90%	105%	87%	114%	92%	71%
September	%	%	%	%	92%	76%
October	93%	93%	91%	99%	92%	82%
November	96%	112%	93%	97%	96%	84%
December	87%	94%	84%	152%	92%	74%
January	91%	95%	89%	91%	93%	79%
February	94%	87%	94%	88%	93%	86%
March	92%	97%	91%	97%	93%	68%

Appendix 2: RCN audit compliance by ward 2019/20

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sec 5	Sec 6	Sec 7	Sec 8
1C Card														↑						
1C Neo														↑						
3A														↑						
3B														↑						
3C														↑						
4A														↑						
4B														↑						
4C														↑						
PICU														↑						
HDU														↑						
Burns														↑						
EDU														↑						
MDC																				
SDC/ SAL																				
Renal																				
Trust overall RAG rating	=	=	=	=	=	=	=	=	=	=	=	↑	↑	↑	=	=	↑	=	=	=

Key

Green: Compliant
Amber: Partial compliance
Red: Non compliant
Blue: Trust agreed workforce requirement
Grey: Not applicable

↑: Improved position compared to 2017/18
↓: Deteriorating position compared to 2017/18
=: Static position compared to 2017/18

Appendix 3: Trust Front-line Nursing Workforce at March 2020

FRONT LINE REGISTERED NURSING WORKFORCE AT MARCH 20

	B5				B6				B7								
Ward	Funded	Contracted	Actual	Variance F-A	Funded	Contracted	Actual	Variance F-A	Funded	Contracted	Actual	Variance F-A	Total Funded RN	Total Contracted RN	Total Actual	Variance F - C	Variance F - A
1C cardiac	45.29	44.97	41.63	3.66	12.15	9.61	9.61	2.54				0	57.44	54.58	51.24	2.86	6.2
1C Neo	18.15	13.52	12.52	5.63	6.25	6.33	6.33	-0.08				0	24.4	19.85	18.85	4.55	5.55
3A	40.71	37.43	35.09	5.62	5.33	7.35	7.35	-2.02				0	46.04	44.78	42.44	1.26	3.6
3B	27.67	23.51	23.07	4.6	5.47	6.47	6.16	-0.69				0	33.14	29.98	29.23	3.16	3.91
3C	40.95	40.53	37.47	3.48	7.99	6.43	6.46	1.53				0	48.94	46.96	43.93	1.98	5.01
4A	58.6	50.33	44.42	14.18	10.65	12.14	11.14	-0.49				0	69.25	62.47	55.56	6.78	13.69
4B	32.16	26.12	25.23	6.93	7.1	7.22	7.51	-0.41	1.69	1.69	1.69	0	40.95	35.03	34.43	5.92	6.52
4C	41.86	40.54	38.87	2.99	5.33	5.53	4.61	0.72				0	47.19	46.07	43.48	1.12	3.71
BU	13.34	12.02	11.41	1.93	2.86	2.17	2.17	0.69				0	16.2	14.19	13.58	2.01	2.62
PICU	105.06	88.49	84.48	20.58	41.08	37.87	39.01	2.07	9.18	10.66	10.7	-1.52	155.32	137.02	134.19	18.3	21.13
HDU	56.16	52.7	47.64	8.52	14.91	15.68	15.45	-0.54	2.66	3.49	3.49	-0.83	73.73	71.87	66.58	1.86	7.15
SDC	12.69	13.35	11.9	0.79	4	4	4.05	-0.05				0	16.69	17.35	15.95	-0.66	0.74
MDC	3.44	2.27	2.27	1.17	1.69	1.77	1.77	-0.08				0	5.13	4.04	4.04	1.09	1.09
OPD	11.37	9.67	9.34	2.03	2.4	2.4	2.47	-0.07				0	13.77	12.07	11.81	1.7	1.96
ED / EDU	37.82	41.74	38.76	-0.94	15.8	14.52	14.5	1.3	3.92	5.92	5.92	-2	57.54	62.18	59.18	-4.64	-1.64
Total	**545.27**	**497.19**	**464.1**	**81.17**	**143.01**	**139.49**	**138.59**	**4.42**	**17.45**	**21.76**	**21.8**	**-4.35**	**705.73**	**658.44**	**624.49**	**47.29**	**81.24**

F = Funded
C = Contracted
A = Actual

- * This table, taken from M12 budget statements, does not include the 25 international nurses who commenced in February 2020 as they commenced on a Band 4 initially. Therefore adjustments made throughout the paper to account for these nurses who are on a Band 5 as part of temporary NMC Covid register

Appendix 4: New Band 5 staff commenced in post in 2019/20

Starters WTE 2019/20	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac		1	0.61				4		0.43				**6.04**
1C Neo		1.61					6			1			**8.61**
3A				0.61			1	0.5		0.5	1	1	**4.61**
3B		1.61					1.61			2			**5.22**
3C		2					0.61						**2.61**
4A		1					5			1	1	4	**12**
4B			1				1			1			**3**
4C							3				1	2	**6**
BU							0.61			1			**1.61**
PICU		2.92	3	1	1	2	6					13	**28.92**
HDU	0.92	2					3.92					6	**12.84**
SDC		0.76											**0.76**
MDC													**0**
DJU													**0**
OPD		1						1			0.51		**2.51**
ED		3	0.8				2						**5.8**
Total	**0.92**	**16.9**	**5.41**	**1.61**	**1**	**2**	**34.75**	**1.5**	**0.43**	**6.5**	**3.51**	**26**	**100.53**
Q total	**Q1: 23.23**			**Q2: 4.61**			**Q3: 36.68**			**Q4: 11.01**			

Appendix 5: Band 5 leavers in 2019/20

Leavers WTE 2019/20	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac							0.31	1	2				**3.31**
1C Neo										1			**1**
3A						1		0.61	1		1	1.38	**4.99**
3B		0.92										1	**1.92**
3C					0.92	0.92						0.75	**2.59**
4A	0.31	1.61				1.84	0.31			0.92		0.31	**5.3**
4B	0.61									0.92			**1.53**
4C				0.92			1			0.92		1	**3.84**
BU		0.23											**0.23**
PICU	0.61		2.92		2	2	3	2.92	1		1.92	2	**18.37**
HDU	0.92	1				0.61		1		0.92		2	**6.45**
SDC			1.67				0.48			0.51			**2.66**
MDC													**0**
DJU	1	3.92								3			**7.92**
OPD					1	0.76			1				**2.76**
ED					1	1				0.33	1	1	**4.33**
Total	**3.45**	**7.68**	**4.59**	**0.92**	**4.92**	**8.13**	**5.1**	**5.53**	**5**	**8.52**	**3.92**	**9.44**	**67.2**
Q total	**Q1: 15.72**			**Q2: 13.97**			**Q3: 15.63**			**Q4: 21.88**			av 5.6WTE

Appendix 6: Band 5 maternity leave in 2019/20

ML 2019/20	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	0	0	2.92	2.92	2.92	2.92	3.92	4.92	4.92	4.92	4.92	2.92	3.2
1C Neo	2.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	3.69	1	1	1	2.9
3A	0	0	0	1	1	1	1	2	2	2	2	2	1.2
3B	2.84	2.84	1	1	1	1	0	0	0	0	0	0	0.8
3C	4.36	3.44	2.64	2.64	2.64	1.72	1.84	1.84	1.84	1.84	2.84	2.84	2.5
4A	3.76	2.76	1.84	0.92	0.92	0.92	3.44	3.44	4.44	3.52	4.52	4.52	2.9
4B	0.92	0	0	0	0	0	0	0	0	0.92	0.92	0.92	0.3
4C	1	1	1	1	1	1	0	0	0	0.92	0.92	0.92	0.7
BU	0	0	0	0	0	0	0	0	0.61	0.61	0.61	0.61	0.2
PICU	2	2	1	1	1.61	2.61	4.53	4.53	3.53	3.53	3.53	6.15	3
HDU	5.76	4.84	5.84	7.76	6.76	5.76	4.84	4.53	4.53	4.53	4.53	5.13	5.4
SDC	0.76	0.76	0.76	0.76	0.76	0	1.76	1.76	1.76	1.76	1.76	1.76	1.2
MDC	0	0	0	0	0	0	0	0	0	0	0	0	0
DJU	0	0	0	0	0	0	0	0	0	0	0	0	0
OPD	0	0	0	0	0	0	0	0	0	0	0	0	0
ED / EDU	4.99	4.99	4.99	4.99	4.99	4.99	4.99	3.99	2	2	1	2	3.8
Total	**29.08**	**26.32**	**25.68**	**27.68**	**27.29**	**25.61**	**30.01**	**30.7**	**29.32**	**27.55**	**28.55**	**30.77**	
Q average	**Q1: 27.02**			**Q2: 26.86**			**Q3: 30.01**			**Q4: 28.9**			**19/20: 28.2**

Appendix 7: Band 5 long term sickness in 2019/20

LTS 19/20	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	0.45	0.68	0.9	0	0	0	0.86	0.54	0	0.35	1.46	0	0.4
1C Neo	0.43	0.43	0.43	0.18	0.18	0.18	0.45	0	0	0	0	0.03	0.2
3A	2.98	3.3	2.62	2.13	1.91	1.22	1.53	1.22	1.6	2.72	1.74	1.85	2
3B	1.7	1.52	1.72	1.12	0.58	0	0	0	0	0	0	0	0.5
3C	0	0	0	2.95	1.75	1.09	0.54	0.2	2	2.74	2.73	1.76	1.3
4A	4.13	3.76	6.23	4.79	4.49	5.9	4.84	4.75	6.06	5.52	3.19	3.38	4.7
4B	1.38	1.42	1.53	1.89	0.98	0.48	1.31	0.74	1.06	0.38	0.15	0	0.9
4C	1.83	2.99	2.27	1.03	0.2	0.45	1.72	1.58	0.99	2.28	2.93	2.39	1.7
BU	0	0	0	0	0	0.18	0.43	0.18	0.01	0	0	0	0.1
PICU	3.07	3.06	1.13	2.59	2.82	4.61	3.61	3.11	2.69	1.77	2.25	2.14	2.7
HDU	3.87	4.16	3.73	1.75	1.94	0.91	2.04	1.08	2.77	2.45	1.99	3.57	2.5
SDC	0.35	0	0	0	0.24	0.56	0.44	0	0	0	0	0	0.1
MDC	0	0	0	0	0	0	0.74	0.2	0	0	0	0	0.1
DJU	0	0	0	0	0	0	0.77	0	0	0	0	0	0.1
OPD	1.6	0.63	0.6	0.36	0.83	0.75	0.6	0.36	0.36	0.37	0.4	0.47	0.6
ED / EDU	0.86	0.84	0	0.35	0.38	0	0.35	2	2	2.74	3.04	4.84	1.4
Total	**22.65**	**22.79**	**21.16**	**19.14**	**16.3**	**16.33**	**20.23**	**15.96**	**19.54**	**21.32**	**19.88**	**20.43**	
Q average	**Q1: 22.2**			**Q2: 17.2**			**Q3: 18.5**			**Q4: 20.5**			**19/20: 19.6**

Alder Hey Children's
NHS Foundation Trust

Appendix 8: Alder Hey Covid-19 Staffing Plan

Alder Hey COVID-19 STAFFING PLAN

Approving Committee:	Professional Standards Scrutiny Panel
Ratifying Committee:	CQAC
Author(s):	Pauline Brown Director of Nursing
Version	Version 1
Date published:	29th March 2020
Date ratified:	30th March 2020 (Professional Standards Scrutiny Panel)

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Appendix I: Registered Nurse to Patient Ratio: Green; Amber; Red Status

1. Introduction

The importance and guidance surrounding safe and sustainable staffing levels is enshrined in national professional nursing and regulatory standards. At Alder Hey, the senior nursing team have worked tirelessly to ensure compliance with national standards (RCN / BAPM / PICS / QNIC / NQB / Hard Truths).

However with the advent of COVID-19, and the predicted and emerging rate of 20% of staff across all groups being unable to work, this has a significant impact on the ability of the Trust and the UK to be able to comply with these standards. Coupled with this, is the intention to significantly increase the number of critical care beds available (from 21 ICU and 17 HDU to 75 ICU and 32 HDU) which further significantly impacts on the Trust ability to meet and maintain standards.

Therefore a temporary model of nursing and support care has been devised for this emergency period.

2. Ward and Departmental Staffing

At all times, the Trust will strive to maintain safe and appropriate staffing levels on all wards and departments in line with the national picture by:

- Maintaining a consistent staffing level pro rata across all wards and departments. No one ward would be at Red status whilst others are Green; staff would be redeployed to ensure consistent staffing levels. Therefore one Amber, all Amber; one Red, all Red
- Adhering to the principles below set out by the senior nursing team:
  - Must ensure a Clinical Co-ordinator is assigned to every shift irrespective of the number of staff on duty
  - Must have the minimum specified number of registered nurses (RN) with specialist knowledge of the patient cohort:
    - Oncology: 4 chemotherapy trained staff Monday to Friday (across ward and day case); 2 at weekend
    - Renal Unit: 2 dialysis trained nurses
    - LTV: Patients only nursed on Ward 4B or HDU; minimum 2 LTV trained staff for 4 LTV patients
    - Neurosurgery: 2 neuro / HDU nurses
    - ENT: minimum 1 tracheostomy trained nurse per shift for 1 trachy patient; 2 nurses if multiple trachies
    - Orthopaedic: minimum 1 orthopaedic experience
    - Cardiac: minimum 3 cardiac trained nurses
    - Neonatal Unit: minimum 2 neonatal nurses
    - Burns: minimum 1 burns nurse per 4 patients; 2 burns nurses if 7 patients
    - General surgery: minimum 1 experienced nurse

- DJU: minimum 1 registered mental health nurse

2.1 Green Status

Green status indicates "business as usual" in line with national nurse staffing standards (RCN / BAPM / PICS / QNIC / NQB / Hard Truths). Please refer to Appendix I for breakdown of expected registered nurse (RN) to patient ratios.

2.2 Amber Status

Amber status indicates a requirement Trust-wide to move to either a lower than normal RN to patient ratio and / or different skill mix within the RN to patient ratio due to either reduction in staff available to work, need to increase critical care capacity, or both.

The **Amber status** signals a need to:

- Invoke **Amber Model of Nursing** (see Appendix I):
  - For the majority of 32 bedded wards, this means a principle of 1 RN co-ordinator and 4 RN team leaders to co-ordinate and deliver higher end care to 8 patients with redeployed team (1 x other RN; 1 x AHP; 2 x Student Nurses; 1 x HCA). This will still equate to staffing levels within national professional guidelines however the skill mix will be different
  - For PICU, this means a principle of 1:1 patient care with supranumery clinical coordinators (1 adults; 1 paediatrics), and supranumery Team Leader per pod. This will still equate to staffing levels within national professional guidelines however the skill mix will be different. The difference in skill mix is largely determined by the number of available ICU trained nurses per shift (usually approx. 25 nurses)
  - For HDU, this means a principle of 1:2 patient care with supranumery clinical coordinator, and supranumery Team Leader per pod. This will still equate to staffing levels within national professional guidelines however the skill mix may be different.
  - Redeploy other RN's from within the Trust to a ward / department (for example Research nurses; ward nurses; OPD nurses; Corporate nurses)
- Redeploy retired RN's to a ward / department
- Redeploy AHP's from within the Trust to a ward / department
- Deploy Student Nurses in line with NMC guidance
- Redeploy other HCA's from within the Trust to a ward / department (for example ward HCA's; OPD HCA's; AHP / Therapy Assistants as HCA's)

2.3 Red Status

Red status indicates a requirement Trust-wide to move to a significantly lower than normal RN to patient ratio, with a different skill mix within the RN to patient ratio, due to either reduction in staff available to work, need to increase critical care capacity, or both.

The **Red status** signals a need to:

- Invoke **Red Model of Nursing** (see Appendix I):
    - For the majority of 32 bedded wards, this means a principle of 1 RN co-ordinator and 2 RN team leaders to co-ordinate and deliver higher end care to 16 patients with redeployed team (1 x other RN; 1 x AHP; 2 x Student Nurses; 1 x HCA)
    - For PICU, this means a principle of 1:1 patient care with supranumery clinical coordinators (1 adults; 1 paediatrics), and supranumery Team Leader per pod. This will still equate to staffing levels within national professional guidelines however the skill mix will be different. The difference in skill mix is largely determined by the number of available ICU trained nurses per shift (usually approx. 25 nurses)
    - For HDU, this means a principle of 1:2 patient care with supranumery clinical coordinator, and supranumery Team Leader per pod. This will still equate to staffing levels within national professional guidelines however the skill mix may be different.
    - For PICU, this means a principle of 1:1 patient care with supranumery clinical coordinators (1 adults; 1 paediatrics), and supranumery Team Leader per pod. This will still equate to staffing levels within national professional guidelines however the skill mix will be different. The difference in skill mix is largely determined by the number of available ICU trained nurses per shift (usually approx. 25 nurses)

- Redeploy other RN's from within the Trust to a ward / department (for example Research nurses; ward nurses; OPD nurses; Corporate nurses)
- Redeploy retired RN's to a ward / department
- Redeploy AHP's from within the Trust to a ward / department
- Deploy Student Nurses in line with NMC guidance
- Redeploy other HCA's from within the Trust to a ward / department (for example ward HCA's; OPD HCA's; AHP / Therapy Assistants as HCA's)

3. Training Plan

It is recognised that a large number of staff will or may be asked to work outside of their usual working environment and / or outside of their usual role as the Trust works together to care for patients and save lives, therefore arrangements for additional training and support for staff have been put in place.

Alder Hey Children's NHS Foundation Trust

A training strategy has been devised which seeks to train a critical mass of staff in the event of critical care surge and / or significantly reduced number of ward / departmental staff available to work. Many services provide a key function in keeping our complex and vulnerable children safe at home and out of hospital, and therefore a cadre of specialist staff will be required to staff and maintain essential services. However the purpose of training so many staff is to maximise the flexibility to redeploy staff as required during times of surge or staffing shortage.

The key training awareness sessions are:

Area	Role training for	Length of training
Critical Care	• All RNs with previous critical care experience (more than 2-3 years ago) • Theatre ODPs • Recovery Nurses • AHPs with respiratory experience • CNSs with relevant experience eg cardiac; respiratory; neuro • Retired critical care nurses • Ward Nurses • Research Nurses	2 day course
Ward	• CNS's • Research Nurses • OPD Nurses • Corporate Nurses • Retired Nurses • AHPs with relevant experience eg physio; OT	1 day course
Emergency Department	• Trainee ANPs • CNSs • Ward Nurses • Research Nurses	1 day course
HCA	• OPD HCA's • Theatre HCAs • Retired Nurses / HCAs • AHPs eg speech therapists; psychology • Therapy Assistants	½ day course
Runner / Helper	• Corporate roles • Admin roles	Training video

There are a number of key critical support services that must continue, may experience significant reduction in staff available to work, and / or cannot readily be backfilled by other Trust staff due to the specialist work, and are therefore not included in the training and redeployment plan. These services are:

- Pharmacy
- Radiology
- Pathology
- Safeguarding (staff can be redeployed to assist)
- Bereavement services (staff can be redeployed to assist)

4. Redeployment process

The overarching Alder Hey COVID-19 Emergency Response Plan sets out our mission and priorities to redeploy our staff and expertise to treat patients with COVID-19, whilst continuing to treat children and young people who have an urgent or emergency health care need from other diseases and conditions.

The plan outlines the new operating model during COVID-19 which will see the prioritisation of the following surge capacity:

i. Regional paediatric intensive care service for the North West
ii. Regional emergency and trauma surgical for paediatrics in the North West
iii. Adult intensive care capacity (Level 3)
iv. Adult high dependency care (Level 2)
v. Regional paediatric medicine service for inpatient admissions that are complex with a length of stay greater than 48 hrs

A redeployment strategy has been devised to enable the key priorities of the Alder Hey COVID-19 plan. Many services provide a key function in keeping our complex and vulnerable children safe at home and out of hospital, and therefore a cadre of specialist staff will be required to staff and maintain essential services.

The redeployment model is based on the following defined phases:

- Identification and alignment of staff to areas of redeployment
- Elective deployment and orientation
- Operational redeployment

4.1 Identification and Alignment of Staff to Areas of Redeployment

Whilst a critical mass of staff have received awareness training as outlined in section 3, in order to enable the most flexible, appropriately experienced and responsive workforce possible, the aim of this phase is to identify and align those staff whom it would be post appropriate to align to a different area and / or role in the first instance based on their existing role, skill set and experience.

In line with the new operating model outlined above, staff will be identified, prioritised and aligned with skills, experience and attendance at the relevant training as follows:

4.1.1 Paediatric Intensive Care

i. PICU RNs not currently working on PICU with recent PICU experience in last 2-3 years (no update training required)
ii. PICU RNs not currently working on PICU with previous PICU experience more than 3 years ago (needed to attend 2 day critical care training programme to refresh)
iii. Theatre ODP's
iv. Theatre Recovery RN's
v. AHPs with respiratory experience
vi. Retired critical care nurses
vii. CNSs with relevant experience eg cardiac; respiratory; neuro
viii. Other Ward RNs and Research RNs
ix. HCA role: Theatre HCA's

4.1.2 Paediatric High Dependency Care

i. HDU RNs not currently working on PHDU (no update training required): must maintain a cadre of existing specialist HDU nurses in neuro, cardiac and neonatal care
ii. HDU RNs not currently working on HDU with previous experience more than 3 years ago (needed to attend 2 day critical care training programme to refresh)
iii. Theatre ODP's
iv. Theatre Recovery RN's
v. AHPs with respiratory experience
vi. Retired critical care nurses
vii. CNSs with relevant experience eg cardiac; respiratory; neuro
viii. Other Ward RNs and Research RNs
ix. HCA role: Theatre HCAs

4.1.3 Adult Intensive Care

i. Adult ICU RNs / ODPs / AHPs
ii. HCA role: Theatre HCAs

4.1.4 Adult High Dependency and Ward Care

i. Adult HDU / Adult Ward RNs / ODPs / AHPs
ii. HCA role: Theatre HCAs

4.1.5 Paediatric Wards

i. CNS: align specific ward to specialism
ii. OPD RN: align to previous ward and / or specialism and / or most appropriate

iii. Research RN: align to previous ward and / or specialism and / or most appropriate
iv. Retired ward RN: align to previous ward and / or specialism and / or most appropriate
v. HCA role: OPD HCAs
vi. HCA role: AHPs eg speech therapists; psychology
vii. HCA role: Therapy Assistants

4.1.6 Emergency Department

i. Trainee ANP
ii. ED RNs not currently working in ED with recent ED experience in last 2-3 years (no update training required)
iii. ED RNs not currently working in ED with previous ED experience more than 3 years ago (needed to attend 1 day ED training programme to refresh)
iv. Other Ward RNs
v. HCA role: OPD HCAs
vi. HCA role: AHPs eg speech therapists; psychology
vii. HCA role: Therapy Assistants

4.1.7 Runners / Helpers

Staff who have been through the support staff training may assist in any of the above areas:

i. Runners
ii. ED / ward clerk
iii. Facilities

4.1.8 Core principles

All staff will be aligned as much as possible based on their role, skill set and experience. However in the event of significant pressure, staff may be redeployed to any area.

Any departments such as Radiology, Pharmacy, Pathology, Safeguarding and Bereavement Services that are not required to identify staff for potential redeployment, will continue to enact their local operational plan to manage staffing.

Wards and departments should continue to compile an off duty rota in the normal way although it is expected that there will be significant gaps that the redeployment process will aim to fill.

Consideration of preferred areas, shift patterns and particular circumstances can be undertaken for individual staff allocated into the identified groups above. It is anticipated that shift patterns may differ considerably from that which an individual

usually works and the Trust is grateful to all staff for their flexibility and willingness in response to this emergency plan.

It is recognised that it will not be appropriate to redeploy some staff based on individual risk assessments.
A daily Safe Staffing Huddle will be undertaken at 0800 to ensure safe and consistent nurse staffing across the organisation with an associated plan identified to address any short notice staffing pressures. The level of staffing (Green / Amber / Red) will be communicated to the daily Tactical Command meeting.

4.2 Elective Deployment and Orientation

4.2.1 All Critical Care (children and adults)

A clear plan has been devised with the aim of elective redeployment based on anticipated critical care surge as follows. Plan to commence week commencing 31st March 2020:

i. Redeploy PICU and PHDU staff not currently working in those areas back to critical care, backfill with RN's from wards / research / OPD / CNSs.

ii. Redeploy adult ICU trained staff to PICU and backfill with RN's from wards / research / OPD / CNSs.

iii. Redeploy adult HDU / ward RN to adult HDU in SDC, backfill with RN's from wards / research / OPD / CNSs.

The above plan signals complete temporary redeployment of staff with critical care experience from their usual department. These staff will be added to the off duty for that area.

4.2.2 Wards and ED

The plan aims to ensure that staff are given the opportunity to fully orientate themselves into the clinical area they are likely to be deployed to ahead of expected critical care surge and / or reduced staffing levels, whilst activity is at an expected lower level. This will enable staff to experience the working of the ward in a safe and planned manner.

All staff will commence orientation shifts once training is complete which will be centrally co-ordinated. Whilst the initial orientation days can be based on the individuals usual working pattern, for example 0900-1700, the orientation will incorporate the introduction of different shift patterns.

As previously identified, consideration of preferred areas, shift patterns and particular circumstances can be undertaken for individual staff allocated into the identified groups above. It is anticipated that shift patterns may differ considerably from that which an individual usually works and the Trust is grateful to all staff for their flexibility and willingness in response to this emergency plan.
Core principles:

- Staff will be placed onto the rota of the area they have been identified to be redeployed to comprising of short shifts (Early shift = 0700-1400; Late shift = 1330-1930), long days (0700-1930), nights (1900-0730), and weekend shifts.
- Wherever possible, staff will be allocated on the previous shift / day to the appropriate area however short notification may be unavoidable due to on the day sickness.
- The Associate Chief Nurses have overall responsibility for the deployment of Pool staff, which they make delegate to the Bed Management team and / or central command team.
- The hospital will declare Green, Amber or Red Status in line with the Nurse Staffing Model together.

