NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 17th December 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/STAFF STORY (9:00am-9:15am)							
1.	**20/21/198**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**20/21/199**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/200**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 26th November 2020.**	**D**	Read minutes
4.	**20/21/201**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read action log
COVID-19 Assurance Plan - Progress Update							
5.	**20/21/202**	**9:25 (55 mins)**	• **Access and Restoration of Services Update:** - **Safe Waiting Management Report.** • **Staff/Patient Safety:** - **IPC COVID Assurance Framework.** - **Flu vaccine status.** - **Staff safety metrics.** • **Financial Framework**	A Bateman N. Murdock N. Murdock M. Swindell J. Grinnell	To provide an update on the progress made with the Access & Restoration initiative undertaken. To provide an update on patients waiting for an appointment more than 52 weeks To provide the Board with an update. To provide an update on the flu vaccine status. To provide an update on staff absences and testing. To provide an overview of the position for Month 8	**A** **A** **A** **A** **A** **A**	Read report Verbal Read report Presentation Presentation Presentation

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			Update. • **COVID Risk Register.**	J. Grinnell	and the latest financial guidance. To discuss the current 5 Key Risks.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**20/21/203**	**10:20 (10 mins)**	**Serious Incident Report.**	N. Askew	To provide board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
7.	**20/21/204**	**10:30 (10 mins)**	**Position Statement for PALS and Complaints. Q2.**	N. Askew	To receive the position statement for Q2. 2020/21.	**A**	Read report
8.	**20/21/205**	**10:40 (40 mins)**	**Corporate Report - Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.** **Cumulative Corporate Report Metrics - Top Line Indicators:** • **Quality.** • **Safety.** • **Effective/Responsive.**	U. Das L. Cooper A. Bass N. Murdock N. Askew A. Bateman	To receive a report of Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
The Best People Doing Their Best Work							
9.	**20/21/206**	**11:20 (5 mins)**	**Cumulative Corporate Report Metrics - Top Line Indicator:** • **People.**	M. Swindell	To receive report of Trust performance against its key People metrics for scrutiny and discussion**,** highlighting any critical issues.	**A**	*(refer to item 8)*
10.	**20/21/207**	**11:25 (20 mins)**	**Alder Hey People Plan Update:** • **Progress against 5 themes within the**	M. Swindell	To provide an update on progress against five of the themes within the People Plan.	**A**	Read report

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			People Plan. • **EDI Task Force Interim Report.**	C. Dove	To receive the interim report from the EDI Task Force Group.	**A**	Presentation
Sustainability through Partnerships							
11.	**20/21/208**	**11:45 (10 mins)**	**Future of ICSs, Commissioning and Provider Collaboratives.**	D. Jones/ E. Saunders	For information and discussion.	**N**	Presentation
Strategic Update							
12.	**20/21/209**	**11:55 (10 mins)**	**Alder Hey in the Park Campus Development update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Lunch (12:05pm-12:30pm)							
Strong Foundations (Board Assurance)							
13.	**20/21/210**	**12:30 (10 mins)**	**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
14.	**20/21/211**	**12:40 (20 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 14.12.20.** - **Approved minutes from the meeting held of the 19.10.20.** • **Safety & Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 16.12.20.**	I Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			• **People and Wellbeing Committee:** - **Chair's Highlight Report from the meeting held on the 17.11.20.** - **Approved minutes from the meeting held on the 14.9.20.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 7.12.20.** - **Approved minutes from the meeting held on the 12.10.20.**	C. Dove S. Arora			
Items for information							
15.	**20/21/212**	**13:00 (4 mins)**	**Any Other Business:** • **Ockenden Report Update.**	All N. Askew	To discuss any further business before the close of the meeting. To note the contents of the Ockenden report.	**N** **N**	Verbal Read report
16.	**20/21/213**	**13:02 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 28th January 2021, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in December 2020: - Reversionary Lease – Laidrah Limited

- Contracts (2) – Hortican Limited

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M8	**J. Grinnell**
CQC Action Plan	**E. Saunders**
Key Points from NHSE/I Proposals for Legislative Change	**D. Jones**
C&M Health Care Partnership Proposed MOU and Cover Letter	**D. Jones**

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 26th November 2020 at 9:00am,** via Microsoft Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Observing:	Mr. E. Amiry	Acute Hospital Inspector, CQC	(EA)
	Mr. A. Cliffe	Mental Health Inspector, CQC	(AC)
Patient Story	Ms. C. Cookson	Lead Clinician, Intensive Support Team	(CC)
	Ms. V. Furfie	Clinical Information Officer, Community Division	(VF)
	Ms. J. Hesketh	Parent of patient	(JH)
Item 20/21/177	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Item 20/21/177	Mrs. R. Lea	Acting Deputy Director of Finance	(RL)
Item 20/21/184	Mrs. J. Chamberlain	SALS Manager	(JC)
Item 20/21/184	Dr. J. Potier	Assoc. Director of OD/Consultant Clinical Psychologist	(JP)
Item 20/21/184	Ms. S. Robertson	Mental Health Practitioner Trainee	(SR)
Item 20/21/187	Mr. L. Stark	Head of Performance	(LS)
Apologies:	Mr. J. Grinnell	Director of Finance/ Deputy Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)

Patient Story

The Chair welcomed Sam's mum, Jane, who had been invited to November's Trust Board to share her son's journey with CAMHS and discuss the support that the Intensive Support Team gave to her family during the pandemic. The Chair also welcomed the Lead Clinician for the Intensive Support Team, Cathy Cookson, and Victoria Furfie, Clinical Information Officer for the Community and Mental Health Division, who was supporting Jane from an IT perspective.

Cathy Cookson introduced herself and the work that the Intensive Support Team carry out and advised that Sam was introduced to the Team by his CAMHS Case Manager who asked for support to understand Sam's behaviour following an additional change to his usual presentation.

Jane informed the Board that Sam is 17 years of age and has a diagnosis of Autistic Spectrum Disorder, Sensory Processing Disorder, severe learning difficulties and recently was diagnosed with epilepsy. It was reported that Sam has been an open case to Liverpool CAMHS for several years. Jane drew attention to Sam's journey with CAMHS and pointed out that there have been some positive experiences but overall, the family had felt let down by the service. Throughout this period of time Jane felt that she had only been listened to on two occasions 1. Following an appointment with a psychiatrist from the CAMHS Service who told Jane that he listened to parents and 2. When she met Cathy and Erin from the Intensive Support Team.

Sam was referred to the Intensive Support Team by CAMHS as a result of being absent from school for an eighteen-month period due to anxiety. During this time, Jane said that she felt totally unsupported and was told that she hadn't taught her son any coping strategies which, as Jane pointed out, was not true as he had never had any difficulties going to school before. Cathy and Erin assessed the family and conducted lots of detailed observations of Sam at home and in school which helped provide a clearer picture of what was emerging with Sam. A Neurology appointment was eventually scheduled for Sam where he was diagnosed with epilepsy.

Jane advised the Board that she had tried to voice her concerns about Sam to a number of professionals on numerous occasions, but it was all to no avail. Jane drew attention to the anxiety that is caused when you can't get the required help that your child is crying out for, especially when they have challenging behaviour and are unable to vocalise the problems they are experiencing. It was pointed out that Sam's journey hasn't been easy but through Jane's and Cathy's perseverance Sam has received the help that he needed. Jane informed the Board that she can't thank Cathy and the team enough for the help and support that they have given to her family, especially Sam and highlighted the importance of other families being able to access this service in the future.

The Chair thanked Jane for sharing Sam's story and drew attention to the point that was highlighted about parents not being listened to enough. The Chair felt that to not acknowledge the expertise and insight of a 24/7 parent or carer has to be a lesson for every professional.

The Chair informed Jane that she was delighted that the Intensive Support Team was able to support to Sam but queried as to whether there are any lessons that can be learnt to ensure other patients and families don't experience the same difficulties as Sam. Jane felt that a much more joined up approach is required to enable professionals to talk to each other, and continuity when seeing a professional from a patient perspective.

Cathy advised the Board that the Intensive Support Team has finished its intervention with Sam but are going to keep in touch with Jane as it is felt that service development needs to be led by parents and it is clear that the Trust needs to listen to parents who have a child like Sam.

On behalf of the Board, the Chair thanked Jane for sharing her story and highlighting some really important issues.