4.2.2 RotAHub

A central RotAHub will be set up to enable all rotas to be devised electronically and enable central co-ordination of all local rotas.

4.3 Operational Deployment through Safer Staffing Huddle

Despite aligning all staff to a specific ward or department, it is anticipated that the number and role of staff available to work will change at very short notice during the surge and therefore the plan aims to ensure that staff are allocated to the appropriate area to respond to operational pressures and aligned to Amber Status or Red Status.

A daily Safe Staffing Huddle will be undertaken at 0800 to ensure safe and consistent nurse staffing across the organisation with an associated plan identified to address any short notice staffing pressures. The level of staffing (Green / Amber / Red) will be communicated to the daily Tactical Command meeting.

Enablers

- Strong leadership in the command centre, Bed Meeting and Associate Chief Nurses
- Real time data (staff availability / sickness / self-isolating)
- Excellent communication to staff at all stages
- Staff flexibility

TRUST BOARD REPORT
Tuesday 7th July 2020

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

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

Section two is the Quarter 4 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

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

National Changes to the Child Death Mortality Process

Some of the changes have been discussed in previous mortality reports following the national guidance issued in October 2018.
The process was designed to:

1) Improve the experience of bereaved families and professionals involved in caring for children
2) Ensure that the information from the child death review process is systemically captured in every case, to enable learning to prevent future deaths.

AHCH is completing the required national child death mortality forms in addition to the hospital mortality forms which provide more complete information for us as an organisation. These national forms were a requirement from April 2019, when we started completing them but there were delays nationally due to technical issues around the new child death mortality database delaying the date to September. Currently we are the only Trust providing these to Liverpool Child Death Overview Process (CDOP).
We are fully engaged with the CDOP process and regularly meet with our partners to ensure that there is learning across the region. Our process and paperwork have been shared and adopted by others and it is continually evolving as specific needs are highlighted or areas for improvement are

identified. The Guidance states that the child death reviews are to be undertaken where the child /young person received most care. On auditing 2019 cases, all but 3 received the majority of their care at AHCH so it was appropriate that the vast majority of reviews were led by Alder Hey.

We are continuing to engage with families via our bereavement team (if they wish to), and the team are working to create a tool to capture this information in a more formal way.

The next significant change for mortality reviews is the introduction of the Medical Examiner system which is currently being launched in hospitals across England and Wales. This system will introduce a new level of scrutiny whereby all deaths will be subject to either a Medical Examiner's review or a Coroner's investigation. The Medical Examiner will be employed by the Trust, but their reporting lines will be external and within NHSI. Legislation is currently going through parliament to mandate that this will be a legal requirement for all Trusts to comply with. AHCH is currently considering which would be the best model for the organisation to adopt and how it will work alongside the processes already in place. These are currently being evaluated as it is vital to avoid replication or any additional stress to the family at this difficult time.

Mortality Figures for the last 5 years

Number of Inpatient Deaths by Year and Month 2014 - 2020

	2014	2015	2016	2017	2018	2019	2020
Jan	2	9	6	4	7	5	6
Feb	4	2	7	5	1	6	4
March	3	3	10	9	6	3	7
April	4	7	7	7	6	5	6+4 adult
May	3	3	8	4	4	4	
June	7	6	6	7	4	1	
July	6	5	6	5	4	5	
Aug	2	5	8	6	5	5	
Sept	6	4	2	5	3	6	
Oct	8	8	8	9	3	3	
Nov	2	3	6	3	7	7	
Dec	7	11	8	5	5	8	
	54	**66**	**82**	**69**	**55**	**58**	**23**

Current Performance of the HMRG

Number of deaths (Jan. 2019 – Dec. 2019)	59
Number of deaths reviewed	59
Departmental/Service Group mortality reviews within 2 months (standard)	49/59 (83%)
HMRG Primary Reviews within 4 months (standard)	42/59 (71%)
HMRG Primary Reviews within 6 months	57/59 (97%)

The HMRG performance target of 4 months has stayed fairly consistent with the limited pool of reviewers working hard and the meetings being well attended. We are completing the new forms required by CDOP and have modified our own forms to enable easier identification of deaths attributed to sepsis.

The issues facing the group remain the same: a limited number of reviewers and some cases are very complex requiring multiple reviews/discussions.

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

In the report, are the figures for the cases reviewed up to date excluding the 5 reviews already completed for 2020 since the figures are too low to be significant.

During the COVID pandemic, adult COVID patients were treated at Alder Hey to provide support to our neighbouring Trusts. There were 4 deaths and these will be reviewed by the HMRG with adult expertise sought when required.

Outputs of the mortality review process for hospital deaths

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review /	Learning Disability
							INT	EXT	AAR	
Jan	5	5	5	1	5	2	1		1	
Feb	6	6	6	2	4	3		1	3	2
March	3	3	3	1	3					1
April	5	5	3	3	4	1		1		
May	4	4	3	3	4	2			1	3
June	2*	2	1	2	2	1		1	1	1
July	5	5	5	5	5	3				
August	5	5	3	4	4	1				3
Sept	6	5	5	5	6	1			1	1
Oct	3	3	3	3	3	2				
Nov	7	7	6	6	7	2				3
Dec	8	8	6	7	8	2			1	5

Potentially Avoidable Deaths

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

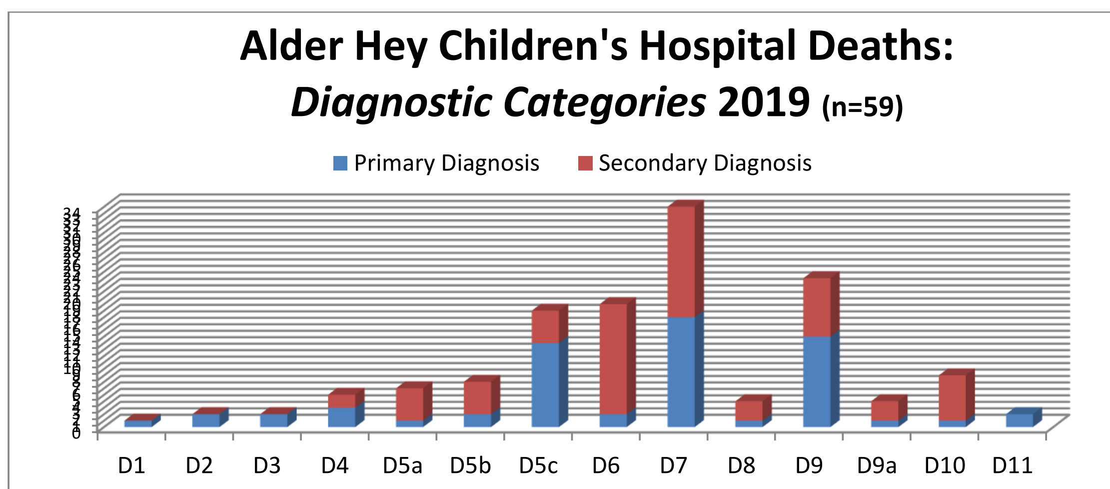
Learning disabilities

The output table of the mortality process above records any children/YP who were identified as having learning disabilities. Out of the 59 cases reviewed, 20 have been identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

Family

The bereavement team at Alder Hey provide an exceptional service and support the family for a considerable time period after a patient has passed away (if wanted). There is ongoing work between HMRG and the bereavement team to improve the feedback that the group receives from families. The family will be informed via a letter (as advised by the new national guidance) that a mortality review is undertaken for every child that dies in Alder Hey and gives them an opportunity to feedback or raise any concerns. The responsible clinician usually offers to meet with the family around 6 weeks after death and it is recorded in the HMRG review as to whether this has been offered. Work is ongoing with the bereavement team as there are always opportunities for improvement in this area as it is vital that the family have a voice, but also that this is done in a way that is sympathetic to their needs and wishes.
If there is any investigation or concern raised, then the Trust informs the family according to its Duty of Candour.

Primary Diagnostic Categories

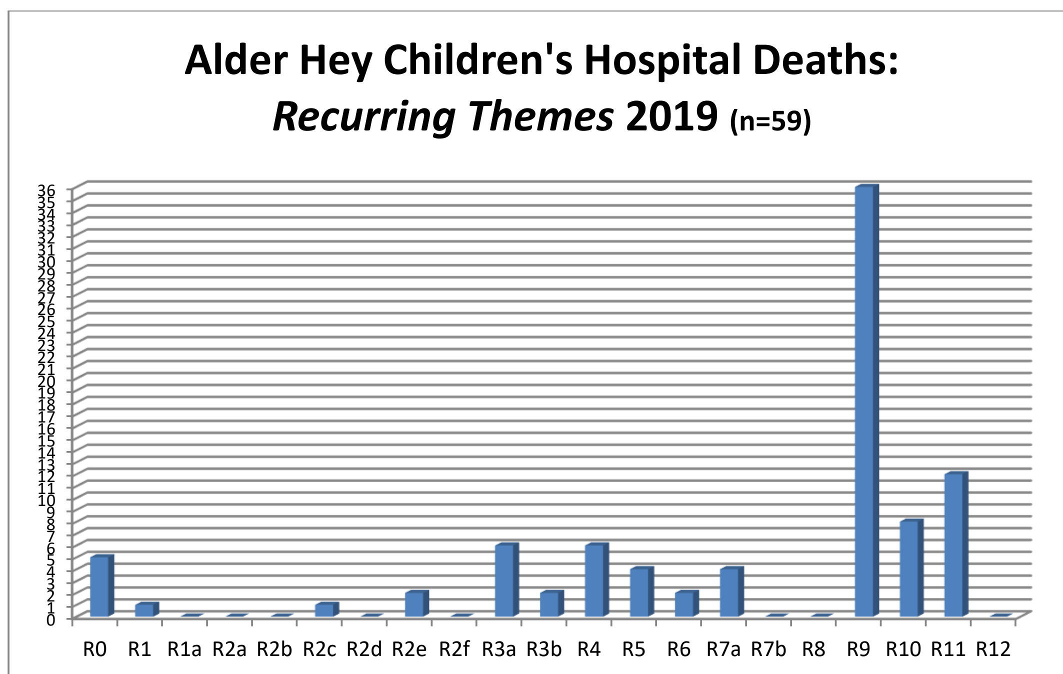


Diagnostic /Disease Categories (based on CEMACH categories - ref Arch Dis Child 2011; 96:922-6 + 927-31)

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

Deaths related to congenital conditions are the highest, being 28% of all deaths. This is not surprising with the case load that AHCH experiences. A number of these chronic conditions can have underlying cardiac conditions hence resulting in a transfer or care in AHCH as the regional cardiac centre.
The second highest diagnostic code is infection which includes some of influenza deaths, of which last winter, were particularly prevalent and severe. The rest of the infections were of a wide variety and no concerning trends or significant areas. There were very few hospital acquired infections ,which is reassuring.

Primary Recurrent Themes



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

The commonest recurring theme was the withdrawal of care in 61 % of cases which demonstrates that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with the full agreement of the family, withdrawing intensive care whilst ensuring the child is comfortable.

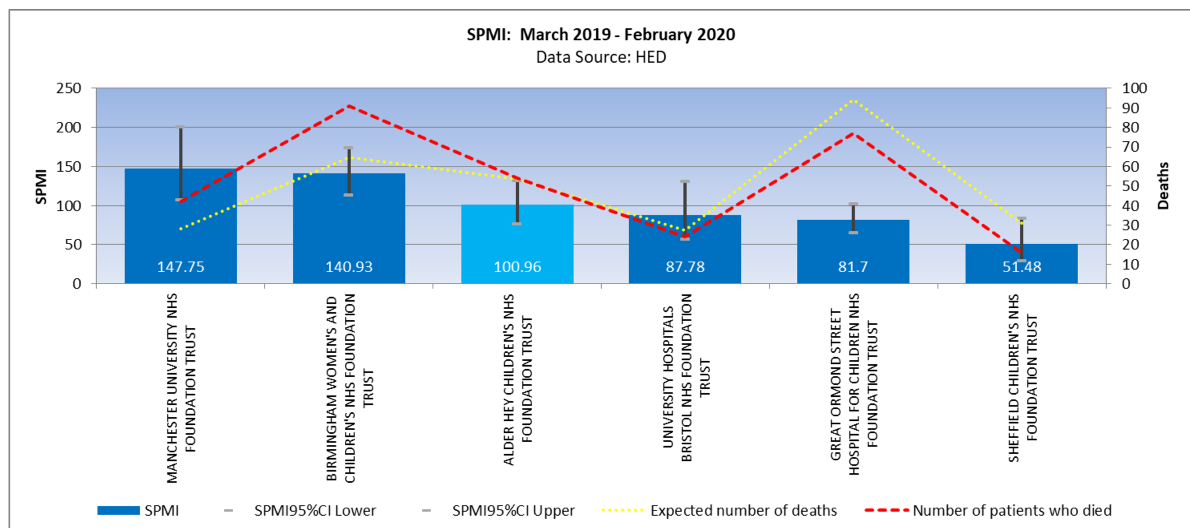
The next commonest recurrent theme at 20% is the children /young people identified with learning disabilities, whom follow the process described earlier on. There are no worrying recurrent themes apparent and the themes are consistent in the figures.

Section 2: Quarter 4 Mortality Report: January 2020 – March 2020

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The most recent data available is for the period 1st March 2019 to 29th February 2020.

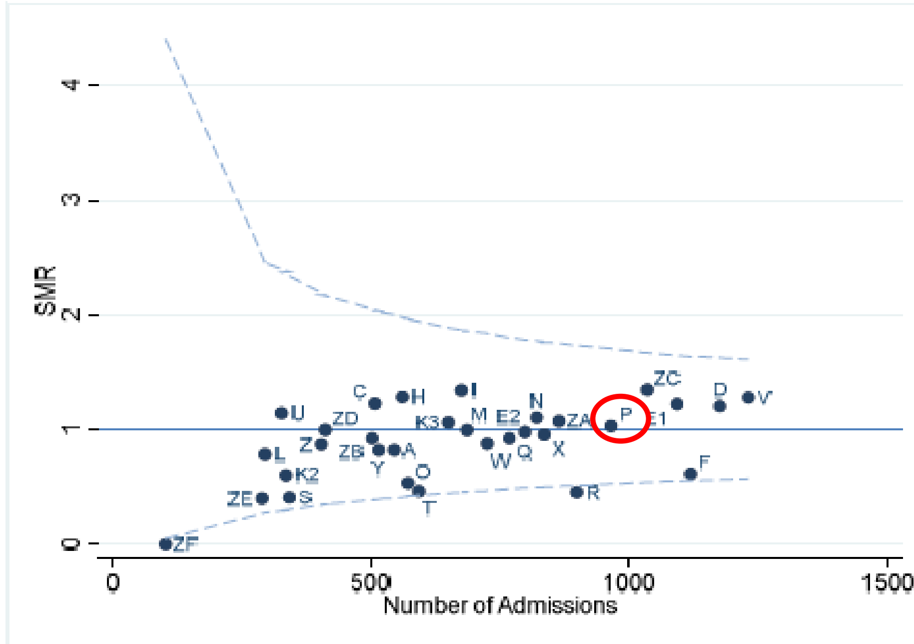


The chart shows that Alder Hey has a mortality level in line with the average NHS performance with 54 deaths against 53.5 expected deaths.

-PICU

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

The chart below is taken from PICANet's most recent report, and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.

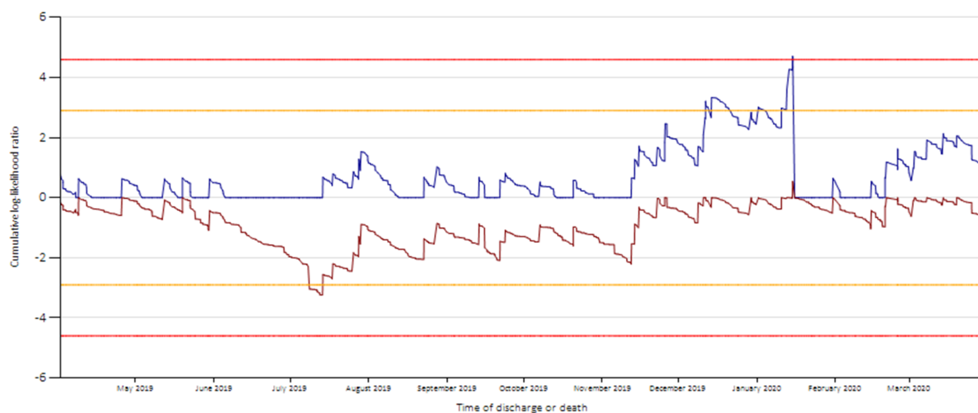


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

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

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'.

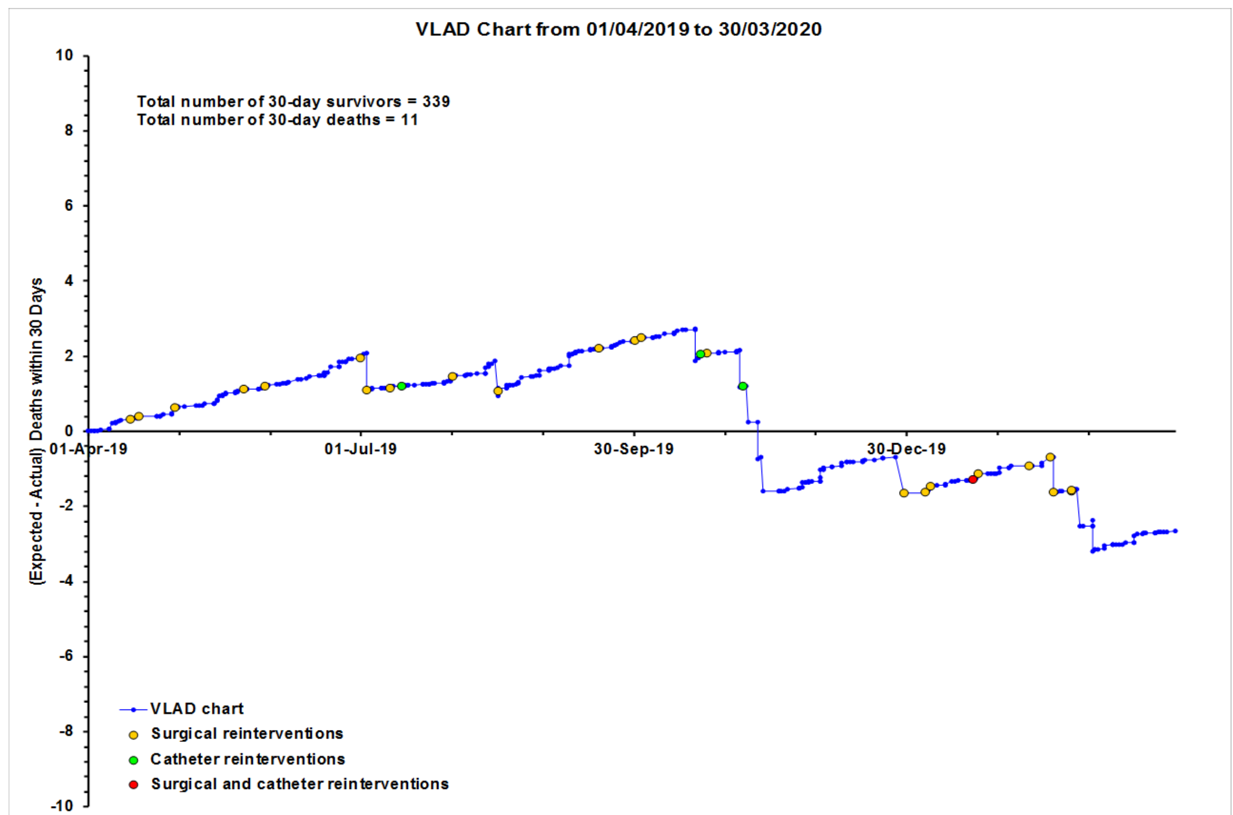


Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet. The above RSPRT chart indicates that we have been in "Safe Zone" between November 2018 and September 2019. In July 2019 the RSPRT trend-line moved below the so-called 'safe zone' indicating continued decrease in the PIM3-predicted mortality rate for the PICU. This represented far better actual mortality than that predicted by PIM3. However between October to December 2019 we had 14 deaths pushing the curve out of the safe zone. Of these 14 deaths, 10 deaths belonged to the group of death inevitable at the time of admission, in retrospect, 3 patients belonged to the group of chronic conditions + comorbidities. One death was an unexpected death who required ECMO post-cardiac surgery. In the 4th quarter we had 10 deaths in the months of January + February and the curve hit the 'warning zone' and had reset. Of these 10 deaths 9 belonged to the group of death inevitable at the time of admission in retrospect and one patient had chronic conditions with multiple comorbidities. All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

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

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

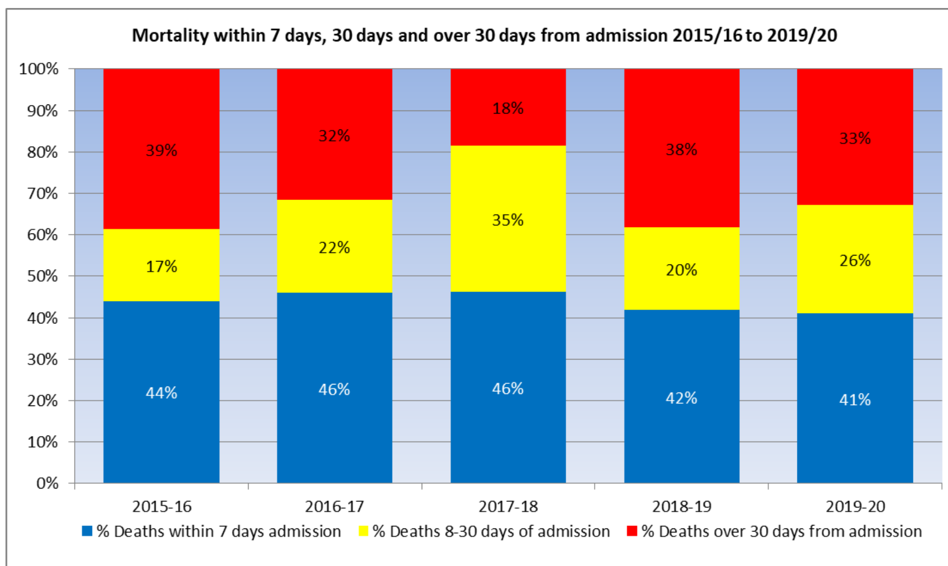


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from April 2019 to March 2020. The survival rate at 30 days was 96.9% against an expected rate of 97.6%.

Real time monitoring of mortality

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the current financial year (April 19 – March 20) 41% occurred within 7 days of admission, 26% occurred within 8-30 days from admission, and 33% deaths occurred over 30 days from admission.

Conclusion

The HMRG is functioning well and the process is continually evolving to improve the process. Over the last few months, the culture has made a huge difference to the accessibility of meetings and has resulted in more in depth discussion and the journey being discussed as oppose to just AHCH aspect.
The implementation of the Medical Examiner process continued apace during the last few months and there is the need to decide how the Trust is going to implement as we have a much lower mortality figures than larger adult Trusts.
One key area, which I am still focused on improving is ensuring that learning comes out of the mortality process that we undertake. This is difficult in any Trust but in the current climate of rapid IT changes it may be possible to ensure that learning points are accessible to the appropriate people in the Trust. This would enable people to reflect on and then raise any issues to ensure the best possible outcome for the population that we look after.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 8**

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

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 9**

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.

The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 11**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th July 2020

Paper Title:	**Access to Specialist Mental Health Services Improvement Plan**
Report of:	**Lisa Cooper, Director Community & Mental Health Services**
Paper Prepared by:	**Rachel Greer, Associate Chief Operating Officer** **Kate Holian, General Manager**

Purpose of Paper:	Decision Assurance Information Regulation	■ ☐ ☐ ☐
Background Papers and/or supporting information:	Previous paper submitted January 2020	
Action/Decision Required:	To note To approve	☐ ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	■ ☐ ☐ ☐ ☐
Resource Impact:	None identified at present	

1. Introduction

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

- Impact of COVID-19 on the provision of Specialist Mental Health Services provided across the Trust
- Current access times for Specialist Mental Health Services
- Revised trajectory for reducing waiting times to the agreed standard presented at Trust Board in January 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).

In January 2020, the Director of Community & Mental Health Services presented a paper to Trust Board highlighting the increasing number of children and young people presenting to locality based mental health services which had led to an increase in access times for assessment and treatment. At Trust Board in January 2020, it was agreed to introduce the following internal monitoring standards for locality based mental health services so as to ensure children and young people had access to safe and effective care by 30 June 2020:

- 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

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.

2.1 Eating Disorder Service

Over the period of COVID-19 referral rates to the Eating Disorder Service are comparable to those in 2019. However, there has been an increase in the number of young people that are presenting at first assessment as being at high physical risk

due to weight loss and then requiring a paediatric admission to stabilise their physical health risk and to support refeeding. Alongside this there has been a decline in some young people 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 impacted on their eating disorder symptoms with their physical and mental health risk increasing.

This has resulted in an increase in the number of children and young people within the service requiring a period of inpatient paediatric treatment. During COVID-19 the service has seen the highest number of paediatric admissions for young people with an eating disorder since the service commenced. 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 7 day period, using an on-call system at weekends to support the paediatric ward and to provide telephone support to parents and young people to try to support avoidance of admission. The remains a cost pressure within the Community and Mental Health Division.

2.2 Tier 4 Inpatient Unit (Dewi Jones Unit)

The Dewi Jones Unit has continued to provide specialist mental health in an inpatient setting (Tier 4) to those children under the age of 13 years. However, admissions to the unit have increased with the unit currently being at maximum occupancy of 7 beds. The cohort of children who have been admitted to the unit are those with an Eating Disorder and this is reflective of regional and national admissions to similar Tier 4 units. Discussions are ongoing with NHS England regarding increased costs associated with this cohort of children e.g. Dietetic support and this remains a cost pressure within the Community and Mental Health Division.

2.3 Crisis Care Service

The NHS Long Term Plan (2019) highlighted the development of 24/7 Crisis Care Services for children and young people by 2023/24. However, as per the NHS England mandate in April 2020, Alder Hey mobilised a 24/7 Crisis Care Service to ensure those children and young people most at risk of harm could access care and support. Staff from across locality based mental health services were redeployed to support the 24/7 offer and all staff have worked flexibly to ensure the needs of children and young people are met. The service offers access via a Freephone telephone number (feedback from young people) which was highlighted as excellent practice nationally and resulted in all NHS providers of Crisis Care services being advised to ensure that this was in place. Staff are based on site 24/7 and provide support to the Trust's A&E on a daily basis.

The continuation of this service is a significant cost pressure within the Community and Mental Health Division.

2.4 Locality Based Services

Whilst referrals to the locality based mental health services have remained fairly consistent (self-referral), all routine appointments for both Choice and Partnership ceased on 23 March 2020 due to COVID-19 and the need to redeploy staff to support with the implementation of the 24/7 Crisis Care Service.

However, during this period of time the locality based mental health services have continued to actively triage and manage waiting lists to ensure all urgent referrals are seen. To support this work staff undertook additional hours and worked flexibly to meet the needs of children and young people.

2.5 Intensive Support Team (Pilot)

The Intensive Support Team commenced in January 2020, as part of the Transforming Care work across Cheshire and Merseyside. The aim of this enhanced/intensive support function is to reduce and manage behaviours that challenge, working with the young person in their own residence, reducing/preventing the need for the use of restrictive practices, inpatient services and out-of-area/residential placements.

During COVID-19 the team have maintained contact with those families known to the service via telephone and virtual sessions. Developed a “Lifeline Online” parent/carer group for those families who have a child or young person with significant learning disabilities and/or challenging behaviours.

The team offer has continued to be active and available to families across Liverpool and Sefton both virtually and face to face to support the most complex and vulnerable children and young people. In addition, clinical support has been provided to the Crisis Care Service to assist with 24/7 support.

2.6 Health Psychology (Medicine Division)

Mental health difficulties for young people with physical health conditions are up to five times higher than in the general population. Unsurprisingly, COVID-19 has had a detrimental impact on the mental health of this population with increased health anxiety (for young people and parents), low mood, and increased risk taking behaviour. Changes in structure and routine, such as reduced access to school and to usual social support systems (both practical and emotional), ongoing uncertainty and frequent change has had a significant impact on young people and parental emotional wellbeing and coping.

The Clinical Health Psychology Department, within the Medicine Division, has seen out-patient activity more than double in comparison to the same time last year. There has been an increased need from open cases requiring additional out-patient appointments, new referrals, staff requesting support within integrated services and wider community services, and in-patient referrals (including the stepped up support for families and staff in response to the Trust offer to adult patients).

New ways of working (virtual appointments and working from home) as well as reduced routine medical and surgical activity within the hospital, has allowed

flexibility to respond to this demand during this period. However, as medical and surgical activity increases the service anticipates their referrals will return to a pre-COVID-19 level. Managing their usual referral rate alongside a continued increase in demand due to the anticipated longer-term impact of COVID-19 on mental health, will further impact on waiting times.

3. Current Access Times

The tables below show the current access times for Specialist Mental Health Services as of 24 June 2020 (excluding Health Psychology and IST)

Table 1: Locality Based Mental Health Services (Liverpool and Sefton)

Choice	Liverpool	Sefton
Number of young people waiting for Choice	125	63
% of young people assessed within 6 weeks of referral (Choice)	33.6%	47.6%
Waiting times (weeks)	0-43	0-19
Partnership	**Liverpool**	**Sefton**
Number of young people waiting for treatment	191	133
% of young people assessed within 18 weeks of referral (Partnership)	50.3%	52.6%
Waiting times (weeks)	0-67	0-56

Table 2: Eating Disorders Service

Eating Disorders Service	April	May	June
% of young people referred urgently seen within 7 days	66.7%*	100%	100%
% of young people referred routinely seen within 28 days	69.2%	90%	100%

*1 breach due to parent unavailability

Table 3: Crisis Care Service

Crisis Care Service	April	May	June
Total Crisis Care Calls	238	381	487

4. Revised trajectories for locality based mental health services

The revised trajectories for the locality based mental health services (Liverpool and Sefton) provide two scenarios to consider. Scenario 1 takes into account the impact of COVID-19 and no increase in referrals compared to 2019/20. Scenario 2 models a potential 15% increase in referrals (this is part of wider Cheshire & Merseyside modelling work).

Measure	Date to achieve 92% target of referral to choice within 6 weeks	Date to achieve 92% target overall pathway wait within 18 weeks (referral to partnership)
Scenario 1: Based on pre-COVD-19 referral rates	30 September 2020	31 December 2020
Scenario 2: Including anticipated 15% increase in referrals	31 January 2021	31 March 2021
Number of young people waiting over 52 weeks	0	0

To support compliance with the proposed changes to access times within locality based mental health services the following work has been undertaken including:

- Capacity and demand modelling to review shortfall, including impact if referrals increase by 15%
- Increased staffing using temporary funds to reduce the impact of staff redeployed to Crisis Care.
- Increase in numbers of Choice and Partnership appointments being offered
- Implementation of evidence-based group interventions targeted at the specific needs of children and young people waiting for an appointment
- Review of all staff job plans to identify additional capacity
- Improved matching of children and young people to staff based on needs and skill
- Strengthening of the consultation model provided into the Local Authority and schools to provide improved management of cases at the point of referral
- Improvements in multi-agency care planning to support discharge/ transition of children and young people who no longer require specialist mental health services
- Robust Clinical Lead and Assistant Clinical Lead oversight of caseload management
- 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.

5. Governance and Monitoring Arrangements

The agreed improvement plans 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.

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 remains low and service provision is not affected by a second wave of COVID-19
- Staff maintain clinical caseloads within the level recommended by the Clinical Service Leads
- Referrals do not increase over a predicted 15% increase

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.

6. Next Steps

The Trust Board is asked to note the contents of this report and approve the proposed changes to previously agreed improvement targets for locality based Specialist Mental Health Services at Alder Hey.

BOARD OF DIRECTORS

Tuesday 07 July 2019

Paper Title:	**ASD and ADHD Improvement Plan (June 2020)**
Report of:	**Director of Community & Mental Health Division**
Paper Prepared by:	**Director of Community & Mental Health Division**

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ☐ ☐
Background Papers and/or supporting information:	Previous paper submitted July 2019	
Action/Decision Required:	To note To approve	☐ ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	■ ☐ ■ ☐ ☐
Resource Impact:		

1. Introduction

Alder Hey currently delivers neurodevelopmental paediatric services across a number of CCG footprints with varying levels of commissioned activity and capacity. Currently, each local CCG area commissions a different level of service from Alder Hey. The services are based within the Community and Mental Health Division at Alder Hey.

A paper previously submitted to Trust Board in July 2019 identified the need for additional improvements and investment in the neurodevelopmental paediatric services provided within the Community and Mental Health Division at Alder Hey.

Investment was agreed in January 2020 with Sefton CCGS regarding NICE compliant ASD and ADHD assessment and diagnostic pathways.

The purpose of this paper is to update Trust Board regarding the implementation of NICE compliant assessment and diagnostic pathways for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). This paper sets out the following:

- Implementation of NICE compliant assessment and diagnostic pathways from 01 April 2020 for both ASD and ADHD
- Impact of Covid 19 on the delivery of these pathways and waiting list management of children and young people
- Proposes metrics for measurement of both new pathways and management of waiting lists

2. Autism Spectrum Disorder (ASD)

From 01 April 2020, all children and young people referred from this date to Alder Hey Childrens NHS Foundation Trust are now assessed and diagnosed within a NICE compliant ASD assessment and diagnostic pathway. This pathway commences assessment within 12 weeks of referral (NICE compliance) and conclusion for all children and young people within 18 weeks (30 weeks total pathway).

The key elements of the new Alder Hey pathway are;

- Standardised referral form across the Alder Hey ASD pathway
- Database merger and consolidation
- Consistency of neurodevelopmental assessments reducing duplication
- Case coordinator introduced for each child (role adheres to NICE guidance)
- Effective capacity and demand management
- Feedback given to families by Case Coordinator

The introduction of the Care Coordination role ensures oversight for each case and improved communication with families. The new pathway meets all national standards including DSM-5 diagnosis criteria and NICE guidance.

2.1 Waiting list management (Cohort pre 01 April 2020)

It was previously agreed with both Liverpool and Sefton CCGs that the management of the children and young people on the waiting list for an ASD assessment pre 01 April 2020 would be seen by 31 December 2020 (Liverpool) and 31 March 2021. However, the impact of Covid 19 on the ability of the Trust to assess and diagnose this cohort of children and young people has been significantly reduced due to staff redeployment, staff absence and the service changes of moving from face to face assessments to the delivery of a virtual assessment.

Whilst the Trust has secured the additional services of another provider (Healios) and requested additional capacity within the current provider (Axia) to support the management of those children and young people waiting pre 01 April 2020, the impact of Covid 19 on both providers is the same as with NHS organisations e.g. staff absence, reduction face to face activity (Axia). However, both providers have provided assurance that they will continue to increase capacity for assessments as per national guidance similar to NHS Trust.

In addition to the above, additional data validation across Liverpool and Sefton Community Paediatric waiting lists highlighted a number of children and young people who were suitable for ASD assessment but had not yet been referred. The

total waiting list of children and young people waiting for ASD assessment pre 01 April 2020 in Liverpool and Sefton is:

- Liverpool – 1837
- Sefton - 758

The additional cohort of children and young people are those who are known to Community Paediatrics and accessing care but who on review by their Community Paediatrician were deemed as potentially requiring an ASD assessment in addition to their current active medical management.

Taking into account the impact of Covid 19 on Alder Hey and the external providers, the waiting list of children and young people pre 01 April 2020 has been reviewed and reprofiled. The Community & Mental Health Division is therefore advising that the waiting list of children and young people will now be zero by 31 March 2021 (Liverpool) and 30 June 2021 (Sefton).

The Community & Mental Health Division is aware that this could be perceived as delivering two levels of service, as new referrals may be concluded earlier than those children and young people who have waited considerably longer. The Divisional Director is currently working with the Parent Carer Forum to agree communication with parents and families regarding this. The intention is to write to all families and outline the approach and provide a potential date by which they will receive a conclusion.

3. Attention Deficit Hyperactivity Disorder (ADHD)

From 01 April 2020, all children and young people referred from this date to Alder Hey Childrens NHS Foundation Trust are assessed and diagnosed within a NICE compliant ADHD assessment and diagnostic pathway. This pathway commences assessment within 12 weeks of referral (NICE compliance) and conclusion for all children and young people within 18 weeks (30 weeks total pathway). The key elements of the new Alder Hey pathway are;

- Standardised referral form with ASD pathway (joint diagnosis)
- Database merger and consolidation

- Move to Nurse led service
- Case coordinator introduced for each child (role adheres to NICE guidance)
- Effective capacity and demand management
- Prescribing improvements
- Sleep management advice and support
- Feedback given to families by Case Coordinator

The introduction of the Care Coordination role ensures oversight for each case and improved communication with families. The new pathway meets all national standards including DSM-5 diagnosis criteria and NICE guidance.

3.1 Waiting list management (cohort pre 01 April 2020)

It was previously agreed with both Liverpool and Sefton CCGs that the management of the children and young people on the waiting list for an ADHD assessment pre 01 April 2020 would be seen by 31 December 2020 (Liverpool) and 31 March 2021. However, the impact of Covid 19 on the ability of the Trust to assess and diagnose this cohort of children and young people has been significantly reduced due to staff redeployment, staff absence and the service changes of moving from face to face assessments to the delivery of a virtual assessment.

During the period April – June, the clinical team have validated all children and young people waiting for ADHD assessment and provided conclusions to the assessment where possible. This additional data validation across Liverpool and Sefton Community Paediatric waiting lists highlighted a number of children and young people who were suitable for ADHD assessment but had not yet been referred. The total waiting list of children and young people waiting for ADHD assessment pre 01 April 2020 in Liverpool and Sefton is:

- Liverpool – 1248
- Sefton - 519

The additional cohort of children and young people are those who are known to Community Paediatrics and accessing care but who on review by their Community

Paediatrician were deemed as potentially requiring an ADHD assessment in addition to their current active medical management.

Taking into account the impact of Covid 19 on Alder Hey the waiting list of children and young people pre 01 April 2020 has been reviewed and reprofiled. The Trust is therefore advising that the waiting list of children and young people will now be zero by 31 March 2021 (Liverpool) and 30 June 2021 (Sefton).

3.2 Proposed Performance Indicators

For those children and young people referred from 01 April 2020 for ASD and/or ADHD assessment and diagnosis the following indicators are proposed:

- % Referral to triage (12 weeks)
- % Total Pathway wait (30 weeks)

In addition, Alder Hey will also report the following information:

- Number of referrals received per month
- Source of referrals received per month

For those children and young people waiting pre 01 April 2020 it is proposed that the reduction in this number for ASD and ADHD is reported to the relevant CCG on a monthly basis and shows a reduction to zero by the agreed deadline.

4. Impact of Covid 19

At this present time (June 2020) and due to the ongoing impact of Covid 19 all appointments with children and young people will be virtual with face to face appointments only being offered if clinically indicated. The ongoing impact of Covid 19 on the delivery of the new Alder Hey ASD and ADHD assessment and diagnostic pathways will be monitored monthly and escalated internally to the Divisional Director and externally to the relevant CCG and SEND Boards should the ability to deliver on the agreed 30 week target be impacted.

5. Risks

The following potential risks are currently identified and being reviewed in relation to their impact on the delivery of ASD and ADHD pathways and waiting list management:

- NHS England directive regarding finances
- Decreased capacity within additional providers
- Potential Covid 19 – second wave

6. Feedback from Children, Young People and Families

At the start of the COVID-19 pandemic, the Community and Mental Health Division were required to rapidly change the way interventions were delivered to ensure the safety of staff and children and young people. In order to be able to continue to support children in the community, staff embraced digital ways of working and moved a significant amount of their interventions to be delivered via telephone or video. There are still aspects of services which cannot easily be delivered in this way and, capacity is not yet back to pre-Covid-19 levels which have impacted on waiting times, but the adoption of digital technologies across community based teams has been received well by children and their families.

Feedback has been positive from families where virtual consultations have taken place. For those families where technology may not be available Alder Hey charity has supported appropriate equipment to be given to families for the duration of assessments and/or treatment.

Feedback from families who have attended Axia for assessment and diagnosis has been overwhelmingly positive with many commenting "Really welcoming" and "Understand our child and what they need".

7. Recommendation

The Trust Board is asked to note the contents of this paper and approve the revised timelines in relation to the management of ASD and ADHD waiting lists within the Community and Mental Health Division.

Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey Youth Forum @TheForumAH #classofcovid19

Lisa Cooper, Director Community & Mental Health Services

Alder Hey Children's NHS
NHS Foundation Trust

The Forum @Alder Hey – What is it?

- Alder Hey is a Children & Young People's organisation
- Launched January 2019
- UN Convention on Rights of the Child
- Signals a commitment to children & young people that we care and can be trusted
- Any child or young person can join (8-19 yrs)
- Offered to join The Forum as an opportunity to change healthcare
- Linked to opportunities for volunteering, apprenticeships, Governor roles, wider NHS work/roles
- Identified priorities: Mental Health, Violence, Homelessness, Food/period poverty, creation safe spaces, environment

Alder Hey Children's NHS
NHS Foundation Trust

What have they done so far….

2020 – Covid World

- Daily check in, challenges on Twitter & awareness weeks
- Hand washing Campaign
- Attended Anywhere videos for appointments
- Innovation Team - Referrals to CAMHS
- Liverpool City Region Metro Mayor Youth Advisory Group
- Alder Hey Governors- New elections 3 member have applied
- AlderPlay App
- Alder Hey Covid Hub Link
- The Reporters Academy - Top tips to support Mental Health Link
- Worked with NSPCC #classofcovid19
- NHS England Youth Forum- #mycovid19pledge campaign
- NHS Cadets programme

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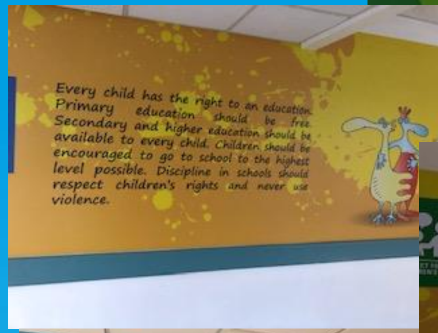

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What do they say about Covid 19…..

- Challenges about exams/no exams (perceived lack of communication about what's happening)
- Being at home 24/7
- Hobbies and volunteering opportunities being stopped
- Transitioning – moving between schools/colleges/universities
- Life feeling like it's on hold
- Why can't under 18s ask the government questions about Covid-19
- Missing friends & family
- What information about Covid-19 should we believe? Fake news (Tik Tok messaging)

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What do they say about Covid 19.....

- There's a 'war against young people'
- Young people are doing good things – shopping for family, relatives, doing exercise, doing school/college work, working
- Challenge of teaching myself – too much/not enough school or college work
- We are interested! We want to be back to school/college
- We're the 'Class of Covid-19' – we're likely to get overlooked, will predicted grades affect our future life chances?
- Impact on children with additional needs – lack of routine being felt
- Young people as key workers

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What do they say about Covid?

- "I don't get to see my Grandma and I used to see her every Sunday at the fact. I miss her and I do facetime her but she could be dead before I see her again"
- "My Auntie got Corona and I was scared she wouldn't make it out of hospital alive but I was so relieved when she was fine"
- "I feel very sad and worried I don't want people to get ill and die of Coronavirus"
- "I'm quite bored and want to go back to school. It's hard to stay home all day. I miss my friends and family"
- "I think my biggest fear is that I might catch the virus. I am classed as being a highly vulnerable person due to my illnesses and conditions and this can sometimes make me anxious and worried"
- "I worry that my Mum will die as she works at xx and that's a Hospital and you die in Hospitals now. I have seen that on the news and they don't make you any better"

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What difference does the forum make to young people?

- Increased sense of ownership and responsibility for own health
- Improved self-esteem, skills & experience with other young people, confidence and development leadership skills
- Younger children have roles models
- Completely accepting of each other & abilities
- Developed community & friendships – support each other

"The Forum makes me feel included in a group, who treat me nicely"

"I do things I thought that I would never be able to do"

"Empowered me to make changes within the hospital"

"The forum helped me grown in confidence and show the real me"

"My confidence has grown and I am not as ashamed of my disabilities anymore"

Mental Health Awareness Week

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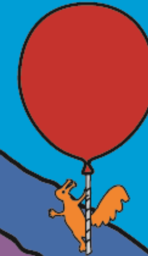


Thank you
@TheForumAH
#alderheyyouthforum

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

29/06/2020

Section	Measure	Trend	W/C 22/06/2020 Last Week	W/C 15/06/2020 2 Weeks Ago	W/C 08/06/2020 3 Weeks Ago	W/C 01/06/2020 4 Weeks Ago	Feb-20 Baseline (Pre Covid)	Commentary
RABD - Performance	ED: 95% Treated within 4 Hours		99.2%	98.1%	99.2%	98.2%	86.8%	The level of attendance remains between 90 to 125 per day and the team continue to achieve the 4 hour standard. . Conveyance rates from NWAS are slowly increasing. The attendnace levels remain well below seasonal norms. The team continue to review and refine processes notably the issue of congestion within the waiting areas and are continuing to develop plans to mitigate this.
	ED: Number of patients spending >12 hours from decision to admit to admission		0	0	0	0	0	No instances
	Weekly Bed Occupancy at Midday (Split by ON and CC Wards)		Midday Occupancy CC - 58.87% ON - 65.43%	Midday Occupancy CC - 61.90% ON - 62.54%	Midday Occupancy CC - 57.14% ON - 62.84%	Midday Occupancy CC - 61.47% ON - 62.69%	Midday Occupancy CC - 81.61% ON - 84.97%	This metric reflects hospital activity as we increase activity through phase 2 of our plan and prepare for phase 3. Underpinning this will be the consistent increased ED attendance and acuity with NEL admission and increased activity through theatres. PPE forcasting currently shows we are able to support increasing levels of activity.
	Was Not Brought Rate (exc WBO & WA)		8.42%	8.85%	9.09%	10.30%	9.95%	We have achieved a consistent rate of performance here and is below the Trust target of 12%. There continues to be a lag with cashing up so we anticipate WNB rate will increase slightly as we confirm patient attendance. Community team working through the backlog following increased activity. As OP acitivty increases we will continue to closely montior attendance.
	Cashing Up		341	249	160	70	131 (full month)	The OP & Divisional Management Teams continue to support cashing up of clinics. This metric is closely monitored through access to care.
	Number of Super Stranded Patients (21 days)		25	20	21	25	37	Discharge planning for complex patients starts on admission with MDTs arranged as soon as possible with parents/carers and both internal leads and external partners with the aim of reducing length of stay. Delayed discharges due to external blockages are escalated promptly to allow Exec to Exec discussions to take place.
	Cancer: 2 week wait from referral to date 1st seen - all urgent referrals		100%	100%	100%	100%	100%	All oncology 2ww waits continue to be seen with the two week time frame. This capacity has been protected throughout the Covid response.
	All Cancers: 31 day wait referral to treament		100%	100%	100%	100%	100%	
	All Cancers: 31 day wait until subsequent treatments		100%	100%	100%	100%	100%	
	31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)		100%	100%	100%	100%	100%	
	RTT: Open Pathway: % Waiting within 18 Weeks		58.2% (May)				92% (February)	The reduction in RTT is consistent with other Acute providers and reflects the significant redcution of available theatre/OP and ward bed capacity. This has been reiterated through the weekly CEO calls. This position will not signficantly improve until the resumption of capacity resumes back to original levels. This is currently being worked through as part of phase 3 planning and is also contingent on PPE availability.
	Waiting List Size		10910 (May)				12,895	This reflects the significant reduction in both referrals into the Trust and Consultant to Consultant referrals. Primary care have been encouraged to review patients and refer into secondary care so we anticipate seeing this reduction in size steady out. The reduction in Waiting List size and referrls is consistent with other Acute providers. This has been reiterated through the weekly CEO calls.
	All Referrals Received (GP, EXT & INT)		775	956	997	866	1830 (Weekly Avg)	This reflects the significant reduction in both referrals into the Trust and Consultant to Consultant referrals. Primary care have been encouraged to review patients and refer into secondary care so we anticipate seeing this reduction in size steady out.
	Referral Variance for period since COVID 2019 vs 2020 (W/C 29/03/2020 to date)		**Overall -55%** ORTH -1101 (-58%) ENT -1072 (-52%) EYE -1066 (-71%) COMM -763 (-51%) PLAS -713 (-53%)	**Overall -56%** ORTH -1044 (-59%) EYE -1010 (-72%) ENT -1007 (-52%) COMM -691 (-50%) PLAS -687 (-55%)	**Overall -58%** ENT -969 (-54%) ORTH -951 (-60%) EYE -944 (-73%) COMM -700 (-54%) PLAS -652 (-57%)			This provides the top 5 specialty break down for reduced referrals.
	Waiting Greater than 52 weeks		(June End Position) 100 Community - 30 Surgery - 70	52 (May) Community - 21 Surgery - 31			0	We have seen an increase in this metric that reflects the challenges with creating capacity . The team are actively reviewing each patient and attempting to create the capacity to accomdate each patient.
	Clinical Incidents resulting in Near Miss (Per 1,000 Bed Days)		20	7	11	7	10	There has been a significant reduction in incidents reported since the start of COVID 19 . However 'near miss' incidents are an excellent opportunity to learn and prevent the same of similar incidents happening, therfore the information is submitted to the divisions weekly to ensure the learning opportunities are included in incident managment discussions.
	Clinical Incidents resulting in No Harm (Per 1,000 Bed Days)		62	50	49	43	46.1	Although there has been a significant reduction in includes reported since the start of COVID 19, the majority of the incidents have resulted in no harm. Nevertheless this information is forwarded to the divisions on a weekly basis to ensure lessons are learned.
	Clinical Incidents resulting in minor, non permanent harm (Per 1,000 Bed Days)		15	25	16	16	11.6	there has been a significant reduction in incidents reported since the start of COVID 19 . However there has been a low level of minor harm incidents reported. The divisions receive weekly reports to ensure there are discussed and themed to ensure learning occurs and minimise the risk of recurrence or the risk of more serious incident occurring through learning and implementation of improvements.