Louise Shepherd reiterated the Chair's thanks to Jane and felt that it was clear that the Trust needs to ensure that this service continues and is made available to those who need it.

20/21/173 Welcome and Apologies

The Chair welcomed everyone to November's Trust Board meeting and noted the apologies that were received.

The Chair welcomed colleagues from CQC and formally welcomed the Trust's new Chief Nurse, Nathan Askew.

20/21/174 Declarations of Interest

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

20/21/175 Minutes of the previous meetings held on Thursday 22nd October 2020
Resolved:
The minutes from the meeting held on the 22.10.20 were agreed as an accurate record of the meeting.

20/21/176 Matters Arising and Action Log

Action 20/21/152.1: *Mortality Report, Q1 (Look into the Bereavement Suite visiting restriction issues to see if there is anything more that can be done to assist families of deceased patients access the suite)* - It was confirmed that the service was able to extend visiting hours for families following a review of practice after the last period of lockdown. The Team Leader of the service has also looked into access for families of patients who come to Alder Hey for a post-mortem. **ACTION CLOSED**

Action 20/21/152.2: *Mortality Report, Q1* (*It was felt that it might be beneficial to keep a lens on the external benchmarking of expected in-hospital deaths, to monitor trends especially in light of the pandemic. Nicki Murdock agreed to liaise with Julie Grice regarding this matter)* - It was confirmed that Julie Grice is investigating external benchmarking with an external organisation. In addition to this, a review of Alder Hey's expected in-hospital death figures for the last five years is also going to take place. **ACTION CLOSED**

20/21/177 Covid-19 Assurance Plan – Progress Update

Access and Restoration of Services Update

It was reported that the Trust is continuing to focus on reducing waiting times by restoring service capacity. The Board received a summary of the progress that has been made in restoring services (*August 2020-October 2020*) against the national restoration targets that have been set. The following points were highlighted:

- *Outpatient Care:* The Trust has achieved a figure of 84% in October against the 100% national target.
- *Day Case and Elective In-patients*: The Trust has achieved a figure of 87% in October against the 90% national target.
- *Diagnostics:* The Trust has achieved a figure of 86% in October against the 90% national target.

- The Trust offered 16,656 Outpatient consultations in October, and treated 2097 day case and elective in-patients.
- It was reported that the new Outpatient Department schedule went live on the 26.10.20 and is expected to increase restoration levels in November 2020.
- Performance remains excellent in terms of timeliness of care and targets have been met in respect to access to cancer care
- The Board was advised that the Trust is looking to achieve a performance figure of 90% plus in November for day case and elective in-patients and also achieve the national target of 90% for diagnostics in November.
- The Board was advised of the piece of work that is being undertaken on the organisation's waiting list measurement and definition following a reporting issue in July 2020 around the number of children waiting over 52 weeks for an appointment. It was agreed to submit an update in December on safe waiting risk management in order to share the findings of the improvement work that is taking place on this matter in association with an advisory company for the three Divisions.

20/21/177.1 Action: AB

- It was reported that there were 47 patients waiting for an appointment beyond 52 weeks in July 2020, this figure will reduce to 24 by the 1st of November.
- The Community Division is making really good progress with the reduction of their waiting list and by December 2020 will have zero children on a consultant led pathway waiting over a year for an appointment.
- A number of progress metrics have been agreed for the Division of Surgery as the Trust is looking to reduce the waiting list to zero for children waiting over 52 weeks for a surgical appointment.
- The Board was advised that the Trust is concerned that the number of inpatients waiting over 52 weeks for surgery is not reducing significantly. In response to this a new set of metrics has been agreed to track improvement. It was reported that the Trust is looking to book treatment dates for all patients waiting over 46 weeks ensuring that the majority are within the 52 week timescale. For patients waiting over 52 weeks, the goal is to reduce the number of surgical inpatients waiting 52 weeks to 80 by the end of the calendar year.
- Nathan Askew asked as to whether a clinical review or a clinical harm review had been conducted for patients waiting 52 weeks and beyond for an appointment. It was confirmed that every patient who has waited over 52 weeks has had a review.

It was concluded that the Trust is in a good position and has done really well to restore services to near national target levels given the Covid prevalence and the conditions around PPE and cleaning that the organisation is working with. The Board was advised that work will continue to restore all services to required levels.