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

29/06/2020

CQAC

Measure	Trend	W/C 22/06/2020 Last Week	W/C 15/06/2020 2 Weeks Ago	W/C 08/06/2020 3 Weeks Ago	W/C 01/06/2020 4 Weeks Ago	Feb-20 Baseline (Pre Covid)	Commentary
Total no of incidents resulting in moderate harm (Per 1,000 Bed Days)	▬	0	0	0	0	0.1	There have been no incidents resulting in moderate harm.
Total no of incidents resulting in major harm (Per 1,000 Bed Days)	▬	0	0	0	0	0	There have been no incidents resulting in severe / major harm during this period.
Total no of incidents resulting in death / catastrpohic (Per 1,000 Bed Days)	▬	0	0	0	0	0	No incidents have resulted in catastrophic harm during this reporting period.
Overall Total number of incidents (Per 1,000 Bed Days)	▲	99	84	76	66	67.9	There has been a reduction in the number of incidents reported during this reporting period, which is a reflection of the reduced activity since the start of COVID 19 'lockdown'.
Total no of medication errors resulting in harm (minor and above) - Requires Validation	▲	June-20 7 (month to date)				2	7 medication incidents associated with harm included 3 administration errors, 1 prescribing error, 1 communication error and 1 laboratory reporting error (reported twice). One unpreventable adverse drug reaction was reported. Actions in response are: reiteration of independent checking, investigation of transcription errors between paper and electronic prescribing systems and ensuring nursing staff are aware of how to escalate medication concerns rather than refusing to give medication.
Pressure Ulcers (Category 3)	▬	0 (month to date)	0 (month to date)	0 (month to date)	0 (month to date)	0	None Reported
Pressure Ulcers (Category 4)	▬	0 (month to date)	0 (month to date)	0 (month to date)	0 (month to date)	0	None Reported
Total no of never events	▬	0 (month to date)	0 (month to date)	0 (month to date)	0 (month to date)	1	None Reported
No. unexpected admissions to PICU (PICANet)		5	4	2	3	12 (Weekly Avg)	Majority of admissions are either new born cardiac or from AED. Cases are all straight forward deteriorations or admissions from other hospitals with some transfers from HDU.
Sepsis: % Patients receiving antibiotic within 60 mins for ED	▲	100% (n=6/6)	100% (n=5/5)	100% (n=8/8)	100% (n=7/7)	86.5%	100% Compliance.
Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients	▼	85.7% (n=6/7)	100% (n=3/3)	100% (n=3/3)	100% (n=8/8)	88.2%	One delay being 77 minutes, however this child was referred to medics by ED and seen on EDU. Due to age decision was made to do a LP prior to starting IVAB, in this case the right decision as the child was haemodynamically stable and had no other organ dysfunction (as per the definition of sepsis). On balance in this case best practice overall was followed, the child had the most appropriate investigations and was given IVAB very quickly upon completion of the LP. It could be argued this patient could be considered an 'Investigation' case as they clinical review prompted investigations for a case of possible infection to then be treated with IVAB to reduce the likelihood of sepsis developing. Second delay 113 minutes on the NEO unit during a night shift. Post Op baby with concerning clinical observations, all processes followed about escalation and review however the incorrect IVAB were prescribed initially. The correct IVAB were prescribed a short while later and promptly given, however this would class as a delay as the decision to treat for sepsis was prior to the incorrect IVAB. It is the same prescriber who has prescribed both sets and it is evident that the doctor was informed about the error at the time of prescription. Although a delay this does support good practice where the nurses have questioned the IVAB to make sure the patient was given the right choice for ?sepsis in a neonate. The sepsis team have always stressed the importance of getting IVAB in promptly however this always has to be done in the correct way making sure it is the right drug for the right patient. Therefore a delay which could have been avoided but good practice to make sure the right IVAB were given. We finish the month of June on 90.9% with a number of patients who were critical deterioration and good catches.
Hospital Acquired Organisms (MRSA, CDIF, RSV, MSSA, CLABSI ICU only, BSI & VRE)	▬	0	0	0	1	2	Bacteraemia reviews recommenced from the 04/06/2020.
No. of Covid pos patients in the hospital (as of 29/06/2020)	▲	1	0	0	1	NA	Covid positive patient numbers continue to be low. This reflects the lower numbers of positive patients seen within paediatrics and adults across Cheshire and Merseyside.
Hospital Acquired COVID-19 Infections	▬	0	0	0	0	NA	There has been no hospital acquired Covid – 19 infection in the Trust for the past 4 weeks.

Alder Hey Children's NHS
NHS Foundation Trust

The Best People doing their best Work

29/06/2020

	Measure	Trend	WC 22/06/2020 Last Week	WC 15/06/2020 2 Weeks Ago	WC 08/06/2020 3 Weeks Ago	WC 01/06/2020 4 Weeks Ago	Feb-20 Baseline (Pre Covid)	Commentary
RABD	Non Elective (Weekly Activity)	▼	166	174	171	190	205	Activity levels remain well below the pre-COVID run-rate.
RABD	IP Elective (Weekly Activity)	▬	63	63	56	55	100	Activity levels remain well down on pre-COVID run-rate following cancellation of all routine actvity. Phase 3 recovery plans continue to be developed within the PPE and social distancing constraints.
RABD	Daycase Activity (Weekly Activity)	▲	345	315	301	237	480	Activity levels remain well down on pre-COVID run-rate following cancellation of all routine actvity. Recovery plans are being developed within the PPE and social distancing constraints.
RABD	Face to Face Outpatient Activity (Weekly Attns) exc WBO & WA (MediTech & EMIS)	▲	1368	1314	1346	1212	5701 per week	In response to COVID-19, OPD initially offered only urgent face to face slots for patients. To compensate for the loss of face to face availability the platform Attend Anywhere was introduced and this, alongside telephone clinics helped to maintain OPD capacity. On the 1st June 2020, OPD have introduced Phase 2 of its response to COVID-19 with a return to the pre-covid schedule with 200 face to face slots available daily. All other template slots have been transferred to video/telephone capacity with the emphasis on still using Video or telephone clinics where possible. Using all three OPD platforms should see a return to the pre COVID OPD capacity.
RABD	Virtual Outpatient Activity (Weekly Attns) (MediTech & EMIS)	▲	3012	3327	3216	2944		
WOD	Absence (All - including sickness and shielding)	▲	372 (9.7%)	369 (9.6%)	351 (9.1%)	359 (9.3%)	6.08%	The Trust overall absence has decreased over the last 3 weeks. **- Non-COVID related sickness- 5.4%** **- COVID-19 related sickness- 0.6%** **- Shielding- 3.7%** Support continues to be provided by the Wellbeing Team and SALS to support all staff across the organisation.
WOD	Absence- including shielding (COVID-19)	▲	165 (4.28%)	164 (4.25%)	156 (4.03%)	164 (4.24%)	NA	COVID-19 related sickness has decreased over the past 3 weeks, whilst shielding has remained static **- COVID-19 related sickness- 0.6%** **- Shielding- 3.7%** A Task and Finish group has been established to develop and implement risk assessments to support and facilitate staff that are shielding return to work in a safe and supportive way.
WOD	Antibody Testing Figures (Cumulative to date position)	▲	3362 (6.90% Positive)	3252 (6.80% Positive)	2860 (6.89% Positive)	1952 (6.92% Positive)		This figure reflects an excellent uptake of Antibody testing by Alder Hey Staff. Our positive rate remians low.
CQAC	Total no of formal complaints	▬	5 (June-20)				10	A very low number of formal complaints were registered in June reflecting the reduced activity across the Trust due to COVID 19.
CQAC	Total no of PALS contacts	▲	79 (June-20)				113	The total number of PALS contacts remain low reflecting the reduced activity as a result of COVID 19. The Trust webpage has recently been reviewed and updated to make it easier and more staraightforward for families to contact the Trust

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th July 2020

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

1. **Purpose of the report**

The report is presented to the Board monthly, to provide assurance of the efficacy of the Serious Incident Management and Duty of Candour process, focusing on learning from experience.

2. **Summary of Serious Incidents, Never Events and moderate harm incidents**

Appendix 1 shows the Trust's previous financial year (2019/2020) and current financial year position i.e. number of serious incidents reported requiring investigation (SIRI) including 'Never Events'. There were 14 SIRI's reported in total during 2019/20.

There were **zero** serious clinical incidents reported in May 2020. There were **zero** serious safeguarding incidents and **zero** 'Never Events' reported. In addition, there were **zero** moderate harm incidents reported during this period.

Appendix 2 shows the progress position with ongoing SIRI's; of which there are **4** in total.

Appendix 3 shows that there were **zero** completed investigations during this reporting period, although none were expected to be completed.

Appendix 1

Table 1 StEIS reported Serious 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 Serious 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										
Open (Total)	4	4										
Closed	1	0										
Never Events												
Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
New	0	0										
Open (Total)	1	1										
Closed	0	0										

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

Appendix 2

Ongoing SIRI investigations update					
StEIS reference	Incident Type	Duty of Candour in line with regulation 20	Immediate lessons Learned	Immediate actions	Further action to be taken
2020/7074	Category 3 Pressure Ulcer under medical device	Completed Compliant	It appears that there is missing information / documentation in relation to skin checking; after the removal of the Plaster of Paris. The Orthotic Team should have checked the skin integrity before they applied the AFO (ankle foot orthosis). Tissue Viability Services should be contacted for wound assessment, if any concern.	Community Nursing team visits booked for wound assessment and management. AFO was removed until the wound was seen by the Tissue Viability Specialist. The Tissue Viability Specialist had a discussion with the Outpatient Matron and Plaster Room Manager and reassurance given about early identification of pressure injury and management. Meditech documentation to be in place. Discussion of the incident at the Patient Safety Meeting; to ensure trust wide communication and learning.	**Progress Update May 2020:** **72 hour review** A comprehensive 72 hour review has been undertaken; during the first quality check stage; further amendments were required. Amendments have been made; and the 72 hour review has been returned for further quality check. Final report due out 14/07/2020.
2020/2282	Never Event - Wrong site surgery (Squint surgery)	Completed Compliant	Specific muscle to be operated on, not noted on consent form. The specific muscle was not identified on the whiteboard in the operating theatre which would assist the	In cases of Squint surgery the muscle to be operated on is to be identified prior to the commencement of the surgery on the whiteboard in the operating theatre – this will be completed by the operating Surgeon and verified with his/her assistant.	**Progress Update May 2020:** **Level 2 investigation** The final report on target for submission to CCG ON 5TH

			Surgeon. The Surgeon sat in the wrong position at the beginning of the case. There was no Registrar available to assist the Surgeon with the surgery.	Verbal confirmation of procedures with the team prior to knife to skin (as per the WHO 5 steps to safer surgery). If the surgeon requires assistance for a procedure and does not have a trained surgical first assistant assigned to the case, or a registrar, the procedure must not go ahead.	June 2020.
2020/608	Diagnostic incident including delay meeting SI criteria Misdiagnosis of the grading of a tumour 2011	Completed Compliant	Routine practice at that time (2011) was that only one pathologist reviewed samples. On occasions samples would be sent elsewhere for second opinion.	At the time there was no awareness that this was a risk, and it was the accepted practice in this MDT in 2011. These risks do not now apply as there is in-house 'double reporting' in all cases.	**Progress Update May- 2020:** **Level 2 investigation** An External Investigation Lead has been sourced. Second extension of 12 weeks requested.
2019/27191	Patient underwent an unnecessary MRI under General Anaesthetic (GA)	Completed Compliant	When a discrepancy on the ordering of investigations is discovered, it should be escalated immediately to the Service Manager who would arrange a clinical review of all patients seen during the clinic. This will ensure that all investigations have been correctly ordered. It is good practice to ensure that clinical staff do not view more than one patient record via	Clinical Director circulated a Trust wide Safety Alert reiterating that staff are to only view one patient record at any one time on Meditech, to minimise the risk of the incident recurring.	**Progress Update May 2020:** **Level 1 investigation** The final report is on target for submission on 17/06/2020.

			Meditech at any one time. The Consultant will undergo standard clinical systems training on each visit.		

Appendix 3

Closed SIRI investigations					
StEIS reference	Incident Type	Duty of Candour in line with regulation 20	Immediate lessons Learned	Immediate actions	Outcome
Nil					

END

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD

TUESDAY 7th JULY 2020

Paper Title:	Digital and Information Technology Update
Report of:	The purpose of this report is to provide Trust Board with a Digital and Information Technology update
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer

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

Digital and Information Technology Update

1. Introduction

The purpose of this report is to provide the Trust Board with an update on Alder Hey Digital and Information Technology progress and to report key areas of digital transformation which have supported Covid-19.

2. Current Progress and Developments

2.1 Covid 19 Digital Programme

From a governance perspective, since the last reporting period, the Digital Oversight Collaborative met in April and June 2020. The April discussion was primarily with regards to Covid plans, the June discussion focussed on delivery and plans for 20/21.

As part of the Trust's Covid 19 programme, a workstream was established in terms of digital requirements, fundamentally to enable staff to work differently both with services/teams and with children, young people and families.

Four key workstreams were established in March 2020:

1. Agile: Deliver technology to ensure all staff are enabled to work digitally and work remotely within teams, departments, divisions and trust wide
2. Virtual Clinics: Enable the delivery of virtual clinics to care for children, young people and families
3. Telemedicine: Support specialist teams across different sites and organisations to use telemedicine and virtual MDTs to care for children and young people
4. MS Teams: Delivery of Microsoft Teams Trust wide

Additionally, work continued to support quality and safety within the Trust with a number of changes to the electronic patient record to support Covid configuration changes in the Trust, and continued work to tackle the long standing scanning backlog.

Progress and scale of embedding change across the key areas has been significant as highlighted in the tables below.

Workstream	Pre-Covid	June 2020
Agile		
Staff working from Home	50	1450
Concurrent Remote Access	100	850
Staff with Trust Mobile Device	1050	1500
Virtual Clinics		
Number of online video consultations	0	c.4.5K
Number of staff trained	0	700
Teams		
Daily Calls / Meetings	0	1000
Teams Messages	0	400,000
Number of Staff Reached through live Broadcast	0	26K
Telemedicine		
Number of Telemedicine Robots	0	6 (inc 1 at LWH)

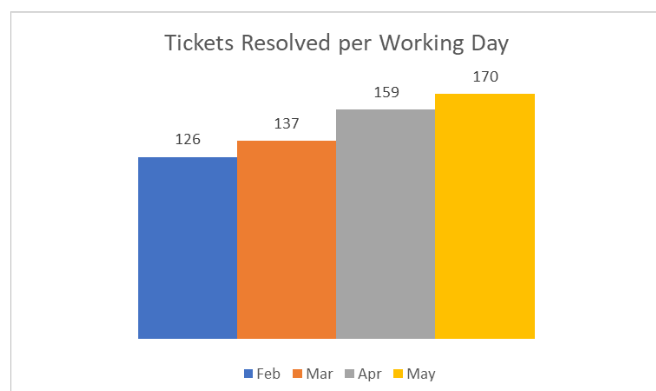
Children seen through Telemedicine Wardrounds	0	10 per day
Scanning		
OP Backlog	2 days	2 days
IP Backlog	85 days	2 days
Printing		
Jan – Dec 19 Monthly Average – 664K		
Jan – May 20 Monthly Average – 459K (29% less)		

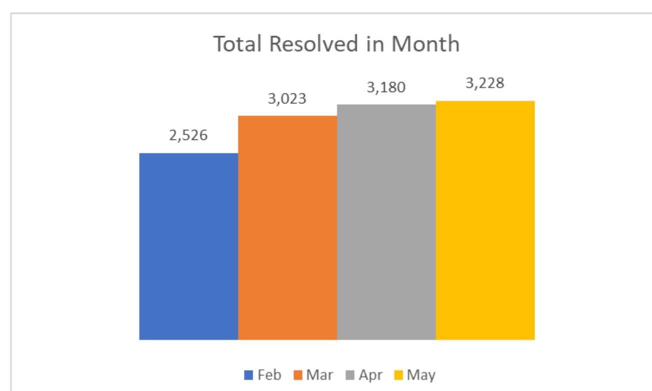
Feedback from staff and patients with regards to the scale of digital transformation delivered through Covid has been broadly extremely positive.

2.2 Operational IT Performance

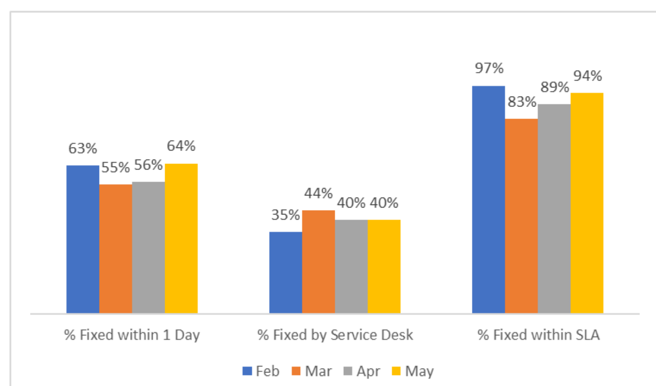
Throughout 19/20 significant improvement work was undertaken in terms of operational IT. Key areas of improvement included staff support model, responsiveness and key performances.

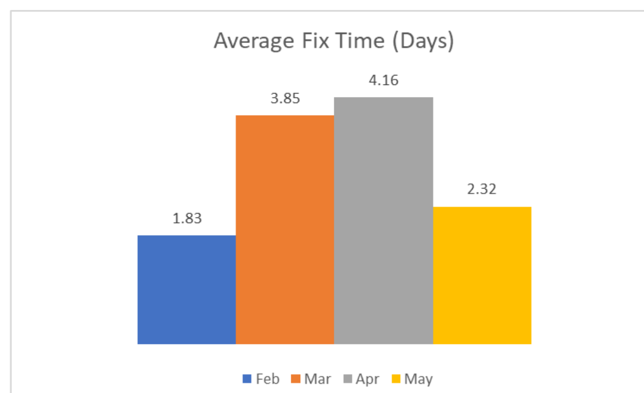
The graphs below highlight a number of key metrics. During 2019, we averaged 100 tickets resolved per day / 2,000 per month, in May 20 we resolved 170 tickets per day and 3228 in month. The number of tickets logged have increased due to staff capturing all activity, additional teams using the service desk and an increase in devices to support - 18% additional during COVID alone.





In terms of the service desk, 30% of contacts to the service desk in May were via the Phone, 70% via Live Chat, Web Portal and Email.





Prior to moving to the new service desk in February, less than 10% of all tickets were resolved at the first point of contact level by the service desk. This is now averaging 40%

resulting in front lint staff having their IT issue or requests responding to and fixed quicker. 64% of all requests and issues reported are now resolved the same day.

2.3 Technology Programmes Update

Programme	**Update**
Core Data Centre Hardware (Non Meditech)	In place providing 2 resilient data centres between Bolton and Alder Hey
New Meditech/Expanse Data Centre	Phase 1 resilience in place should there be a critical failure Phase 2 build with joint programme with CCC underway
PC / Device Refresh Project and Windows 10 Upgrade	3520 devices upgraded to Windows 10, 70 devices remaining In support of COVID, over 650 new, additional laptops have been deployed
Bleep upgrade	System upgraded in May to help support issues with Bleep coverage 100 new devices issued in June
Cyber Security	A range of significant tools and systems implemented and in place across the Trust to support proactive cyber monitoing Collaboration with specialist Trusts

2.4 Digital Maturity – Electronic Patient Records

Excellent work has been undertaken with regards to digital maturity in Alder Hey including Electronic Patient Records developments, achievements of HIMSS Level 6 and removing paper records.

The Alderc@re project is making progress, which will see the Trust move to a web based electronic patient record system in 2021.

As part of the preparation for this, work is ongoing to reduce the amount of paper in use including scanning of any current and legacy paper records into the electronic document management system.

The scanning of records was outsourced in December 2019. Work has been ongoing to support the continued improvement for Paper Free Health Records with a recommendation to increase outputs from 10,000 to 25,000 images per day. Alongside, there has been a continued focus to improve the electronic document management system.

There are significant quality, safety and financial benefits to be gained from the digitisation of paper records.

Whilst most of the focus to date has been to clear the imminent issue of records, work is being progressed in parallel undertaken to understand the transformation and automation opportunities within our approach to Transcription.

3. Locking in Best Practice and Digital Futures Priorities for 20/21

Priorities for 20/21 have been reassessed through the Digital Oversight Collaborative and Executive Team. The summary below highlights the shape of the priorities areas for 20/21.

Priority 1: Digital Children, Young People and Families

Aim: to enable a Digital First service to support new models of care and access to care through a centre of virtual medicine including:

- Digital Front Door
- Online Patient Services
- Digital Consultations Attend Anywhere
- Telehealth/Telemedicine
- Virtual ED/Front Door

Priority 2: Digital Quality and Safety Improvement

Aim: to support and enable safe and high quality care and zero harms through technology:

- Alder C@re (go live into 21/22)
- Clinical Safety Priorities
    - Paperfree / scanning / transcription transformation
    - E-Consent full roll out
    - Electronic Anaesthetic Charts
    - Bedside Verification
- HIMSS 7

Priority 3: Tech Roadmap

Aim: to ensure our digital support and technology are current, effective and resilient:

- Office 365 Phase 2
- One Drive migration
- Ongoing equipment refresh
- Phase 2 disaster recovery infrastructure
- Cyber security defenses and accreditation
- Continued use of Mezz Room 5 as a digital support centre for staff
- Training transformation
- Ongoing service improvements

Priority 4: Digitally Enabled Staff

Aim: to ensure our workforce has the appropriate skills and tools to deliver new models of care and ways of working:

- Ensuring staff have the right equipment to work effectively
- Supporting Agile
- Supporting staff on Site
- Teams / O365 maximisation
- e-Roster
- Estates plans

- Digital skills

4. Recommendations

Trust Board is asked to:

- Note digital progress to support Covid 19
- Note operational updates and progress with technology and digital maturity programes
- Note and support priorities identified for 20/21

Kate Warriner
Chief Digital and Information Officer
July 2020

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

7th July 2020

Paper Title:	**Alder Hey People Plan Update**
Report of:	**Human Resources & Organisational Development**
Paper Prepared by:	**Deputy Director of HR**

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☐ X ☐
Background Papers and/or supporting information:	None.	
Action/Decision Required:	To note To approve	X ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	☐ X ☐ ☐
Resource Impact:	None	

1

Introduction

The purpose of this paper is to provide the Board with a monthly strategic update against the Alder Hey People Plan.

Our People Plan Pillars

During the Trust response to the coronavirus pandemic a number of additional measures and actions have been put in place to support the health, safety and wellbeing of all staff. These measures have included the support from the Staff Advice & Liaison Service (SALS), and wellbeing team, implementation of enhanced risk assessments for those staff identified as clinically at risk, vulnerable and those from BAME backgrounds. In addition DSE risk assessments and agile working support has been put in place. Further work is currently underway in readiness to support those staff who are currently shielding that *may* be able to return to work from 1st August 2020.

Staff Advice and Liaison Service (SALS)

The Staff Advice and Liaison Service are providing advice, guidance and support on a range of domestic and work related issues. The service combines the best of the staff support already on offer in the organisation with a number of new elements to bring about the consistency and ease of access to staff support.

As part of the offer of support it includes Care First – an Employee Assistance Programme which offers confidential support and advice on a range of issues such as financial, family or housing, including strategies for managing separation and isolation, a variety of mindfulness and relaxation techniques, how to support vulnerable colleagues and links to national sources of support and information.

Staff can also find support, including dedicated counselling and psychological support, through The Alder Centre and Clinical Health Psychology.

During the pandemic SALS has engaged with 200 contacts, which have been a combination of face to face visits and calls/emails. The concerns have related to worsening of pre-existing mental health concerns in addition to anxieties developed during the pandemic. The most recent concerns are from those staff shielding and anxieties about the potential return to the work place. The SALS team are part of a recently established task and finish group set up to review and agree the processes relating to the return of those staff who have been shielding.

Wellbeing Team

The HR team accelerated the launch of the Trust's Wellbeing team, and this team is now fully operational within the HR team, supporting staff and managers with the processes of managing sickness absence.

Over recent months the team have directly contacted those staff off sick offering additional support and signposting as required. The team has contacted all staff who have been shielding.

This team will also support the process of those staff who are currently shielding, supporting a safe and supportive return to the workplace.

Sickness Absence

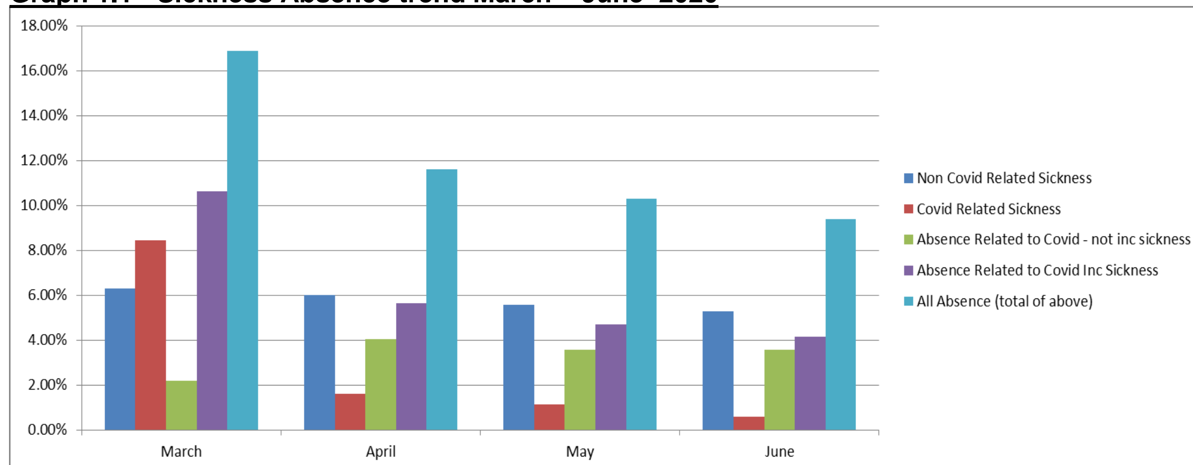
As of end of June 2020, COVID-19 related ***sickness*** absence contributed to 0.54% (21 staff) of absence. Covid19 related total absence (i.e inclusive of those shielding, isolating and those sick with covid symptoms) contributed to 3.86% (149 staff). General sickness absence (non COVID-19 related) accounted for 5.42% (209 staff), resulting in a total absence position of 9.28% (358 staff).

Overall general sickness absence has remained relatively static and COVID-19 related sickness absences have seen a steady decrease since March 2020.

Table 1. Sickness position as of End of June 2020

Reason	%	No of Staff
Non Covid Related Sickness	5.42%	209
Covid Related Sickness	0.54%	21
Absence Related to Covid - not inc sickness	3.32%	128 (116 shielding)
Absence Related to Covid Inc Sickness	3.86%	149
All Absence (total of above)	9.28%	358

Graph 1.1 - Sickness Absence trend March – June 2020



Graph 1.2 Sickness absence per staff group as of 30th June 2020

The highest levels of sickness absence are amongst the Estates and Ancillary staff group, which has the highest number of staff shielding as a result of COVID-19 followed by Additional Clinical and Nursing staff groups.

Helping keep safe and connected while working from home

To help keep everyone at Alder Hey as safe as possible we have all had to completely reorganise the way we work, whether in the hospital, in community settings, on the interim site or working from home. Across the Trust a large proportion of staff, clinical and non-clinical, have embraced the technology available and are supporting the Trust remotely in line with the advice and guidance from the Government.

As part of the support available for staff who are working differently we have produced a series of resources for staff and managers, including Working from Home guides, Display Screen Equipment (DSE) Health and Safety information and self-assessment tools to support staff to work from home safely.

A triage team, led by Health and Safety, have been supporting staff and managers to complete DSE Self-assessments and ensuring staff have the equipment needed to continue working from home effectively.

In addition we have heard from staff about how difficult it can be at times to join up with colleagues, to talk and plan together as a team. The Wellbeing Team provided welfare support to staff who are shielding the team have also been providing staff with access to Trust communications and guidance so they remain informed about the Trust's ongoing response to COVID-19. In addition we have developed a Working from Home Big Conversation guide to help teams to remain connected and 'in the loop' through the utilisation of Microsoft Teams.

Support for Black, Asian and Minority Ethnic staff

Emerging evidence and research has indicated that, alongside a previous list of health related physical conditions, there are demographic factors that could affect people's risk factor in relation to Covid-19 health outcomes. The evidence and data suggests that people from Black, Asian and Minority Ethnic (BAME) communities appear to be disproportionality affected by Covid-19 and furthermore, evidence suggests the impact may also be higher among men and those in a higher age bracket.

This week, the Trust was asked to provide a comprehensive response to the Regional Chief People Officer for NHSE/I to evidence the actions we have taken in regards to the safety of

BAME staff, and Amanda Pritchard, Chief Executive/Chief Operating Officer for NHSI/E has also written to all Trusts urging completion of risk assessments for all at-risk staff groups, including BAME, and to publish this information for all staff to see. The Trust has, and will, continue to comply with any regional or national requests for information.

Alder Hey has taken a number of proactive steps to ensure we have supported, and will continue to support, the ongoing safety of our BAME colleagues, which are detailed below, and have been shared with the region:

- **BAME Risk Assessments**

Working in partnership with our Occupational Health provider, Team Prevent, the Trust responded swiftly to the need to risk assess our BAME staff; we wanted to have an early tool so that the risk assessments were not delayed and managers could quickly support groups of individuals.

On 5th May 2020, the Chief Executive, Louise Shepherd, wrote to an open letter to all staff, accompanied by a demographic risk assessment, and requested that all BAME colleagues undertake the risk assessment. This quick response by Alder Hey received positive feedback from BAME colleagues.

The Trust asked managers and staff to feedback their views and experience of undertaking the risk assessment. We also consulted LNC and JCNC members, who provided us with robust, but constructive, feedback.

On the 20th May 2020, we held the first of what are now weekly open consultation sessions with BAME colleagues. These take the form of conversations via MS Teams, and participants can contribute as much or as little as they wish. These events have been chaired by myself or my deputy, and hosted by the EDI Manager and the Freedom to Speak Up Guardian, using 'Listening into Action' style methodology to run the sessions.

These conversations will continue; they have been a rich source of honest and open feedback from colleagues on areas such as the risk assessment process, PPE, communication and a range of other employment issues. We have also set up a venue where, observing social distancing, colleagues can 'drop-in' to chat about any issues, if they aren't able to use MS Teams.

That first conversation, alongside feedback from the Trade Unions, led us to review and refresh the demographic risk assessment documentation; Version 2 was shared with BAME colleagues in hard copy, alongside a personal letter from the Director of HR & OD, to their home addresses on the 19th June 2020. This new version addresses all of the issues raised

by staff and Trade Unions, and considered all issues contained within the Risk Reduction Framework recently published by the Faculty of Occupational Medicine. We asked those who hadn't yet completed a risk assessment to use the new form, and for those who had already completed theirs, to review the new process to ensure nothing had been overlooked in the first risk assessment discussion.

The risk tool over time will continue to be updated as relevant new data becomes available and we have been advised by our occupational health provider that there is a national project commissioned by the Office of the Chief Medical Officer for England to NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group). The aim is to have a data-driven risk prediction model for COVID-19, supported by NHS Digital.

Total Numbers of staff identified as BAME	Total Number of BAME staff not in work due to long-term sick/shielding	Total number of risk assessments undertaken	% of risk assessments undertaken (of total number of staff in work identified as BAME)
288	17	228	84%*

*the outstanding risk assessment will be completed within the next 2 weeks.

The top concerns raised through the process, and actions taken as a result of the risk assessments, include:

- Issues regarding safe use of PPE
- Communication between the Trust and BAME staff
- Redeployment
- Amendment to shift pattern
- Reduced on call in higher risk area
- Adjustments to ensure adequate social distancing

Divisional HR Business Partners have been working with teams to ensure support has been given to both staff and managers in order to complete the risk assessments

- **Freedom to Speak Up and other sources of support**

Letters from the CEO and Director of HR & OD have outlined to BAME colleagues the full range of support available for any staff member concerned about their wellbeing through our Staff Advice and Liaison Service (SALS), which is led by our Associate Director of OD, a consultant clinical psychologist.

We have also ensured that colleagues are aware that they are able to speak up about matters that are of concern to them to a trusted individual either by accessing the Freedom to Speak up (FTSU) team, or contacting the Trust FTSU Guardian directly. The Trust is keen to build a stronger BAME network, and the conversations have been a fantastic way to engage and talk to staff about what they want from a network.

Operational HR

Summary of formal Employment Relations Activity – January 2019

Following the release of Baroness Dido Harding's guidance and recommendations related to people practices in May 2019, the HR team identified a number of actions including regular reporting of employee relations activity to board. A full overview is provided quarterly and summary view is provided monthly to provide assurance and oversight.

The national Social Partnership Forum (SPF) issued a statement on the management of industrial relations during the pandemic in April 2020.The guidance confirms that disciplinary and other employment procedures will be paused during the pandemic but there are exceptions to this in the case of employees requesting them to continue or if the cases are serious or urgent then they will proceed. During the pandemic all cases have been managed on a case-by-case basis. Some cases have been placed on hold and others where there has been the agreement to proceed have been held virtually or in accordance with the social distancing measures and appropriately risk assessed.

In June there were a total of 16 employee relations cases as detailed below which has seen an overall reduction in case work.

Table 2- Employee relations activity per division as of 30th June 2020

Division	B&H	Investigation	Disciplinary	Grievance	Org. Change	Employment Tribunal	Total
Surgery	1	2	2	2	0	1	8
Medicine	1	2	0	1	0	0	4
Community	1	0	1	0	0	0	2
Corporate	1	0	0	0	0	0	1
Total	**4**	**4**	**3**	**3**	**0**	**1**	**16**

Workforce Mandatory Training KPI's – May 2020

PDR Position

PDR's were paused at the beginning of the COVID pandemic to allow for staff to focus their efforts and energies on the crisis. We will officially restart the PDRs in July, with a focus on a simpler process for this year, enabling conversations and support to take place, but in a way which recognises that things are different this year. We will be asking all staff to have these conversations between July and the end of October.

Training data

Despite pausing all training as a result of COVID, colleagues have, overall, managed to stay on top of compliance with their mandatory training; the trust remains over 90% compliance as do most of the divisions and departments, with the exception of Surgery and other corporates. As the Trust starts to move into more 'business as usual' operation, we will focus on supporting those areas to increase compliance, and ensure the remaining departments maintain at levels above 90%.

Trust	Overall Mandatory Training
Trust	90.88%
Division	
Alder Hey in the Park	93.61%
Capital	93.48%
Community	92.63%
Corporate Other	87.34%
Executives	100%
Facilities	85.03%
Finance	97.73%
Human Resources	94.03%
IM&T	93.50%
Medicine	92.13%
Nursing & Quality	92.83%
Research & Development	96.51%
Surgery	88.91%

Staff Group	Overall Mandatory Training
Add Prof Scientific and Technical	91.98%
Additional Clinical Services	91.27%
Administrative and Clerical	93.35%
Allied Health Professionals	95.00%
Estates and Ancillary	85.65%
Healthcare Scientists	91.97 %
Medical and Dental	85.34%
Nursing and Midwifery Registered	90.37%

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 7th July 2020

Report of	Development Director
Paper prepared by	Associate Development Director-Site (30/06/20)
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Trust Directors Report

Campus Development report on the Programme for Delivery

7th June 2020

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 the Month 2 in Quarter one of 2020/21 the programme Delivery Timetable l. rag rates projects against planned commencement date. Current RAG rating is of the end of Qtr. 1.

2. Programme Delivery Timetable

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

Added a row to the programme plan for monitoring of relocations from retained estates.

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										
Acquired buildings occupation			*							
Police station (LF) occupation										
Commence relocations from retained estate.										
Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks)										
Main Park Reinstatement (Phase 2/90%)										
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										

*Currently under review by the Operational Delivery Group and Executive team, alternative use for clinical services being discussed to support COVID related changes.

Both the Clinical Hob and Dewi Jones unit project is now on track and should still deliver within the planned timeframe.

RAG rated red within this quarter

Alder Centre occupation will not take place until end of September the beginning of October, this is due to some delay on the construction due to COVID19 and more so a delay to furniture orders being processed (manufacturers not receiving orders during COVID19)

Capital Cost

The development team fully appreciate the relevance of projects costs extending beyond available budget and how this could impact the overall capital monies available to the Trust. It is anticipated that to complete the landscaping of the Alder Centre it may take the spend over the current budget by an estimated £30k which is reflected in the comments section of Table2. The finance department continues to support the Team in monitoring and taking relevant actions to make every effort to stay within the financial envelope available.

Table 2. Demonstrates the current anticipated capital cost of all projects for the campus developments along with relevant comment as of end of June 2020.

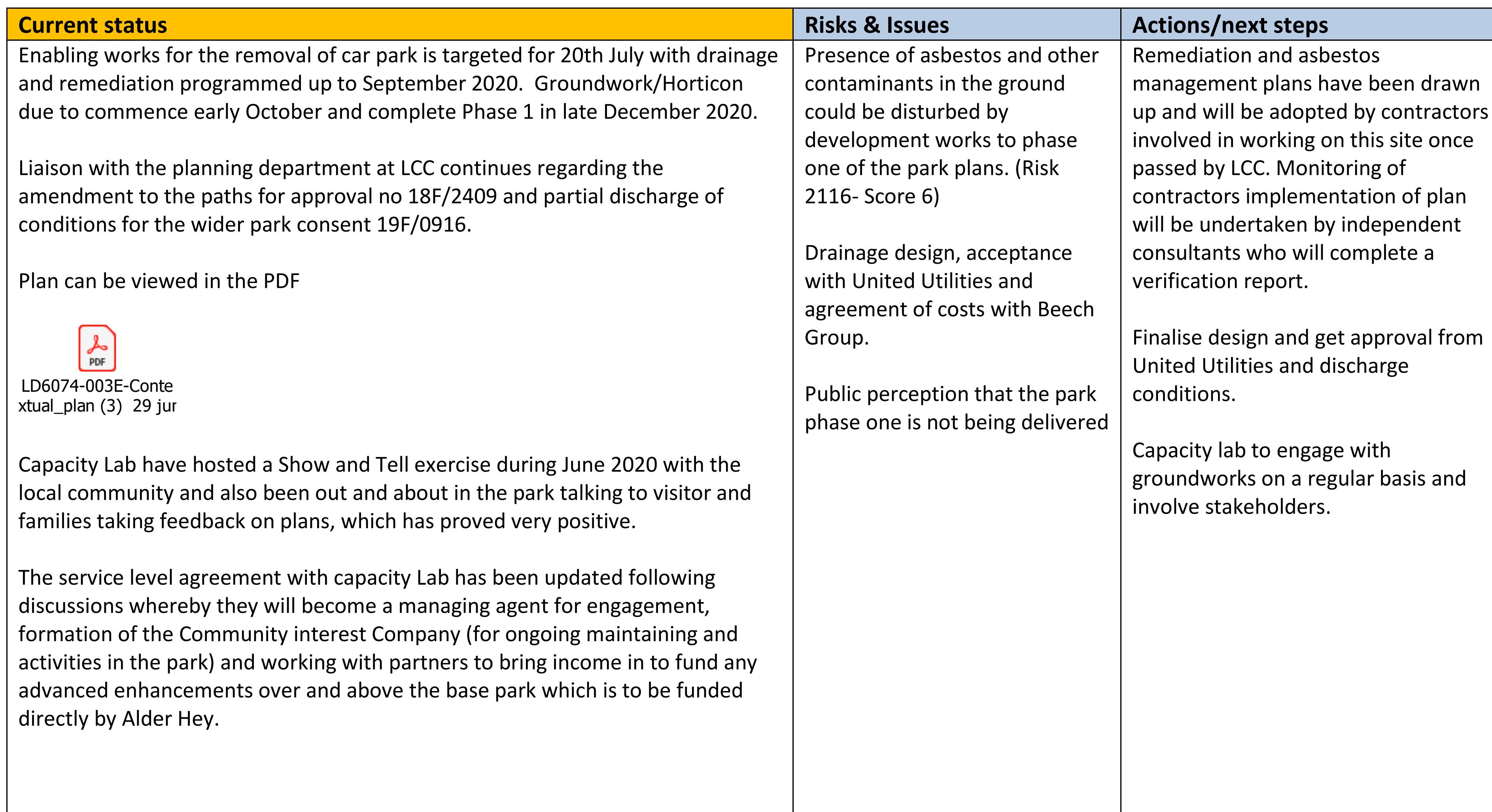
Estates Savings Target	Budget	June Estimate	June Comments
The Park	1,750	3,000	Alternative funding options focus on tendering for a lead partner(s) to support income generations, contribution and management/maintenance of the park (this will require agreement from LCC)
Alder Centre	2,184	2,214	The charity have now underwritten the funding shortfall @ £204k. Small overspend remaining of £30k
C Cluster Hub & Dewi	19,822	20,017	As agreed by Trust Board
Infrastructure - Utilities	1,200	1,200	
Landscaping	481	500	Slight risk to £500k as the plan has not been developed. However there is potential to combine this with the Neonates
Attenuation	600	600	
Infrastructure - Roads (inc s278)	858	858	
Demolition and decomm	2,356	2,656	Asbestos removal costs will exceed budget as higher than the cost estimated prior to CHP development – pressure is C. £300k. Possible increase in costs further £175k spend which would be offset with revenue savings to be confirmed
Relocations	1,227	1,227	Mersey design working on police ground floor £6.5k
Neonatal	11,869	14,000	The £14m cost includes just Neonatal but this cost could increase to £16m to include A&E expansion/EDU to the lower floor. This is yet to be decided.
Institute retention	0	0	
Development team	1,100	1,135	Slightly over budget
Office sunk costs	0	0	
Job Shop	0	0	
Vet	0	0	
Long term corporates	0	0	
Community/Off site	0	0	
NE Site Development	0	0	
Institute re-works	360	360	
Office Requirement	3,000	2,570	Decision taken not to purchase Prescott Road following a review of desk requirements in light of gains made from home working during the covid 19 situation.
Medical Records	0	0	
Staff removals	250	250	
Car Park	100	100	`
	47,157	50,687	
Revised Budget	47118	47,118	
Under/(Over) Budget	-39	-3,569	

There has been a positive movement in the anticipated overall capital budget by C. £300k over the last month due to both the non Purchase of 410 Prescott Road (there were some associated costs with the process) and the receipt of the tenders for the works to the Knotty Ash Nursing home which came in under the anticipated over budget costs.

Alder Hey Children's NHS
NHS Foundation Trust

3. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Enabling works for the removal of car park is targeted for 20th July with drainage and remediation programmed up to September 2020. Groundwork/Horticon due to commence early October and complete Phase 1 in late December 2020. Liaison with the planning department at LCC continues regarding the amendment to the paths for approval no 18F/2409 and partial discharge of conditions for the wider park consent 19F/0916. Plan can be viewed in the PDF  LD6074-003E-Conte xtual_plan (3) 29 jur Capacity Lab have hosted a Show and Tell exercise during June 2020 with the local community and also been out and about in the park talking to visitor and families taking feedback on plans, which has proved very positive. The service level agreement with capacity Lab has been updated following discussions whereby they will become a managing agent for engagement, formation of the Community interest Company (for ongoing maintaining and activities in the park) and working with partners to bring income in to fund any advanced enhancements over and above the base park which is to be funded directly by Alder Hey.	Presence of asbestos and other contaminants in the ground could be disturbed by development works to phase one of the park plans. (Risk 2116- Score 6) Drainage design, acceptance with United Utilities and agreement of costs with Beech Group. Public perception that the park phase one is not being delivered	Remediation and asbestos management plans have been drawn up and will be adopted by contractors involved in working on this site once passed by LCC. Monitoring of contractors implementation of plan will be undertaken by independent consultants who will complete a verification report. Finalise design and get approval from United Utilities and discharge conditions. Capacity lab to engage with groundworks on a regular basis and involve stakeholders.

Alder Centre

Current status	Risks & Issues	Actions/next steps
The construction work has undergone some delay as previously reported due to CCOVID 19, also there is a delay to the furniture order due to COVID 19 as manufacturers are not working and the furniture is being custom ordered to fit with the design and colouring of the centre. The longest lead in time for some piece is 12 weeks. This will likely delay the occupation of the building until sometime in September as orders placed in June. There has been a further delay of one week due to an incident on the Galliford Try advance works site which affected the Alder Centre. Overall this will not add any delay to the opening of the centre as there is a lag time between handover and commissioning and furniture delivery. Whitefield and brown the builder will be claiming compensation from Galliford Try due to the incident; it will not have any financial impact for the Trust. The expenditure against the budget is undergoing a full review at the current time and discussions with both the QS and the Design team are in progress and to be negotiated due to predicted overspend on completing the project. Projected initially last month to be C. £30 K this could potentially increase due to a claim for lost time during COVID 19, to be discussed an update for next month's report will be available.	Delay on Furniture order due to COVID 19 (Included in Risk 2203- score 9) Expenditure to complete the Alder centre will exceed the budget available. (included in risk register 2226 - score 12)	Trust procurement team are working with the supplier and awaiting regular updates on when the orders can be placed. Review and negotiate cost with AHMM (Design team)

Acquired Buildings Occupation (neighbouring sites)

Current Status	Risks/issues	Action/next steps
Knotty Ash Nursing Home The tender process was completed and cost came in under the anticipated over budget costs which is positive. All parties notified of the outcome and the 10 day standstill period has come to an end. The contractor has not yet been appointed due to a review by the operational delivery teams	Resistance from staff to move either location. (2102 risk score 9) this is likely to reduce or close if one of the alternative	Undertake a focused piece of work on increasing the level of remote working, with involvement of the Director of Human Resources and

and the executive team on the opportunity to utilise the build to support clinically focused work to support both Alder Hey and the Local Healthcare partners. This would entail the displacement of the planned relocations (Medical records, transcription and Scheduling and booking department). An alternative plan/options appraisal has been developed and the executive team will be taking a decision on this on the 30th June. Should the decision be to go with one of the options for those services then during July 2020 the Executive and Operational Teams will work up an alternative use of the nursing home. This is could entail a complete redesign of the nursing home and require a change to planning permissions depending on the services to be developed there. If the anticipated programme put forward by Mersey Design Architects is accepted by bidders then the building would be ready for occupation in December 2020 which is would be 3 months behind the plan set in January 20, this is partly due to COVID 19 and partly due to delaying the strip out of the building to achieve the best price possible by including in the tendering process. .	options is taken forward. Medical records storage exceeds the space available. (risk 2013- score 8) Refurbishment works not delivered to planned timetable (risk 2105 score 9). Capital cost not is available to cover alternative plans for clinical activity in the nursing home.	Organisational Development and the Chief Digital Information Officer. M&T currently working up a programme for digitisation of all stored records (making excellent progress, COVID 19 has helped the situation by allowing more manpower to concentrate on this work).
Ability to expand campus and link into the hospital –the Trust are still in the view that the most viable option for long term expansion space (Clinical services) would be to acquire the on Eaton Road and will be seeking to discuss commercial deals that could be completed over the next 3-5 years with current occupiers/owners.		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	Risks/issues	Actions/next steps
Status unchanged since last report The Police have recently postponed any discussion about the Trust taking space in their building as they intend to use it themselves over the Covid crisis. It is unclear at present how long this postponement is likely to last. The status of this is likely to go red in QTR2	Police do not release the space while decisions are made in regards to additional police funding and its use. (2088 risk rating 12) This will mean a delay to the old management block being vacated and therefore delay to demolition of the building.	Weekly discussion and communication with the police estates departments. Development team are currently working up the contingency plan. Expected to complete this end of January. This will need executive approval but will initially go to the newly formed agile working group lead by the Director of HR&OD.

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

Current status	Risks/issues	Actions
This is currently at the planning stage and will be reliant on relocation of current building occupants to other locations and installation /diversion of current engineering and IM&T services.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	Executive approval for all relocations as they are required. Liaison with all service providers /departments to ensure timely planning for works to be completed.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
The current plan is commence demolishing building still occupied on the retained estate in the Autumn of 2020. This links to relocating current departments and also taking down the old boiler house (requires temporary Skid plants to be installed)		

The service level agreement with capacity Lab has been updated following discussions whereby they will become a managing agent for engagement, formation of the Community Interest Company (for ongoing maintaining and activities in the park) and working with partners to bring income in to fund any advanced enhancements over and above the base park which is to be funded directly by Alder Hey. They have a plan through a partnership and bid approach to generate funding and work with all stakeholders across the community and wider region. It is anticipated the partnership model will bring in funding to advance works beyond the base park (base park to be funded by Alder Hey in line with the land exchange agreement with LCC) in order to deliver the full vision for the park.	Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 12) LCC do not agree to a future Community Interest Company for Sustainability.	Weekly review of the programme and progress with Capacity Lab, with weekly presence on site. Capacity lab to hold regular discussion with LCC and also keep the local community up to date with progress.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
Masterplan of Infrastructure works is currently being prepared. Roads and landscaping – the Trust is looking to appoint a design team during Qtr. 2.	Nil at present time.	Ensure timely process /programme is adhered to.

Clinical Hub and Dewi Jones Construction

Current status	Risks/issues	Actions
Slight delay to signing of contract with Galliford Try (GT). Following an extensive technical review of the contractor's proposals some issues required resolution. Most have now been resolved and only those that can be dealt with post contract signature remain.	Planning conditions are outstanding, these are to do with traffic management LCC do not grant planning amendments.	Continue with weekly meetings with Galliford Try. Full contract to be signed by CEO by 3rd July 2020.

For information, the architectural review focused on the preliminary design details of the value engineered elements of the building. These are now in a position to move forward to submission to LCC for planning amendments. The building services review highlighted several issues that required resolution. These are also now in a position to be dealt with post contract. The contract document itself is agreed between the parties and has had input from Bevan Brittan, the Trust's legal adviser. The schedules and supporting documents/drawings to the contract are being assembled so that the contract is ready to sign by 3rd July. Area of the temporary car park has been handed over to Galliford try for their compound (they also have to meet welfare /safe COVID measures for staff) this equates to 90 spaces which is part of a planned reduction to the temporary car park capacity in line with planning conditions and campus master plan. For information- an incident occurred on 24th June, although GT had completed all the relevant site scans and checks in regards to the advance work. A fence was relocated by GT to establish their appropriate site boundary and this was not communicated within their team, they therefore dug beyond the previously scanned area and in the process they caught the duct and power cables which extended to the switch in the alder centre causing temporary loss of power. The supply was isolated immediately following the incident. No injuries occurred as a result of the incident and a complete and thorough Health and safety review has been undertaken by GT with Trust Health and Safety Rep involvement. Work to repair the cable/duct have commenced and are due to be completed on July 1st. The Trust will receive a full investigation report from Galliford Try.		Receive and share GT incident report with Health and safety. Development team to review.

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
Following last month's Trust Board approval to start design work to increase the detail and therefore the cost certainty, the development team now have a series of meetings in place/commenced with a wide group of users to work through a detailed specification. Stage 2+ of the design process is where we are at the current time and the plan is to move towards a planning application at the end of August. The Division of Surgery together with the development team will be seeking Board approval in September and will then look to tender at the end of September for the construction. The procurement route has been agreed in principle with Project Co.	Costs of new unit exceed current financial envelope. Project Co engagement extending the programme and increasing costs; • Planning and any unknown Section.106 or section S.278 costs • Impact of Covid-19 on construction costs. Cost of PFI management of the Process versus VAT savings. Not reaching agreement with PFI risks a workable interface with the CHP being achieve Planning permission fails to be	Plan to gain approval for tendering the work at the end of September 2020. Firm up process with PFI management.

	achieved within the timescale of the overall programme delivery.	Maintain open communication with the LCC planning departments.

North East Plot Development

Current status	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 some of Alder Hey's vision for the future. Price Waterhouse and Cooper (PWC) have been engaged in a piece of work across the trust and a well-attended senior level workshop was held on the 25th June looking at potential opportunities to work with Step Places on future developments beneficial to the Trust work and commitments. The outcome report is awaited at the current time.	Local community resistance to Trust non-development aspects and planning submission.	PWC final report and suggestions to be received Maximise our offering/ support /negotiation on development content and opportunities.