Louise Shepherd drew attention to the fantastic effort that has taken place to restore services for patients at Alder Hey and felt that to have achieved the national goal within a month is remarkable. It was pointed out that the rescheduling of outpatients has been a major whole Trust effort. The Booking and Scheduling Team has worked tirelessly for the last eight months, not only to stop services and restart them but to restart them all over again and it was felt that the Board should recognise the team's efforts.

Louise Shepherd advised the Board that there has been a recognition in the latest settlement of the additional resources that will be required to clear the backlog that was created at the beginning of the year. As expected, there has also been an

increase in mental health referrals which has risen exponentially. Taking all of this into account it was felt that forward projection and assessment of the overall ask is required to look at how the Trust can tackle these issues and go over and above the work that is taking place presently.

On behalf of the Board, the Chair noted the fantastic work that has taken place across the Trust by staff to help with the restoration of services and asked for the Board's thanks to be conveyed to respective staff members.

Staff/Patient Safety

IPC Covid-19 Assurance Framework

The Board received an update on IPC, triage and the Tracing Team at Alder Hey from the new Director of Infection, Prevention and Control, Beatriz Larru. A number of slides were shared with the Board which provided information on the following areas:

- Multiple routes of transmission.
- Hierarchy of controls.
- Systems in place to monitor the prevention and control of infection.
- The actions taken to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- The actions taken to ensure appropriate antimicrobial use to optimise patient outcomes to reduce the risk of adverse events and antimicrobial.
- The routes established in which to provide suitable and accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
- The routes to ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
- The systems in place to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection.
- The provision of secure adequate isolation facilities.
- Adequate access to laboratory support.
- Policies in place designed for the individual's care and provider organisations that will help to prevent and control infections.

The Chair thanked Beatriz Larru for providing the Board with an overview of the work that has taken place to keep the hospital safe for children, young people, families and staff. Louise Shepherd felt that it was an outstanding presentation and thanked all those involved for their hard work.

Fiona Marston drew attention to the gap in the network with community testing and the NHS and asked for further detail on this matter. It was reported that this issue is a national problem but Alder Hey has implemented a process to address this. Staff are asked to report into their line manager if they have tested positive following a test in the community. The Tracing Team are provided with this information and then make contact with the respective staff member to look at the possible route cause for contracting the virus.

The Board was advised that this is one of the challenges that the Trust has recognised during the pandemic, especially how information is shared across the region and further afield. It was reported that there is an active stream of work

taking place at the moment to try and integrate information into the regional reporting system so there is more real time data across the region.

Flu Vaccine Status

The Board received a number of slides which provided information on the highlights of the Flu Campaign, the progress and challenges.

It was reported that 86.73% of staff members have received a flu vaccination. In order to achieve the Trust's target of 90% it will require a further 124 members of staff to have a vaccine. Attention was drawn to the recent flurry of staff members asking to have a vaccine as the Trust pivots towards delivering the Covid-19 vaccine on the 1st of December. It was pointed out that the Trust hasn't received the Covid-19 vaccine to date and is still awaiting the PGD document that allows nurses and Allied Health Professionals to deliver the vaccine.

Self-Testing – The Trust has been issued with the packs to enable staff to self-test for Covid-19. A total of 2000 packs were issued during the first two days. Each pack contains 25 tests so staff are able to test themselves twice a week for twelve weeks and results are available within half hour. It was reported that the Trust has agreed to be part of a daily testing pilot.

Flu vaccination in the Community – It was reported that 65% of staff based in a community setting have been vaccinated. Nicki Murdock conducted a session with a cohort of staff who have been quite resistant previously, following this session numbers have increased. Further vaccination sessions have also been scheduled for the next two weeks.

Staff Safety Metrics

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

- Non Covid-19 related sickness – 5.20%.
- Covid-19 related sickness -0.72%.
- 27 members of staff are shielding.
- 28 members of staff have Covid-19 symptoms or have tested positive.
- 40 members of staff are self-isolating.
- Overall absence – 7.64%.

The Board was informed that there are a large number of measures in place presently to support staff. There is also a big focus on supporting staff members who are absent due to long-term sickness and SALS is being wrapped around all of them. It was reported that staff who are having to shield are being re-deployed where possible in order to remain active and engaged.