Communications

Current status	Risks / issues	Actions/next steps
Comprehensive Communication plan developed which requires finalising and Trust Board Sign off. Due to COVID 19 this has not progressed over the last month. Weekly meetings between development team and Communications department are now in place to cover the park development. Fortnightly meetings established to discuss wider campus development progress. Show and tell events for staff have occurred over the month of June with some	Loss of reputation, locally and regionally. Lack of engagement internally and externally	Maintain links with community and support their development work.

webinar type sessions also being delivered. Some of these were extended over the web to the 'Friends of Springfield Park' and the wider community including local councillors.		

Car Parking

Current status	Risks/Issues	Actions/next steps
As reported above as part of the overall reduction required (250 spaces) some 90 have been handed over to GT for their compound and around 50 spaces have been removed in order to site some additional facilities to support COVID. Still to be removed by the end of September is 110 spaces. The Trust are in discussion with LCC about obtaining a lease for 80 spaces available off site and ten minute walk from site on Thomas lane. There is public pressure to reinstate the parkland as part of the land exchange agreement which is currently 2 years behind plan. In addition to this the developer who purchased the East plot is from early discussion with the planning department going to have difficulty in gaining planning permission for residential parking if Alder Hey do not reduce the current parking numbers. Retained estate planned reduction are detailed in the table below.	Car parking cannot sustain a reduction to current Numbers by June 30th 2020 (risk 2202- score 12) Staff resistance to change. Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	Take forward the lease option with LCC by end of July 2020. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan. 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.

4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of the end of June 2020.

Alder Hey Children's NHS
NHS Foundation Trust

Board Assurance Committees Re-set Proposal

Erica Saunders

7 July 2020

Alder Hey Children's NHS
NHS Foundation Trust

PRINCIPLES

- Reflects and supports our post Covid-19 plans
- Enabling but safe – reduced burden
- 'Form follows function' – risk based
- Measure what matters: high level KPI's
- Better alignment with information flows/data driven
- Greater Divisional focus
- Improved accessibility for governors

Alder Hey Children's NHS
NHS Foundation Trust

RATIONALE AND SCOPE OF REVIEW

- Safe re-start requires robust governance and decision-making
- Emerging NHS landscape
- New organisational shape/revised Plan
- Post Covid ways of working - assurance to reflect this
- Keep pace with DHSC requirements of Boards
- Effective use of management time – digital tools
- Opportunity to address issues raised in Well Led reviews e.g. timeliness of information
- Committee changes in two phases
- Opportunity for NEDs to revisit committee work

Alder Hey Children's NHS
NHS Foundation Trust

PROPOSED CHANGES

Phase I

Name of Committee	Proposed Changes	High Level Summary of Duties
Board of Directors	Revise meeting schedule to align with performance report availability No other changes proposed	• Provide strategic leadership to the organisation • To ensure compliance with all applicable law, regulation and statutory guidance • To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients
Audit Committee	Move to a combined **Audit and Risk Committee (ARC)**	• Governance, Risk Management and Internal Control • Internal Audit • External Audit • Counter Fraud • Financial Reporting • Whistleblowing • Risk identification and mitigation • Risk Register and Assurance Framework • Strategy, Policy, Procedures and Action Plans • Best Practice and Training
Integrated Governance Committee	As above Operational risks to be overseen by Executive through '**Care Delivery Board**' (formerly Operational Delivery Board)	
Resources and Business Development Committee	Remain as is, with Terms of Reference refreshed and to incorporate monthly presentation of issues from Divisions Revise meeting schedule	• Finance and Performance • Business Development • IM&T • Partnerships • Monitor strategic business risk

Alder Hey Children's NHS
NHS Foundation Trust

PROPOSED CHANGES
Phase I continued …

Name of Committee	Proposed Changes	High Level Summary of Duties
Clinical Quality Assurance Committee	Move to a **Safety and Quality Assurance Committee (SQAC)** Revise meeting schedule	Safety – 'Avoid bad things' • Monitor agreed specific high level KPI's = Zero Harm • Champions and drives safety culture • Oversee responses to and learning from SI's • Continue oversight of key issues eg sepsis, mortality etc • Monitor strategic safety risks Quality – 'Do things well' • Oversee Inspiring Quality next phase • Monitor CQC action plan • Oversight of performance against CQC KLOE's • Monitor strategic quality risks
Workforce and Organisational Development Committee	Move to a **People and Wellbeing Committee (PAWC)** Revise meeting schedule Move to monthly (previously bi-monthly)	• Oversee People Strategy delivery against five key pillars • Monitor workforce KPIs and other relevant indicators/standards. • Support the development of leadership capacity and capability within the Trust, including talent management. • Champion equality , diversity and inclusion agenda • Support effective partnership working with Trade Unions. • Monitor strategic workforce risk

Alder Hey Children's NHS
NHS Foundation Trust

PROPOSED CHANGES
Phase II

Name of Committee	Proposed Changes	High Level Summary of Duties
Innovation Committee	TBC	• Oversee the development and acceleration of the Trust's Innovation Strategy • Approve investment decisions and ensure due diligence in line with the Trust's Scheme of Delegation

Other areas for consideration in Phase II
• **Research Management Board** • **Academy next steps**

Alder Hey Children's NHS
NHS Foundation Trust

POTENTIAL BUSINESS CYCLE CHANGES

In order to ensure that the most up-to-date Trust metrics are being received at each point in the governance structure, the following changes to the Board and committee arrangements are proposed:

Current Board / Committee	Frequency		Proposed Board / Committee	Frequency
Board of Directors	Monthly *(first Tuesday of the month)*		Board of Directors	Monthly *(PENULTIMATE Tuesday of the month)*
Audit Committee	Quarterly	}	Audit and Risk Committee	Quarterly
Integrated Governance Committee	Bi-monthly	}		
Clinical Quality Assurance Committee	Monthly *(third Wednesday of the month)*		Safety and Quality Assurance Committee	Monthly *(last week of the month, following on from Board)*
Innovation Committee	Monthly		Innovation Committee	Monthly
Resources and Business Development Committee	Monthly *(last Wednesday of the month)*		Resources and Business Development Committee	Monthly *(last Wednesday of the month)*
Workforce and Organisational Development Committee	Bi-monthly		People and Wellbeing Committee	Monthly

MEMBERSHIP

Alder Hey Children's NHS
NHS Foundation Trust

Audit and Risk Committee

The Audit Committee Membership shall comprise:

- Non-Executive Directors x 3 [one of whom shall be the Chair]

(The Chair of the Quality and Safety Committee will be a standing appointed member of the Committee)

NB As this is a statutory committee the membership needs to reflect those requirements – Executive Directors are in attendance only **not** members.

The Risk Committee Membership shall comprise:

- Non-Executive Directors x 3 [one of whom shall be the Chair]
- Director of Finance
- Medical Director
- Chief Nurse
- Director of Corporate Affairs
- Chief Operating Officer
- Director of Human Resources
- Chief Digital and Information Officer
- Associate Director of Nursing and Governance

The following would be expected to attend each meeting:

- Internal and External Audit representatives
- Divisional Directors
- Director of Marketing and Communications
- Development Director
- Director of Strategy & Partnerships

People and Wellbeing Committee

- Non-Executive Directors x 3 (one of whom shall be the Chair)
- Director of Human Resources & Organisational Development
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Director of Corporate Affairs
- Director of Marketing & Communications
- 1 x Representative from each Division

The following would be expected to attend each meeting:

- Deputy Director of Human Resources
- Head of Learning & OD
- Equality and Diversity Officer
- Chair of Staff Side

MEMBERSHIP continued…

Alder Hey Children's NHS
NHS Foundation Trust

Safety and Quality Assurance Committee

- Non-Executive Director x 3 (one of whom shall be the Chair)
- Medical Director
- Chief Nurse
- Director of Nursing
- Director of Finance
- Chief Operating Officer
- Director of Corporate Affairs
- Director of Human Resources and Organisational Development
- Divisional Directors

The following would be expected to attend each meeting:

- Deputy Director of Nursing
- Associate Director for Nursing and Governance
- Director of Infection Prevention Control

Innovation Committee

- 1 Non-Executive Director [Chair]
- 2 Non-Executive Directors
- Chief Executive
- Medical Director
- Clinical Director of Innovation
- Director of Finance
- Operational Director of Finance / Exec Lead for Innovation
- Director of Corporate Affairs
- Chief Digital and Information Officer

Resources and Business Development Committee

- Non-Executive Directors x 3 [one of whom shall be the Chair]
- Director of Finance
- Director of Operational Finance and Innovation
- Chief Operating Officer
- Director of Human Resources
- Chief Digital and Information Officer

The following would be expected to attend each meeting:

- Director of Corporate Affairs
- Associate Director of Finance
- Director of Marketing and Communications
- Development Director
- Director of Strategy & Partnerships

SCHEDULING

Alder Hey Children's NHS
NHS Foundation Trust

Day	TUE	WED	WED	TUE/WED	THUR	THUR	THUR	THUR
Meeting	Trust Board	Quality & Safety Committee	Resource & Business Development Committee	People and Wellbeing Committee	Innovation Committee	Execs	Care Delivery Board	Audit & Risk Committee
Time	10:00-16:00	10:00-12:30	09:30-13:00	14:00-16.00	13:00-16:00	9:30-13:00	9:30-13:00	14:00-16:00
September 2020	**22nd** (Aug Corp Report) (Aug Cttee Highlight Reports) (July Cttee Minutes)	**23rd** (Aug Corp Report)	**30th** (Aug Corp Report)	**8th** (July Corp Report)	14th	3rd, 17th, 24th	10th	17th
October 2020	**20th** (Sept Corp Report) (Sept Cttee Highlight Reports) (Aug Cttee Minutes)	**21st** (Sept Corp Report)	**28th** (Sept Corp Report)	**6th** (Aug Corp Report)		1st, 8th, 22nd	15th	
November 2020	**24th** (Oct Corp Report) (Oct Cttee Highlight Reports) (Sept Cttee Minutes)	MON **30th** (Oct Corp Report)	**25th** 1.30-4pm (Oct Corp Report)	**7th** (Sept Corp Report)	16th	5th, 19th, 26th	12th	19th
December 2020	**22nd** (Nov Corp Report) (Nov Cttee Highlight Reports) (Oct Cttee Minutes)	**23rd** (Nov Corp Report)	**30th** (Nov Corp Report)	**1st** (Oct Corp Report)		3rd 10th 24th	17th	
January 2021	**26th** (Dec Corp Report) (Dec Cttee Highlight Reports) (Nov Cttee Minutes)	3rd Feb (Dec Corp Report)	**27th** (Dec Corp Report)	**6th** (Nov Corp Report)	18th	7th 21st 28th	14th	21st
February 2021	**23rd** (Jan Corp Report) (Jan Cttee Highlight Reports) (Dec Cttee Minutes)	THUR **25th** (Jan Corp Report)	**24th** (Jan Corp Report)	**2nd** (Dec Corp Report)		4th 18th 25th	11th	
March 2021	**23rd** (Feb Corp Report) (Feb Cttee Highlight Reports) (Jan Cttee Minutes)	**24th** (Feb Corp Report)	**31st** (Feb Corp Report)	**3rd** (Jan Corp Report)	15th	4th 18th 25th	11th	

RECOMMENDATIONS & NEXT STEPS

Alder Hey Children's NHS
NHS Foundation Trust

The Board is asked to discuss and **APPROVE:**

- The revised Board Committee Structure
- The revised schedule of meetings
- A review of all changes following six months of operation
- Revised Terms of Reference to be discussed and approved by the Committees for ratification by the Board in September

Alder Hey Children's
NHS Foundation Trust

Audit Committee

Confirmed Minutes of the meeting held on **Thursday 30th April 2020 at 2:00pm**
Via Microsoft Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. A. Marsland	Non-Executive Director	(AM)
In Attendance:	Mr. G. Baines	Assistant Director, MIAA	(GB)
	Mr. J. Grinnell	Director of Finance	(JG)
	Mrs. C. Liddy	Director of Operational Finance	(CL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. M. Moss	Counter Fraud Specialist, MIAA	(MM)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Apologies:	Ms. K. Jenkinson	Interim Accountant	(KJ)
	Mrs. V. Martin	Counter Fraud Specialist, MIAA	(VM)
	Mrs. R. Lea	Associate Director of Finance	(RL)
	Ms. J. Preece	Governance Manager	(JP)
	Mr. R. Tyler	E&Y Accounts Manager	(RT)

Welcome and Introductions

The Chair welcomed everyone to the meeting and noted the apologies that had been received. It was reported that Michelle Moss would be representing Virginia Martin at today's meeting and Louise Shepherd would be joining members to share the Annual Governance Statement with the Committee.

20/21/01 Minutes of the previous meeting held on 16th of January 2020

Resolved:
The minutes from the meeting that took place on the 16.1.20 were agreed as an accurate record of the meeting.

Attention was drawn to the two matters under the meeting review section of the minutes;
1. Clinical audit issue (FIT testing) to be raised to CQAC. 2. Request to the Innovation Committee to provide a regular update on action taken by the Trust following a piece of work conducted by KPMG. It was confirmed that both of these items have been actioned.

20/21/02 Matters Arising and Action List

Action 19/20/07: *Draft Counter Fraud Report (update on the identification of fraud risks)* – It was agreed to discuss this action under the relevant agenda item during today's meeting.

Action 19/20/37: *Counter Fraud Progress Report Q2 (fraud awareness)* – It was agreed to discuss this action under the relevant agenda item during today's meeting.

Action 19/20/54: *Waiver Activity Report (including details of the reason for the waiver)* – This action has been completed and has been included on the agenda. **ACTION CLOSED**

Action 19/20/50.3: *MIAA Progress Report ('receipt of management responses' KPI for inclusion in reporting for 2020/21)* – It was agreed to set a 10 day standard turnaround period for receipt of written management responses for draft audit reports. **ACTION CLOSED**

Action 19/20/50.4: *MIAA Progress Report* – The information relating to the number of contingency days allocated in the Audit Plan has been included in the annual report and signed off. **ACTION CLOSED**

Action 19/20/50.5: *MIAA Progress Report (develop an internal audit questionnaire in conjunction with MIAA for introduction from 2020/21)* – This action will be discussed once a date has been agreed to commence the audit plan. **ACTION TO REMAIN OPEN**

Action 19/20/50.6: *MIAA Progress Report (introduce a mechanism to review the effectiveness of External Audit)* – This action will be discussed once a date has been agreed to commence the audit plan. **ACTION TO REMAIN OPEN**

Action 19/20/51: *Follow-up Audits (introduce summary table with percentages and details of audit contacts, information received and that outstanding)* - It was agreed to keep this action on the log and receive an update in September 2020. **ACTION TO REMAIN OPEN**

Action 19.20/63: *Draft Internal Audit Plan 20/21* – The information relating to audits conducted over the last 5 years was shared with Committee Members in December 2019 but has not been included in the document due to an oversight. MIAA have agreed to update the template for next year and ensure it is included in the 2020/21 Plan. The purpose of the request for this information is to enable an informed judgement to be made that audits being conducted are appropriate over a period of time. The days for each audit has been included in the Audit Plan. The agreed dates for undertaking the audits remains outstanding and the agreement of some dates may be delayed due to the current COVID 19 situation. When the approach to commencing the Audit Plan (see later in minutes) is agreed the dates for each audit will be set and included in the MIAA Progress Report. **ACTION CLOSED**

Action 19/20/65: *Counter Fraud Progress Report (HR to provide the CFS with the information required to complete fraud investigations)* – Training has gone ahead with HR and a meeting has taken place to discuss what information can and cannot be disclosed when conducting an investigation. Lessons learnt have been identified and shared with the HR team. In addition to this, bespoke training has been conducted with HR, Finance and the Procurement team and a protocol has been compiled to highlight the process that should be followed when carrying out a HR/fraud investigation. **ACTION CLOSED**

Action 19/20/69.1: *Audit Committee Self-Assessment* – The Annual Report template has been updated for Sub-committees to include the assurances received and their impact on the Trust's assurance framework. **ACTION CLOSED**

Action 19/20/69.1: *Audit Committee Self-Assessment* – The Chair confirmed that the requests to CQAC regarding Audit Committee input to the Clinical Audit Plan, updates from CQAC regarding significant Clinical Audit findings and receipt of Clinical Audit's Annual Plan and Annual Report have been made. However, due to current operating circumstances, Clinical Audit is on hold and therefore there is a delay in producing documents. In addition,

the requirement for receipt of the Annual Plan and Annual Report have been added to Audit Committee's Workplan. **ACTION CLOSED**

Action 19/20/69.4: *Audit Committee Self-Assessment (update the Audit Committee Work Plan)* – The work plan has been updated and has been included on April's agenda.
ACTION CLOSED

20/21/03 Internal Audit Progress Report.

The Internal Audit Progress Report was submitted to the Committee to provide an update on assurances, key issues and progress against the Internal Audit Plan for 2019/20.

It was reported that work has been substantially concluded on the agreed 2019/20 Internal Audit Plan but fieldwork stalled on the 'Non-Clinical Claims' review in December as a result of staff sickness, and then again in March due to Covid-19. It was confirmed that the Trust has asked for this review be deferred until 2020/21.

Attention was drawn to the following reports that have been finalised and the assurance levels allocated:

- Safeguarding – Substantial Assurance.
- Conflicts of Interest – Fully compliant in three areas and partially compliant in two areas.
- Data Security and Protection Toolkit – Substantial Assurance.

The Chair raised concerns in respect to the six month delay of the Non-Clinical Claims review and queried as to whether anything had been implemented to address the matter. It was reported that a meeting had taken place with the lead in October and a sample had been selected, but the process stalled due to a double bereavement and subsequently Covid-19. The Chair advised that these two reasons do not account for the whole six month delay with Covid-19 only impacting very recently and asked for feedback from the management on the subject. Erica Saunders advised that there was no further factual information to add at the present time but agreed to liaise with the Director of HR to negotiate a reasonable time frame in which to conduct the review.
20/21/03.1 Action: ES

The Chair acknowledged that the Non-Clinical Claims review will take place during 2020/21 but requested that management look into the reasons for the audit being delayed and provide feedback to the audit contact regarding audits not being delayed.
20/21/03.2 Action: ES

The Chair queried why the Infrastructure audit was carried out in the form of an advisory piece of work when this had not been agreed by the Committee, and requested comments from the internal auditors and management regarding this matter.

Gary Baines provided some background information and confirmed that it was always the intention to conduct an advisory piece of work, which MIAA were comfortable with. Upon reflection by MIAA, from a lessons learnt perspective, it was felt that this request should have been documented so that a discussion could take place during an Audit Committee meeting for clarity and approval purposes.

The Chair asked as to whether the approach was made for support outside of the Audit Plan or directly via the Audit Plan. Gary Baines reported that contact was made with MIAA to see if there was any room in the Plan to carry out a gap analysis; this was costed up and a discussion took place via the Audit Committee in 2019 where it was agreed to undertake the Infrastructure audit by swapping it with planned work on cyber security.

The Chair advised that she had checked the respective minutes but found that they weren't clear as to whether it was to be an advisory piece of work. It was pointed out that from a management perspective requesting external help to address issues is the right thing to do, but from an Audit Committee viewpoint this piece of work shouldn't have taken place on an advisory basis as Infrastructure is a long standing process and therefore an assurance basis was appropriate. Attention was drawn to the importance of supporting management who have concerns and wish to commission work to support their rectification. The Chair confirmed that where this results in a "lower" audit opinion this will not be viewed negatively by the Committee, in fact the opposite as it demonstrates a mature approach to risk and control. The Chair also advised that there is a need to be cautious in commissioning MIAA to undertake advisory work outside of the Audit Plan as this may affect MIAA's ability to then undertake work requested in the Audit Plan.

Following discussion, it was pointed out that the Audit Committee wants to continue to support management to raise areas of concern for external support but it was felt that some thought needs to be given when making a decision about:

1. Who is going to conduct the work.
2. How the work will be funded. For example, department budget or Audit Plan.

The Chair asked that MIAA take into account these two decision points in terms of advisory assignments.

The Committee was informed that the audit for DPST and Conflicts of Interest were conducted on a slightly different basis; DPST was carried out via a toolkit approach and an opinion was given without recommendations, and Conflicts of Interest was conducted via an NHSE guidance checklist process with compliance statements being given for individual components. For clarity purposes, a request has been made to MIAA for an additional column to be included in the Annual Plan and Progress Report to highlight the process that has been used to carry out individual audits e.g. assurance, advisory, checklist.

20/21/03.3 Action: GB/KS

The Chair drew attention to the hard work that has taken place to finalise audits during extremely challenging times and thanked management, MIAA and Jill Preece for their support in achieving this end result.

John Grinnell highlighted the broader support received from MIAA across departments to assist with the audit process and again offered thanks for their help during the crisis.

Resolved:
The Audit Committee received and noted the contents of the Internal Audit Progress report.

20/21/04 Director of Audit Opinion and Annual Report 2019/20.

The Audit Committee received the 2019/20 Head of Internal Audit Opinion for the Trust, together with the internal audit coverage and output during 2019/20. The following points were highlighted:

- The overall opinion for the period from the 1.4.19 to the 31.3.20 provides Substantial Assurance that there is a good system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.
- Attention was drawn to the specific section at the beginning of the report in respect to MIAA's response on internal audit issues arising from the Covid-19 pandemic. It was agreed by the National Heads of Audit that this information should be included in the Head of Audit Opinion report for 2019/20 given the unique circumstances.
- MIAA provided an overview of the report drawing attention to the basis for forming the opinion, the internal audit coverage/outputs and the one high level risk that was raised out of the 30 recommendations raised. Upon reflection it was felt that that the overall outcome was positive, there were a number of substantial assurance opinions given and all of the audits identified in the Plan were delivered, with the exception of the Non-Clinical Claims audit which has been deferred until 2020/21 at the request of the Trust.
- The Chair felt that the Director of Audit Opinion and Annual Report summarises the work that the Trust has done over the year and queried the date of the next external review for MIAA. It was reported that an external review will take place in 2021 but the organisation conducting the review has yet to be confirmed.
- The Chair also commented that completion of the Plan within the year had been helped by undertaking the majority of the fieldwork for the audits by the end of January and therefore confirmed that this should continue, subject to any exceptional circumstances as a result of Covid-19.

Resolved:
The Audit Committee approved the Director of Audit Opinion and Annual Report for 2019/20. It was noted that the Trust received a 'Substantial Assurance' opinion from the Head of Internal Audit Opinion.

20/21/05 Final Internal Audit Plan – 2020/21.

The Audit Committee received the Internal Audit Plan for 2020/21 and was provided with an overview of the review and scope of the Plan.

The Chair highlighted the importance of having an open debate about the commencement of the Audit Plan given the likely impact of Covid- 19. It was reported that a meeting has been scheduled for the 11.5.20 between MIAA and management in order to agree the areas that can be targeted earlier taking into account the sensitivity of the pressures that management are under re the scoping of work.

The Chair queried the views of management in respect to the best approach for this matter. John Grinnell acknowledged that the next six to eight weeks will be really challenging and suggested having a monthly catch-up with MIAA in order to review and adapt the Plan as the NHS evolves its approach over the year. It was also felt that the Trust may have to look at the risk profile as the Plan progresses.

Claire Liddy explained that due to national guidance around Covid-19 there will be a number of audits that won't take place, one of which is Workforce Planning as it has been paused. The organisation will need to adapt the Plan to reflect the evolving changes to the NHS as a result of the pandemic. It was confirmed that the finance audits can take place in Q1.

The Chair requested that the Audit Committee be included in the scoping discussions for the Risk Management audit, DMO audit and the Clinical Audit review as they are assurance functions.

In conclusion, the members of the Audit Committee agreed the following actions:

20/21/05.1 **Action:** Monthly catch-up meetings to take place between the Trust and MIAA to review the Audit Plan for 2020/21 and the timing of audits. **(KS/JG/CL)**
20/21/05.2 **Action:** Verbal update on the Plan to be provided during May's Audit Committee. **(KS)**
20/21/05.3 **Action:** Formal update report on the Plan to be shared with the Audit Committee at the end of June. **(KS)**
20/21/05.4 **Action:** Audit Committee to be involved in the scoping discussions for the Risk Management audit, DMO audit and the Clinical Audit review. **(KS/KB)**

Resolved:
The Audit Committee approved the Internal Audit Plan for 2020/21. With the exception of the finance audit, it was noted that the Plan likely won't commence until Q2.

20/21/06 Internal Audit Charter.

Resolved:
The Audit Committee received and approved the Internal Audit Charter.

20/21/07 Counter Fraud Annual Report 2019-20.

The Chair requested an update on the two outstanding actions on the Action Log that date back to 2019 (*19/20/07 and 19/20/38*).

Action 19/20/07: *To provide an update on the identification of fraud risks within Ulysses to enable compliance with the annual self-assessment (Standard 1.4 - page 4 of the annual report)* – It was confirmed that the Trust is in a position to finalise how the fraud and bribery risk is articulated. It needs to be framed in such a way so that it captures the essence of it without having to underpin a risk register in its entirety. This action will be concluded by the end of May 2020. Michelle Moss advised that this Standard can be turned green if the benchmarking is reviewed, signed off and the risk is included on the risk register.
ACTION TO REMAIN OPEN

Action 19/20/37: *Follow-up recommendations (Introduction of e-learning modules on fraud awareness to be included as part of the induction process)* – It was confirmed that this standard has been changed to green as a result of the work that has taken place throughout the year by Counter Fraud. Four bespoke presentations have been conducted with Finance, HR, Procurement and IT and the Trust is looking to conduct fraud assessment training for medical consultants. Melissa Swindell submitted the mandatory training e-learning proposal for fraud awareness to the Education Governance Committee, but a decision was made not to incorporate the e-learning module as part of the Trust's mandatory training. Counter Fraud is confident that the bespoke training that took place with the Trust is enough to evaluate and assess this Standard. **ACTION CLOSED**

Michelle Moss advised the committee that 'Standard 2.4' has been risk ranked as amber following the conclusion of the 'Conflicts of Interest' review which was undertaken as a joint review between Internal Audit and Counter Fraud as part of a proactive piece of work. In order to achieve the Standard an organisation has to achieve 80% compliance in respect to decision makers completing declarations. The sample that was tested during the review reflected a 60% return.

The Committee was informed of the issues that have been experienced with the embedding of the new system for conflicts of interest and it was reported that an internal recommendation has been made to enlist the support of the Divisions to incorporate this area of work into their local practices.

The Chair queried the implications if the Trust does not meet the Standards. Michelle Moss confirmed that there are no penalties incurred for not meeting Standards. It was reported that NHS Counter Fraud Authority will review these Standards and conduct an engagement meeting with Counter Fraud to ensure that the Plan that the Trust has received for the year is deliverable and as many Standards as possible are being met or recommendations are being made.

The Audit Committee received the 2019/20 Counter Fraud Services Annual Report. It was reported that the overall Standards compliance is green and this information will be submitted and uploaded onto the online system for review and approval by the end of May 2020. Michelle Moss agreed to circulate an e-mail with a link to enable sign off to be done remotely.

20/21/07.1 Action: MM

The Committee was advised that there are five on-going investigations at the Trust, one case is in the process of being prepared for the CPS and there are still a number of cases awaiting closure. Michelle Moss agreed to liaise with John Grinnell regarding the outstanding cases awaiting closure.

20/21/07.2 Action: MM

The Chair queried the lack of feedback from Counter Fraud following the joint Conflicts of Interest audit that was conducted between Counter Fraud and Internal Audit. The Committee was advised that this hadn't been included in the MIAA Progress Report due to an omission. It was confirmed that an updated version of the Progress Report will be circulated to committee members.

20/21/07.3 Action: KS

Resolved:
The Audit Committee received and approved the 2019/20 Counter Fraud Annual Report.

20/21/08 Counter Fraud Plan 2020/21.

The Audit Committee received the Counter Fraud Annual Work Plan for 2020/21 and was provided with an overview of the programme of work which comes with a caveat for change as a result of the on-going pandemic.

A query was raised as to why recruitment and fraud haven't been included in the Work Plan for 2020/21. It was reported that there is an awareness of these two areas of work but they aren't on the radar at the present time and therefore will not be prioritised this financial year.

Resolved:
The Audit Committee received and approved the Counter Fraud Work Plan for 2020/21.

20/21/09 E&Y Technical Update Report.

The Audit Committee received the Health Audit Committee briefing for Q1 from Ernst and Young. It was pointed out that the briefing was compiled at the beginning of March and therefore may not be as pertinent as normal due to the changes that have been made as result of the pandemic.

The Chair queried as to whether the auditing of the 2019/20 Quality Account has been suspended or delayed. Ernst and Young reported that they won't be providing an audit opinion on the 2019/20 Quality Account, but agreed to confirm as to whether the Trust can publish the Report if it has been prepared.

20/21/09.1 Action: HR

Attention was drawn to page 4 of the briefing where it provides good practice recommendations for inclusion in the Quality Account. The Chair asked for the respective statements/disclosures to be included, if possible, in the Quality Account for 2019/20 and future reports.

20/21/09.2 Action: ES

The Director of Corporate Affairs advised that the Trust made a decision to defer the publication of its Quality Account Report following receipt of a letter from NHSE/I at the end of March 2020 re the 'reducing of burdens'. However, the majority of the report has been compiled and will be concluded, therefore it has been agreed to publish the organisation's Quality Account Report later on in the year to ensure the Trust fulfils its public accountability.

Hassan Rohimun provided an update on the current progress of the year-end audit. The following points were highlighted:

- Ernst and Young have commenced the year-end audit and are expecting to receive the financial statements on the 1.5.20. In the event of any issues contact will be made with the Trust in order to provide an update.
- As a result of current arrangements the deadlines for reporting have been deferred to the 25.6.20 therefore there may be a possibility that some of the work that is being undertaken by Ernst and Young won't be completed in line with the Trust's Audit Committee timetable. Attention was drawn to the possibility of implementing a delegated arrangement prior to submission, if required.

The Chair pointed out that the Trust had arranged for committee meetings to take place a week later in April and May to accommodate the deferred submission date, but advised that in the event May's committee meeting needs to re-scheduled contact should be made with the Trust to flag this matter.

- HR drew attention to two issues arising as a result of Covid-19; 1. *Evaluation* – It was reported that RICS have provided guidance to their member valuers highlighting considerations that need to be made as a result of the pandemic. A number of valuers are now referring to 'material uncertainties' in reports. The Committee was advised that if this narrative features in the Trust's report consideration will need to be given from an auditing perspective. 2. *Going Concern* – It was reported that the planning round has been suspended and funding for 2020/21 is yet to be agreed. It was confirmed that further guidance will be provided by NHSI in terms of future funding.

Resolved:
The Audit Committee received and noted the Health Audit Committee briefing for Q1 from Ernst and Young.

20/21/10 Audit Committee 2019/20 Annual Report.

The draft 2019/20 Audit Committee Annual report was submitted to the Committee for approval.

The Chair drew attention to the sections in the report relating to MIAA and Ernst & Young and asked that comments be provided in the event that any amendments to the accuracy of factual information are required.

20/21/10.1 Action: MIAA/E&Y

John Grinnell queried as to whether reference to Covid-19 and its impact should be included in the Annual Report. Erica Saunders advised that there will be a section in the Trust's Annual Report that will refer to Covid-19 and felt that it is important to capture this in brief in all relevant reports. Erica Saunders agreed to liaise with Jill Preece re the additional text that is to be included in the 2019/20 Audit Committee Annual Report.

20/21/10.2 Action: ES

The Chair asked for her gratitude to be relayed for the support that was given by Jill Preece in respect to the compilation of the Audit Committee Annual Report and Work Plan.

Resolved:
The 2019/20 Audit Committee Annual Report was approved subject to the inclusion of the additional text relating to Covid-19 and its impact.

20/21/11 Draft Annual Governance Statement 2019/20.

The Chief Executive, Louise Shepherd, provided the Audit Committee with an overview of the Draft Annual Governance Statement (AGS) for 2019/20 and requested approval of the document to enable it to be incorporated in the Trust's final accounts.

The Committee was advised that the AGS forms part of the Trust's overall final accounts process and covers all aspects of the control environment and risk strategy. Attention was drawn to the substantial assurance rating that was awarded to the organisation following an

internal audit review by MIAA. The substantial rating was confirmed by the Director of Audit Opinion in 2020.

The Chair felt that the report was very comprehensive but drew attention to a small number of drafting and spelling errors that need rectifying before the document is included in the final accounts. It was also felt that the first time an abbreviation is introduced in the report it is important to use the full term before continuing to use the acronym. Erica Saunders agreed to amend the AGS accordingly.

20/21/11.1 Action: ES

Resolved:
The Audit Committee received and approved the draft AGS to enable it to be included in the Trust's final accounts.

20/21/12 Gifts & Hospitality Register.

The 2019/20 Gifts and Hospitality Register was submitted to the Audit Committee for noting purposes. The Chair queried as to whether each line is reviewed in order to confirm that the declaration is within policy. Erica Saunders advised the Committee that submissions tend to be signed off locally but felt that the organisation needs to embed a more frequent review of declarations. The Chair also requested that the Register is reviewed holistically, as well as line by line noting that there were a couple of individuals who had received regular gifts and hospitality from the same organisation for which individual line entries might be in line with policy but when added together may provide a different perspective. Erica Saunders agreed to liaise with Claire Liddy to discuss the development of a process for gifts and hospitality that will ensure checks are robust without restricting colleagues. A report will be submitted to the Audit Committee during September's meeting.

20/21/12.1 Action: ES/CL

Attention was drawn to the nature of activities that take place in the innovation and research space at the Trust that link into the commercial sector. The need for transparency was highlighted, whilst offering parameters for staff and ensuring that the declaration process is straight forward. Hassan Rohimun highlighted the importance of reaching out and communicating with all staff to make sure they are aware of the Trust's gifts and hospitality process.

Resolved:
The Audit Committee received and approved the 2019/20 Gifts and Hospitality Register.

20/21/13 Waiver Activity Report.

Resolved:
The Audit Committee received and noted the contents of the Waiver Activity Report.

20/21/14 Board Assurance Framework.

The Audit Committee received the 2019/20 Board Assurance Framework Year-end review and March update. The Committee was advised that the report provides information on the year-end position, a refresh of strategic risks by the Board and the introduction of the risk to the organisation as a result of the Covid-19 pandemic.

The Chair queried as to whether the top corporate risks should be shared with the Trust Board following the cancellation of the Integrated Governance Committee. It was reported that the Board will be updated on risk via May's Trust Board agenda.

Resolved:
The Audit Committee received and noted the contents of the 2019/20 Board Assurance Framework Year-end review and March update

20/21/15 Audit Committee Work Plan.
Resolved:
The Audit Committee received and approved the Work Plan for 2020/21.

20/21/16 Any Other Business.

There was none to discuss.

20/21/17 Meeting Review.

This item wasn't discussed.

Date and Time of the Next Meeting: Thursday 28th of May, 2:00pm-4:00pm, via Teams

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th July 2020

Paper Title:	**Resource and Business Development Committee Assurance Report from the May meeting**
Date of meeting:	**24th June 2020**
Report of:	**Ian Quinlan, Non-Executive Director**
Paper Prepared by:	**Julie Tsao, PA**

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Resource and Business Development Committee meeting held on 24th June 2020 along with the approved minutes from the meeting held on 27th May 2020.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ✓
Resource Impact:	

1. **Introduction**
   The Resource and Business Development Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

   Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality, finance and workforce including delivery and development.

2. **Agenda items received, discussed / approved at the meeting)**

   Finance Report to include:
   M2 financial position
   Financial architecture and key risks
   Alder Hey in the Park Campus Development update
   Covid-19 Commercials:
   PPE manufacturing
   Mask commercialisation
   M1 Corporate Report
   Future Productivity and Benefit Opportunities.
   Digital Update
   Marketing and Communications Activity
   Board Assurance Framework

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**

   Key risks included:
   Board Assurance Framework – Next phase of plan will be presented at the July Trust Board.

4. **Positive highlights of note**

   Future Productivity and Benefit Opportunities – Going forward it was agreed to include metrics to track waste as well as productivity.

5. **Issues for other committees**

   None.

6. **Recommendations**
   The Board is asked to note the committee's regular report.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed **Minutes of the meeting held on Wednesday 27th May 2020 at 1:30pm, 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)
	Claire Liddy	Director of Operational Finance	(CL)
	Dame Jo Williams	Chair	(JW)
In attendance:	Sian Calderwood	Neonatal Service Manager	(SC)
	Mark Flanagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	RG)
	Rachel Lea	Acting Deputy Director of Finance	(RL)
	Dani Jones	Director of Strategy	(DJ)
	Erica Saunders	Director of Corporate Affairs	(ES)
	David Powell	Development Director	(DP)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies	Stuart Atkinson	Associate Director Estates	(SA)
	Sue Brown	Associate Development Director	(SB)
	Graeme Dixon	Head of Building Services	(GD)
	Nicki Murdock	Medical Director	(NM)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)

20/21/07 **Minutes from the meeting held on 30th April 2020**
Resolved:
The minutes of the last meeting were approved as an accurate record.

20/21/08 **Matters Arising and Action log**
There were no outstanding actions.

John Grinnell referred to the Children's Tariff Working Group (CTWG) who are working together to agree on a Children's Tariff for complex cases. The (CTWG) are meeting tomorrow, John Grinnell advised he would update the Trust Board at their next meeting on 2nd June 2020.

20/21/09 **Declarations of Interest**
There were no declarations of interest.

20/21/10 **Finance Report**
Month 12
Claire Liddy referred to a national exercise that is carried out annually following the close of the accounts in March. This has highlighted an impairment in the Trust accounts in relation to Alder Hey Living Hospital Joint Venture.

NHSI have requested that the transaction is recorded as a DEL from an AME. The Trust's accountants EY have been informed and are comfortable with this change. This however does change the final Control Total from a 295 to an 83 positive variance. As this is a technical change it does not affect the end cash position or the statutory accounts.

Month 1
The Trust achieved a break-even Control Total position as required by NHSI. The new financial regime for 20/21 consists of block contract payments set by NHSI with a retrospective top up made for any additional costs or differences that have not been included to achieve an overall breakeven position.

To achieve a breakeven position, the Trust requires a top up payment under the new financial regime of £4.1m. The top up consists of 2 elements; COVID-19 expenses incurred in April and other costs that have not been included by NHSI in the contract payments such as lost income, increased capital charges and recent service investments. COVID-19 expenses include staff not using annual leave in the same way as previous years. Alder Hey is awaiting guidance on how this should be accounted.

A breakdown of the spend incurred is included in the M1 paper. Other top ups that come in at £4.1m; 0.7m relates to top up changes, this reflects a reduction in non-clinical income i.e. car park and catering. A submission has been made to NHSI for the reimbursement of these costs.

A number of RABD members asked if was likely that the £4.1m would be reimbursed. Whilst Alder Hey had stayed within the guidance it was noted that the expenses would be scrutinised. Alder Hey would receive confirmation on the reimbursement in June 2020.

Cash in the bank at the end of April was £107m.

Financial Framework
Rachel Lea updated RABD on a changes since the last meeting, this included changes to the phases, the phases are now as follows:
Phase 1 April – July
Phase 2 August – October
Phase 3 November – March

Whilst the final guidance is awaited for phase 2 RL noted the expected changes including the continuation of block contracts with a refined top up mechanism focusing on cost control and financial grip. A further change is £250K Covid-19 spend limit is to be removed, all capital spend must now be pre-approved.

RL referred to a slide on NHSI expected increase/decrease in relation to a number of expenditures for Phase 2.

Members of RABD noted concerns in relation to increasing activity due to a number of new factors including lack of PPE and social distancing. RABD noted Claire Liddy is leading on innovating new ways of obtaining and using PPE. Adam Bateman noted there is no NHSI cost category for PPE, CL advised that the centre (NHSI) are picking up those costs, for now.

RL went through the current financial governance position noting that a further version would be presented at the Operational Board on 4th June 2020.

RL re-highlighted 20/21 financial risks.

Resolved:
RABD received and noted:

- **Technical change to the 2019/20 Trust Accounts**
- **M1 Finance report**
- **Financial Framework**

20/21/12 **Neonatal Business Case**

Adam Bateman introduced the Neonatal Business Case re-iterating the importance for Alder Hey to be able to provide a state-of-the-art Neonatal Service for families here at Alder Hey. AB advised that it was important to share with RABD today the current position however there is no conclusion at the moment. This is mainly in relation to the financial sustainability of the scheme. The main purpose of presenting today is to move forward with the design and development.

Sian Calderwood gave an overview of the changes that have been made since the original business case was approved in 2018. Currently as the Commissioners have advised they are unable to support the level of staffing requirements as per the British Association of Perinatal Medicine (BAPM) these standards have been removed however this will be reviewed going forward. The clinical pathways have been reviewed improving the length of stay for patients. All the changes highlighted within the presentation have had a positive financial impact reducing the costs by £1.2m. The Commissioners have agreed to pay £8.4m leaving a £0.9m gap.

SC went through changes in how the Neonatal team are in working in responsive to COVID-19 with virtual ward rounds and less travel between the two sites. As there are positive benefits for both the patient and staff this will continue to be developed further. Another option being looked into is whether it would be possible to carry out surgery at the Liverpool Women's site. This will also continue to be further reviewed it was noted that if this is possible it would not change the cot bed numbers required at the Alder Hey site.

SC went through the 4 options in relation to where the build would be best placed. A number of queries were raised in relation to the draft photo of the extension used on the slides. David Powell gave a number of explanations on the architects current position noting that this is still in a draft position.

CL gave an overview of the build capital history explaining a number of increases since the scheme began in 2018. The Chair queried contingency plans for the draft schemes. Russell Gates responded noting two contingency plans that had been included within the schemes.

CL highlighted the required business development targets for the proposed schemes. RABD raised a number of concerns on whether the targets would be achievable.

SC concluded the presentation asking RABD for support to invest £150k to further the design option A (lightly) and option B and B+ in full to, planning permission stage process. A query was raised on whether option A required to be pursued any further, it was agreed that following the discussions option B and B+ would be taken forward.

Resolved:

RABD noted progress to date on the Neonatal Business Case and supported:

- Investment of £150k to further design option B and B+ in full to, planning permission stage process.

- Further work to develop Business Development Targets by July 2020.

20/21/13 Cluster/Dewi Construction Contract

Following approval last month to present an update to Trust Board on 5th May 2020 a further update was received. Trust Board had approved the project to move forward to contract signature therefore the revised budget is £21,475,526. However, the team's target will be to bring the scheme within the original budget of £21,279,817.

A Letter of Intent has been issued to Galliford Try for the advanced works up to £487K. The advanced works will start on site on 1st June 2020, whilst the Trust's technical team sign off the proposals and the contract documents are finalised. The intention is to have the contract ready for signature by the end of the first week in June.

Russell Gates highlighted a number of pre and post contract risks to mitigate noting the due diligence that would continue to be carried out.

Resolved:
RABD acknowledged the good progress in terms of the reduction in cost along with the continued effort to bring the scheme in at its original budget.

20/21/14 PPE Manufacturing Proposals

Claire Liddy updated RABD on the current position. Cheshire and Merseyside region have supported the review of a local manufacturing hub. CL is leading progress and has been liaising with a number of local factories who would be able to provide support with PPE. CL referred to a factory based on the Wirral who have many years healthcare pharmaceutical packaging experience.

Options for providers for PPE alternatives i.e. gowns/aprons are also being looked into.

CL provided assurances that the factory chosen would be working to British Standards, as noted by Claire Dove if masks aren't made to these standards they are unusable.

Resolved:
RABD noted to current position in relation to PPE proposals.

20/21/15 Month 1 Corporate Report

ED performance for April is 96.5%. Attendances are significantly lower than the same time last year however the opportunity of lower attendances has been used to establish more robust breach management and escalation processes. Adam Bateman noted his thanks to the ED department in relation to the work that has been carried out to comply with social distancing.

Cancer Care access has remained as expected. Services under non-urgent have seen lower patient numbers meaning a number of patients are waiting longer than previously expected. Adam Bateman referred to governance arrangements ensuring urgent patients are being seen. Virtual appointments are being used to comply with social distancing. AB referred to a phase 2 plan for Outpatients noting that details of this are due to be presented at Trust Board on 2nd June 2020.

Resolved:

RABD received M1 Corporate report.

20/21/16 RABD Terms of Reference

Under duties the Chair made reference to review productivity and efficiency noting that this isn't currently covered on the agenda and for this to be included.
Action: JT

Erica Saunders noted that an additional NED was required and was under review. Erica referred to discussions with the Chair in relation to Monitor performance assuring the Board that performance is in line with plans, noting this sentence is to be amended.
Action ES

Resolved:
Subject to the above amendments RABD APPROVED the Terms of Reference.

20/21/17 Any Other Business

Marketing Report

Mark Flanngan provided a update:
- Launch of the revised staff newsletter Alder Hey Life.
- National coverage has been aired on an Alder Hey patient, baby Erin.
- COVID staff briefing phase 2 to commence.
-

Date and Time of Next Meeting: Wednesday 24th June 2020, 09:30, via Teams.

Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 7 July 2020

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

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

Board Assurance Framework 2020/21

1. Purpose

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

2. Review of the BAF

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.

Board members will notice that corporate risks are now linked to BAF Risks – a summary of these risks can be found at appendix A. The full BAF document is included as Appendix B.

BAF Risk Register - Overview at 30 June 2020

BAF Risk Register - Overview at 30 June 2020
3.4: Financial Environment (S)   1.3: Keeping children, young people, families and staff safe during COVID-19 (S)
1.2: Inability to deliver accessible services to patients, in line with national standards, due to rising demand (S)
2.1: Workforce Sustainability and Development (S)   2.2: Employee Wellbeing (S)
2.3: Workforce Equality, Diversity & Inclusion (S)
3.2: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S)   4.1: Research & Innovation (S)
1.1: Inability to deliver safe and high quality services (S)   4.2: Digital Strategic Development and Operational Delivery (S)
1.4: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (S)

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

3. Summary of BAF - at 30 June 2020

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

Ref, Owner	Risk Title		Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 PB	**Inability to deliver safe and high quality services**		3x3	2x2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to rising demand**		**3x5**	3x2	STATIC	STATIC
1.3 AB	**Keeping children, young people, families and staff safe during COVID-19**		**5x4**	3x3	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**		3x2	3x1	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development**		4x3	4x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**		3x4	3x3	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**		3x4	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**		3x4	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**		4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**		**4x5**	4x3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
4.1 CL	**Research & Innovation**		3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**		4x2	3x2	STATIC	STATIC

8. Changes since 2 June 2020 Board meeting

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 score in month. Restart following Covid and positive movement in actions. Full system reshape and governance underway and not yet settled; focus on ensuring C&YP are among the system priorities.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Actions reviewed. Ongoing consultation is in place with BAME staff during the pandemic.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  Following review with specialty leads no issues identified

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to rising demand (AB)***
  The effects of the loss of capacity for planned and urgent care during COVID-19 continue; waiting times are increasing and in the Division of Community & Mental Health and the Division of Surgical we have some patients waiting over 52 weeks for care. Presently we focused on the safe management of children and young people on the waiting list by getting the following components of the system right:
    - Maximise capacity, safely
    - Effective clinical review and prioritisation
    - Provide a scorecard with helpful and accurate information against defined clinical and safety standards
    - A single-version of the truth waiting list, with excellent data quality
    - Good administration/ documentation of a patient's pathway
    - Capacity & demand model that projects trends in waiting times

  We continue to make progress in restoring services with an increase in face-to-face outpatient capacity of 300 patients per day from the 29 June 2020. From the 8 June our operating capacity increased to 110 sessions per week, from 70 sessions.

- ***Keeping children, young people, families and staff safe during COVID-19 (AB)***
  On keeping staff safe: Our antibody testing results for staff at 7% is the lowest in the region and indicates a low infection rate of staff in the Trust and the extremely low prevalence rates amongst patients at Alder Hey. Our supplies of PPE have been good and we have

maintained access to equipment for staff and have support an increase in elective activity. Comfort boxes have been provided to staff to provide them with some comforting items and to recognise their outstanding work. Risk assessments of at risk members of staff have taken place. We continue to support members of staff to work from home where possible. On keeping patients safe: We have made good progress in increasing access to care with capacity expanded in theatres, outpatients and Radiology. Nonetheless, there is significant further work to do to clear the backlog. Our testing pathways for emergency admissions and surgical operations is in situ. We have undertaken clinical reviews of patients on the waiting list who are considered to be at risk.

- ***Inability to deliver safe and high quality services (PB)***
  No change to BAF score in month. Rota hub fully operational with staff in place to support. All staff have now returned to their substantive roles apart from those shielding. Change in government advice re shielding with risk assessments needed for staff to be supported back to work safely. Gradual ramp up of services back to pre COVID levels with capacity increasing. Daily safer staffing huddles fully established across the Trust ensuring staffing in line with national guidance and staffing remains green. ECP students interviewed and allocated substantive posts for September starts but continue as Band 4s until end of July as do the band 3's. Sickness remains high in certain areas. Still awaiting final CQC report.

- ***Financial Environment (JG)***
  Financial arrangements beyond M4 still remain unclear as national guidance awaited. Significant work underway with all divisions to create a new financial framework that will be fit for purpose in this new environment.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Review pre-June Trust Board

- ***Digital Strategic Development and Operational Delivery (KW)***
  BAF reviewed, good progress made, new core resilient infrastructure operational.

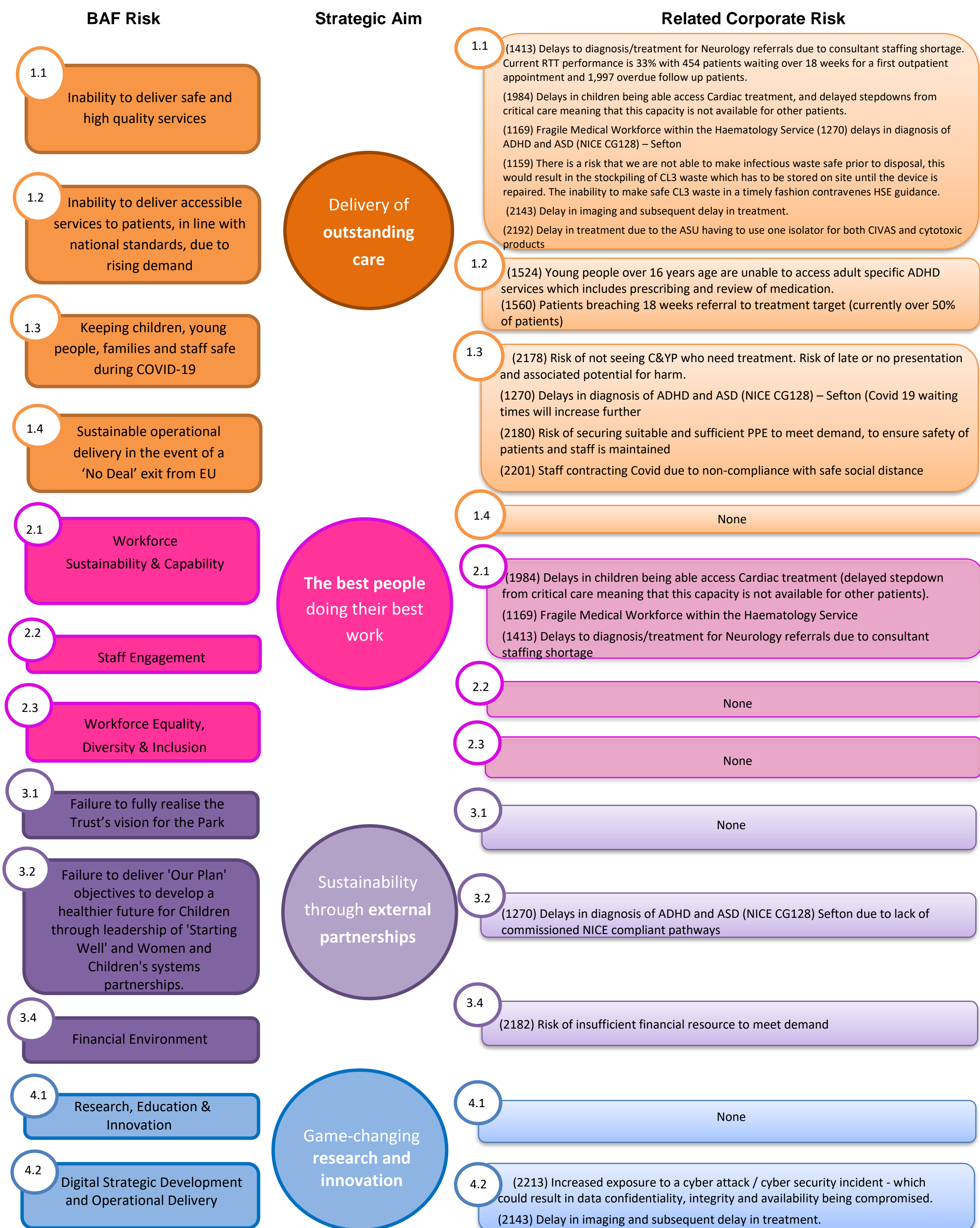
- ***Workforce Sustainability and Development (MS)***
  Activities related to this have been paused until end of June 2020. During July a action plan will be drawn up to implement key requirements to progress mitigations against this risk.

- ***Employee Wellbeing (MS)***
  Actions reviewed many of which are now complete. Wellbeing team and SALS team established in the organisation to support the Wellbeing strategy.

- ***Research & Innovation (CL)***
  Risk reviewed – no change

Erica Saunders
Director of Corporate Affairs
7 July 2020

Appendix A. Links between BAF and high scored risks – as at 30 June 2020



Board Assurance Framework 2020-21

NHS
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: 1715, 1131, 1984, 1921		
Exec Lead: Pauline Brown	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. International recruitment in line with UK Guidance International nurses commenced in post Feb 20	27/07/2020	no changes to Indian Govt policy currently all borders still closed. Close liaison with our international recruitment partners to operationalize he recruitment of our 10 Indian nurses as soon as we can
Alignment of workforce plans across the system	27/07/2020	Rota hub fully operational daily safer staffing huddles working well to ensure safe staffing across the Trust. Gradual re opening pre

		COVID bed capacity in June

Executive Leads Assessment

June 2020 - Philip O'Connor
no change to BAF score in month. Rota hub fully operational with staff in place to support. All staff have now returned to their substantive roles apart from those shielding. Change in govt advice re shielding with risk assessments needed for staff to be supported back to work safely. Gradual ramp up of services back to pre COVID levels with capacity increasing. Daily safer staffing huddles fully established across the Trust ensuring staffing in line with national guidance and staffing remains green. ECP students interviewed and allocated substantive posts for September starts but continue as BAND 4s until end of July as do the band 3's. Sickness remains high in certain areas. Still awaiting final CQC report

May 2020 - Pauline Brown
No change to BAF score in month. RotAHub now established and majority of staff initially redeployed have returned to their substantive roles. Daily Safer Staffing Huddles well established. Although high sickness levels continue in some areas, all staffing remains at "Green" status and developmental opportunities being identified for some staff to undertake quality improvement work such as audits, training resources, specialist link roles, etc. 113 student nurses have joined the organisation on 3 month temporary contracts in line with the national pandemic response: 48 students working at Band 4 and 65 students working at Band 3. Comprehensive induction programme given to ensure students fully supported and will want to work at Alder Hey substantively in the future. Awaiting CQC report

April 2020 - Pauline Brown
No change to BAF score in month. New risk and associated controls and actions added to Risk Register (2138) regarding potential risk to staffing related to COVID-19 pandemic due to surge in critical care patients and / or staffing shortages due to increased sickness. Workstream for redeployment of staff established. Staffing models of Amber and Red devised in response to major surge / sickness however there has not been a requirement to work to these staffing levels and staffing has remained in line with national nursing standards (RCN / PICS / BAPM). 20 nurses from India joined Alder Hey in March 2020. Due to COVID-19 pandemic, national strategy implemented to enable the nursing staff to join the NMC register with immediate effect. The nurses have been allocated appropriately with the majority being allocated to work in critical care based on service requirement and their knowledge, skill and expertise. An additional cohort of 10 nurses from India has had to be postponed due to COVID restrictions. 23 nurses from HEI commenced in the Trust in April 2020. 47 3rd year students who were due to complete their degree in September 2020 have signed up voluntarily to join the workforce and will be added to the NMC register. This cohort of nurses constitutes our usual pipeline of new starters in October 2020 therefore will be allocated in line with expected October position and opening of winter beds Professional standards workstream established as part of Trust COVID response Draft CQC report received and undergoing factual accuracy. Risk owner changed to Pauline Brown

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 rising demand		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective			Link to Corporate risk/s: 1524		
Exec Lead: Adam Bateman		Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand. A loss of capacity during COVID-19 has made access to care extremely challenging.

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	- Daily reports to NHS England - Daily performance summary - Monthly performance report to Operational Delivery Group - Performance reports to RABD Board Sub-Committee - Bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	- Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee - Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	- Significant decrease in waiting times for Sefton SALT - Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	- Monthly performance report to Operational Delivery Group - Corporate report and Divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	- Monthly oversight of project delivery at Programme Board - Bi-monthly transformation project update to CQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - Operational Delivery Board as a forum to collectively address challenged areas and to submit cases for investment where access to care is challenged
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes

Gaps in Controls / Assurance

1.ED workforce plan aligned to demand and model of care aligned to type of presentations
2.Enhanced paediatric urgent care services required in primary care and the community
3.Additional capacity required in Specialist Mental Health Services and Community Paediatrics (ASD & ADHD). Request submitted to Sefton CCG for urgent investment and commissioning of NICE compliant ASD & ADHD diagnostic pathways.
4.Comprehensive, real-time and digital access times dashboard for Community Paediatrics and Specialist Mental Health Services.
5.Dynamic emergency demand and capacity model to reduce cancelled operations and more precisely predict surges in demand

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Countermeasure summary describes actions to improve access to care 2. Additional action required around a new business case to develop a sustainable workforce and models of care	31/07/2020	Waiting times for developmental paediatrics have been severely affected by COVID-19 and the need to severely curtain outpatient activity. 18 weeks RTT performance in May is now 44%, from 69.3% in April. In mitigation there has been significant uptake in the use of virtual appointments, and new referrals are being directed, where appropriate, to the new ASD & ADHD pathway.

1. Additional workforce capacity required in learning disability services. 2. New pathway for ASD and ADHS patients in Sefton 3. Use external partner to reduce waiting times in ASD	30/06/2020	- All community based services delivering most patient consultations digitally, unless clinically indicated. - Catkin outpatient building increasing capacity w.c. 1st June to facilitate priority F2F appointments in CAMHS, Community Paediatrics, Eating Disorders, Crisis Care and Psychology. - CAMHS: Waiting list trajectory is being reset and will be shared at Access to Care Delivery Group. Additional partnership caseload taken on by staff and risk stratification took place to identify all risky cases and ensure sufficient monitoring was in place for these . - Services in the Community & Mental Health division are actively liaising with schools to support a safe return to activity where needed when schools reopen. .
Produce capacity model at specialty level that defines the increase in capacity required to meet clinically set waiting times	03/07/2020	Preliminary analysis from the model indicates that capacity will need to be higher than pre-COVID levels as follows: * 30% increase in outpatients capacity * 18% increase in theatre capacity * 25% increase in surgical day case capacity

Executive Leads Assessment

June 2020 - Adam Bateman
The effects of the loss of capacity for planned and urgent care during COVID-19 continue; waiting times are increasing and in the Division of Community & Mental Health and the Division of Surgical we have some patients waiting over 52 weeks for care.

Presently we focused on the safe management of children and young people on the waiting list by getting the following components of the system right:
? Maximise capacity, safely
? Effective clinical review and prioritisation
? Provide a scorecard with helpful and accurate information against defined clinical and safety standards
? A single-version of the truth waiting list, with excellent data quality
? Good administration/ documentation of a patient's pathway
? Capacity & demand model that projects trends in waiting times

We continue to make progress in restoring services with an increase in face-to-face outpatient capacity of 300 patients per day from the 29 June 2020. From the 8 June our operating capacity increased to 110 session per week, from 70 sessions.

May 2020 - Adam Bateman
In May significant focus has been given to safely opening up access to care for children.

To support access to care we have:

opened up urgent face-to-face appointment capacity (190 per day)
Increase the use of virtual appointments
From the 26 May increased the number of urgent operating lists to 8, from 5 during Phase 1 of the COVID-19 response

In order to safely open up
* PPE availability
* Patient testing
* Safe environment

We have changed the physical environment and patient pathways to achieve safe access to care:
* new pre-operative pathway
* new waiting room layout and patient flows in OPD
* re-configuration of ED to segregate patient waiting and flow

April 2020 - Adam Bateman
The onset of the COVID-19 public health emergency is having an adverse effect on access to care because of the need to direct staff and capacity to deal with the pandemic. Focus is on maintain access to care for children who require urgent treatment.

The Emergency Department, as part of its improvement plan, is focused on improving time-to-triage. Nonetheless, a huge effort has gone in to redesigning the ED layout to be COVID-19, and to support the testing of suspected patients. This effort has detracted from wider waiting time improvement efforts.

In learning disability services a significant investment has been secured to increase the workforce and reduce waiting times. There is now an improvement trajectory to reduce waiting times such that all new referrals triage within 12 weeks and diagnosis within 18 weeks from April 2020, subject to re-assessment of trajectory following COVID-19.

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 COVID-19		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Adam Bateman	Type: External,	Current IxL: 5x4	Target IxL: 3x3	Trend: STATIC

Risk Description

The manifold effects, direct and indirect, of COVID-19 represent significant challenge. This includes, but is far from limited to, the potential for physical and psychological harm as a result of delayed access to care, isolation, psychological impact of lockdown, and risk of contracting the virus.

Existing Control Measures	Assurance Evidence (attach on system)
Formal strategic and tactical command arrangements in place	agendas & minutes
Detailed COVID-19 Plan agreed and being deployed	
Work programme on keeping our staff safe enacted	
Plan to establish adult invasive capacity progressed	
COVID Specific Scorecard in place	Scorecard to Strategic Meetings
Work Programme established looking at keeping Children & Young People safe	Agendas / Minutes / Actions
Access to Care Group re-established to monitor waiting lists	
24/7 CAMHS crisis line in-situ	Staff rota
Access to emergency and urgent operating theatres	Weekly capacity plan
Clinical review of waiting lists to identify clinically urgent patients requiring assessment and/ or intervention	Electronic patient record
Urgent face-to-face outpatient appointments maintained and digital outpatient consultations established	Outpatient schedule
Waiting list monitoring via weekly Access to Care Delivery Group	Minutes
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	

Gaps in Controls / Assurance

Recovery plan (protecting staff and recovering access times for patients) for phases 2 and 3 to be finalised

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Ensure adequate supply of PPE to keep staff safe and to meet capacity plan	31/07/2020	
Keeping Children & Young People Safe Workstream	30/06/2020	Workstream continues to meet weekly. Specialities have populated vulnerable patient template to outline risk and considerations that may affect current pathway and identify alternative pathways
Increase patient antigen testing for emergency admissions, planned operations and where clinically suspected	30/06/2020	
Develop and implement COVID phase 2 plan enabling the delivery of increased elective capacity whilst maintaining the ability to respond in the event of a further surge	30/06/2020	Interim phase 2 plan agreed until mid-June 2020. Further forward look required on next stage of elective restart plans
System wide response for pandemic influenza, focused on the continuity of public and critical services	29/05/2020	
Increase OPD capacity by 30% above pre-COVID levels Increase theatre capacity by 20% above pre-COVID levels Increase radiology capacity by 20% above pre-COVID levels	31/08/2020	Progress to date: Theatre schedule increased to 110 theatre sessions per week following the opening of DSU in June Outpatient capacity increased to 300 face-to-face attendances per day Radiology activity levels at 70% of pre-COVID levels
Introduce Patient Safety: Waiting List Dashboard	09/07/2020	

Risk assess at risk staff members including those shielding and from a BAME background	10/07/2020	90% completion of BAME risk assessments - ongoing risk assessments for all vulnerable and at risk staff. There are currently 130 staff sheilding
Identify patients who are at risk via the Patient Safety: Waiting List Dashboard Provide a new Patient on Waiting List Review to document a clinical review	24/07/2020	New Patient on Wait List review form now available on Meditech

Executive Leads Assessment

June 2020 - Adam Bateman
On keeping staff safe:
Our antibody testing results for staff at 7% is the lowest in the region and indicates a low infection rate of staff in the Trust and the extremely low prevalence rates amongst patients at Alder Hey.
Our supplies of PPE have been good and we have maintained access to equipment for staff and have support an increase in elective activity.
Comfort boxes have been provided to staff to provide them with some comforting items and to recognise their outstanding work.
Risk assessments of at risk members of staff have taken place.
We continue to support members of staff to work from home where possible.

On keeping patients safe:
We have made good progress in increasing access to care with capacity expanded in theatres, outpatients and Radiology. Nonetheless, there is significant further work to do to clear the backlog.
Our testing pathways for emergency admissions and surgical operations is in situ.
We have undertaken clinical reviews of patients on the waiting list who are considered to be at risk

May 2020 - John Grinnell
Good progress made on managing surge/adult support. Focus now on a safe restart to our planned activity, maintaining a safe environment and testing scenarios for managing the backlog and potential winter pressures.

April 2020 - John Grinnell
COVID programme continues to be reviewed at Trust Board monthly

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 in the event of a 'No Deal' 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: 3x2	Target IxL: 3x1	Trend: STATIC

Risk Description

Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity. 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020.

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.	Internal team meets regularly; work stream leads identified; risk assessments undertaken. Assurance framewroks completed and submitted to NHSE.

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.

Executive Leads Assessment

February 2020 - Lachlan Stark
Following review with specialty leads no issues identified

January 2020 - Lachlan Stark
11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020.

December 2019 - John Grinnell
Risk reviewed in line with 31 January 2020 scheduled exit. Business to remain 'as is' given 12 month transition period. Business continuity plans to remain in place ready for resurrection if required.

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: 1169, 1984		
Exec Lead: Melissa Swindell		Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Risk Description

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

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

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. Succession plans Board to Ward

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	31/07/2020	activities attributed to this risk have been paused, with a view to review in June 20.
2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. This includes the introduction of a pilot wellbeing team to support the management of sickness absence. Target is 4% absence rates across the organisation.	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	31/07/2020	activities attributed to this risk have been paused, with a view to review in June 20.
4. Succession planning to be completed for the Executive Team. To be rolled out to the Divisional senior management teams in January 2020	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.

Executive Leads Assessment

June 2020 - Sharon Owen
Activities related to this have been paused until end of June 2020. During July a action plan will be drawn up to implement key requirements to

progress mitigations against this risk.
May 2020 - Sharon Owen As per previous update activities attributed to this risk have been paused until June 2020.
April 2020 - Sharon Owen Activities attributed to this have been paused until June due to Covid19.
March 2020 - Melissa Swindell Given the rapid development of the response required to the Covid pandemic, activities attributed to this risk have been paused, with a view to review in June 20.

Board Assurance Framework 2020-21

NHS 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: 3x4	Target IxL: 3x3	Trend: STATIC

Risk Description

Failure to support employee health and wellbeing 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 WOD (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.
Listening into Action Guidance and Programme of work	Dedicated area populated with LiA info on Trust intranet
Staff surveys analysed and followed up (shows improvement)	2018 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
BAME, Disability and LGBTQI+ Staff Networks	Meetings minuted and an update provided to WOD
LGBTQI+ Network launched December 2018	Monthly network meetings established and open to any staff member or volunteer who identifies as LGBTQIA+.
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

Gaps in Controls / Assurance

1. Staff Advice and Liaison Service (SALS) not yet implemented
2. Wellbeing team to support sickness absence not yet implemented
3. Junior Doctor experience not as positive as it should be

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Develop a proposal to implement a SALS service	30/06/2020	SALS is being progressed, as is the implementation of the wellbeing team.
2. Appoint to the wellbeing team	30/06/2020	Team Leader appointed; team to be appointed Jan 2020
3. Detailed action plan in response to 2018 HEE visit. Use of £60k welfare monies to re-purpose a new JD mess. JD Forum refreshed	30/06/2020	JD mess agreed, will be fully in place February 2020

Executive Leads Assessment

June 2020 - Sharon Owen
Actions reviewed many of which are now complete. Wellbeing team and SALS team established in the organisation to support the Wellbeing strategy.

May 2020 - Sharon Owen
actions reviewed and on track

April 2020 - Sharon Owen
Reviewed risk - all actions on track.

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: 3x4	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.

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

Gaps in Controls / Assurance

1. Workforce not representative of the local community we serve
2. BME staff reporting lower levels of satisfaction in the staff survey

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.	31/07/2020	activities attributed to this risk have been paused, with a view to review in June 20.
1. Work with Community Engagement expert to develop actions to work with local community	31/07/2020	activities attributed to this risk have been paused, with a view to review in June 20.

Executive Leads Assessment

June 2020 - Sharon Owen
Actions reviewed. Ongoing consultation is in place with BAME staff during the pandemic.

May 2020 - Sharon Owen
Risk reviewed - activities attributed to this risk remain on hold during the pandemic and to be reviewed in June

April 2020 - Sharon Owen
Risk reviewed - , activities attributed to this risk continue to remain on hold during the covid19 pandemic - review in June 2020.

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: No Risks Linked		
Exec Lead: David Powell		Type: Internal, Known	Current IxL: 3x4	Target IxL: 3x2	Trend: STATIC

Risk Description
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations

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

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	01/09/2020	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	31/07/2020	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	15/07/2020	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust

Executive Leads Assessment
May 2020 - David Powell Review pre-June Trust Board
April 2020 - Susan Brown Reviewed actions due to the impact of COVID and to update on progress of the cluster project/budget discussions and VE exercise.
March 2020 - David Powell Review with regard to Covid 19 planning.

Board Assurance Framework 2020-21

NHS 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

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
Children's Transformation Programme - established and running - planning underway to become the 'Starting Well' delivery vehicle for One Liverpool(developing). SRO Louise Shepherd confirmed.	

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	30/09/2020	Paused through Covid period; for consideration as phase 3 and beyond plans developed
1. Strengthening the paediatric workforce	30/09/2020	Significant work through Covid and recovery; Mutual aid provided across NW and joined up recovery planning and approaches underway. Enhanced offer with C&M Paediatric Network and plan to further support each other on strengthening the paediatric workforce through Womens & Children's programme.
2. Develop Sefton and Knowsley plans for C&YP - align with One Liverpool where possible/appropriate	30/09/2020	Refresh of Sefton plans underway following Covid; Dani Jones allocated as SRO for C&YP at Sefton Provider Alliance - priorities well aligned with North Mersey.
3.Collaboration with LCCG and system leaders to develop 28/02/2019 next stage of One Liverpool; develop the programme of work for C&YP / Starting Well - Children's transformation partnership to take a leadership role	30/09/2020	Collaborative workshops during June with One Liverpool strategy directors; proposal agreed for refreshed priorities in light of Covid to be presented to ICPG in July. Through Starting Well this suggests the focus be on Mental Health, targeted action on inequalities and Childrens community hubs.

4.Continue to develop joint partnership hosting arrangements for existing and pending ODNs with RMCH	30/09/2020	Re-establishment of NWPPB commencing in June following pause for Covid. New network developments for Paediatric Cirtical Care and Surgery prioritised.
5.Develop Business Model to support centralisation agenda and Starting Well	30/09/2020	Refresh of One Liverpool priorities following Covid underway during June; priority areas of focus to be agreed at ICPG in July, and subsequent programme resource to be sought through reestablished Provider Alliance in July.
Significant 'system' reshape underway as a result of Covid pandemic. Command and control remains and governance through Hospital and OOH Cells and Recovery group is shaping. Alder Hey working actively to advocate for C&YP in this new governance and work closely with the new system on delivery.	30/09/2020	

Executive Leads Assessment
June 2020 - Dani Jones Risk reviewed; no change to score in month. Restart following Covid and positive movement in actions. Full system reshape and governance underway and not yet settled; focus on ensuring C&YP are among the system priorities.
May 2020 - Dani Jones Risk reviewed; impact of Covid ongoing & producing positive partnership efforts, but collective focus remains on recovery for the coming weeks. No change to risk rating in month.
April 2020 - Dani Jones Risk reviewed; continued Covid-related delays to actions. Risk score remains static for May given strategic nature of 3.2; experience same system-wide. 'Our Plan' in light of long term impact of Covid to be explored through Trust Board during remainder of Q1.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships		Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led			Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell		Type: Internal, Known	Current IxL: 4x5	Target IxL: 4x3	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
5. Childrens Complexity tariff changes	31/08/2020	Work ongoing with NHSI tariff team with revised timescales to agree a proposal by end of Aug 2020
1. Revised financial plan pending updated guidance from NHSI	31/07/2020	Alder Hey has progressed its financial framework for the remainder of the year, however we are still awaiting NHSI financial guidance which is due imminently.
6. Submit COVID Capital Costs through national system	31/07/2020	Further submission through the hospital and out of hospital cells -awaiting feedback on prioritisation process.
4. Long Term Financial Plan	31/07/2020	Awaiting financial guidance from NHSI and have re-lodged unresolved financial gap. Revisit once NHSI guidance has been published and work up mitigating actions
2. Five Year capital plan	30/10/2020	Significant aspects of Capital Programme progressing e.g. cluster, Dewi, Neo. Further review of long term capital plan to be revisited once clearer8 the impact of COVID on our wider finances
3. Cost of Winter	31/07/2020	Revised Operational Plan due to be completed end of July 2020 which will incorporate winter capacity plans and any associated costs
1. RABD to oversee productivity and waste reduction programme	31/03/2021	

Executive Leads Assessment

June 2020 - John Grinnell Financial arrangements beyond M4 still remain unclear as national guidance awaited. Significant work underway with all divisions to create a new financial framework that will be fit for purpose in this new environment.
May 2020 - John Grinnell Month 1 position is break-even subject to reimbursement of COVID costs and top-up shortfall. Critical going forward that robust financial governance arrangements ensure overall cost base is reasonable given the operating environment.
April 2020 - John Grinnell Trust delivered 2019/20 control total subject to final audit. Focus for first quarter of 2020/21 is having clear financial framework and governance associated with COVID financial arrangements. Key risk during this period is lost cost control and/or any COVID costs not covered by the centre.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

<table>
<tr><td>BAF 4.1</td><td colspan="2">Strategic Objective:
Game-Changing Research And Innovation</td><td colspan="3">Risk Title: Research & Innovation</td></tr>
<tr><td colspan="3">Related CQC Themes:
Responsive, Well Led</td><td colspan="3">Link to Corporate risk/s:
No Risks Linked</td></tr>
<tr><td colspan="2">Exec Lead:
Claire Liddy</td><td>Type:
Internal, Known</td><td>Current IxL:
3x3</td><td>Target IxL:
3x2</td><td>Trend: STATIC</td></tr>
</table>

Risk Description
Failure to grow research & innovation due to potential gaps in capacity and funding

Existing Control Measures	Assurance Evidence (attach on system)
RABD review of commercial contracts per SFI. Trust Board oversight of shareholding and equity investments.	Reports to RABD / Trust Board and associated minutes
Programme assurance via regular Programme Board scrutiny	Reports to Programme Board and associated minutes
Establishment of Research Management Board	Research Management Board established.
Establish Innovation Board Committee	Committee oversight of Innovation strategy with NED expertise
Innovation team re-organised and funded to ensure adequate capability. Establish role of Managing Director of Research and Innovation to provide unified vision.	
Alder Hey Innovation LTD governance manual established	

Gaps in Controls / Assurance
Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete collaboration contract with University of Liverpool. This is a strategic agreement - deadline reset to March 2020 as part of 3 year join planning with UoL VP. Create standard approach to agree 3 year strategic R&I roadmaps with each University Partner	30/09/2020	Plans, data and costs now exchanged but final agreement still to be reached. Longstop date Dec 2019, but conclusion expected before this; timescale therefore revised.
Agree incentivisation framework for staff and teams: for research time & innovation time.	31/12/2020	Target date reset to 31/12/20

Executive Leads Assessment
June 2020 - Claire Liddy Risk reviewed - no change
May 2020 - Claire Liddy Risk reviewed - no change. Delays continue to COVID response plan.
April 2020 - Claire Liddy Review - static status. Two over due actions that have been affected by delays relating the COVID-19 workstream.

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 and Operational Delivery	
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 1715	
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x2 / Target IxL: 3x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

Lack of secondary data centre / disaster recovery - significant progress with new arrangements in place
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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of cyber actions including managed service and cyber accreditation	31/07/2020	inCyber deep dive undertaken, 'cyber savvy' communications shared with staff across the Trust, cyber essentials plans in place
Testing and commissioning of secondary data centre	30/06/2020	All servers migrated to new core infrastructure
Commission Meditech DR at CCC and move primary Meditech infrastructure to AH	31/07/2020	

Executive Leads Assessment

June 2020 - Kate Warriner
BAF reviewed, good progress made, new core resilient infrastructure operational

May 2020 - Kate Warriner
BAF reviewed, good progress against plans.

April 2020 - Kate Warriner
BAF reviewed. Good progress against plans.