Financial Framework Update

In Month 7 the Trust's actual performance was a £1.3m deficit which is £0.3m behind plan. It was reported that as of the 1.10.20 Alder Hey is operating under a fixed funding envelope which includes resources for Covid-19 and restoration. It was pointed out that the envelope does not include a retrospective top up. NHSI have set a target for the Cheshire and Merseyside system to breakeven by March 2021

It was reported that the Trust's revised plan for 2020/21 is £5.2m deficit. £2.8m of this figure relates to reduced non clinical income and annual leave accrual and this is

being lobbied with NHSI but remains unsolved at the present time. The remaining £2.4m gap is for the organisation to resolve. It was reported that work is taking place via various routes to come up with a plan to mitigate the £2.4m risk, for example, via procurement, managing the 'Alder Hey £', themes being managed via the Care Delivery Board and Sustainability Delivery Group. It was confirmed that a further update will be provided on this matter during December's Board.

20/21/177.2 Action: JG

The Board was advised of the likely key features of the future 2021/22 model; block income will remain with a marginal rate for over performance, there will be no opportunity to grow in the way as previous years, cost efficiency will still be required with a possible stretch for underlying deficit providers, there will be positive support form NSHI on Paediatric Tariff and there will be a population based commissioning with a focus on outcomes and pathways.

Attention was drawn to the next steps for the organisation, which are to:

- Continue to work with the Cheshire and Merseyside system on 2020/21 plans and unresolved issues to ensure Alder Hey receives a fair share of any new allocations.
- Accelerate through 'Managing the Alder Hey £' cost improvement and restraint to mitigate the £2.4m gap in 2020/21 and support in 2021/22 onwards.
- Reshape the financial strategy for the next 5 years under new NHS architecture. 2021/22 initial position is to be presented to RABD and Trust Board in December.
- Position Alder Hey both regionally and nationally to secure new national funding for both restoration and Mental Health.

Louise Shepherd asked as to whether the incentive scheme for restoration has ceased. The Board was advised that the Trust is having to report its targets whilst NHSI reflect on the programme. It was pointed out that when the local incentive scheme was implemented there wasn't a tiered approach, therefore NHSI are now looking at whether there should be different incentive rules for each tier. Funding is not expected to be stopped for month 7 but the Trust is getting close to hitting its targets and therefore, will be requesting information on the detail of incentives if the Trust goes over its targets. It was agreed to raise this matter during the call with the regional team.

20/21/177.3 Action: RL

Kerry Byrne raised the issue of the £2.1m deficit that relates to non-clinical income and queried as to whether the Trust has given any thought to acquiring income via the international/private patient route in the next six to nine months. It was reported that a strategic session is going to take place early in 2021 and this area of work will be discussed during the session.

20/21/177.4 Action: KMC

Covid-19 Risk Register

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

It was felt that the main themes of the risk register reflect the conversations that are taking place across the organisation at the present time. The Care Delivery Board has homed in on key issues as a result of focussed discussions and have commenced a review of associated risks. The Assurance Committees are part of

this process with the Audit and Risk Committee scrutinising and challenging the work that is taking place to mitigate these risks.

Attention was drawn to the information in table 6, 7 and 8. It was reported that the detail of these risks has been described as action overdue, but it was confirmed that work has taken place to address the housekeeping issues in the register, that each risk has an allocated owner and actions have been updated. December's report will reflect the updated actions.

Kerry Byrne advised that the Audit and Risk Committee received an excellent set of reports from the Care Delivery Board during November's Committee meeting highlighting the discussion and work that is taking place to mitigate risks. Kerry Byrne felt that splitting the remit of the Integrated Governance Committee between the Care Delivery Board and Audit and Risk Committee was the right thing to do.

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

20/21/178 Proposed Approach to Patient Safety

The Board was provided with an overview of the Trust's Safety Day that took place in November 2020. It was reported that a large number of staff from different professions attended the summit and the initial feedback and thoughts were that staff really welcomed the opportunity to shape the future direction of patient safety and help develop the Trust's overarching safety aims for 2021.

It was reported that discussions took place in respect to having a new structure for safety and quality as well as having a new process for RCAs with tighter recommendations and greater oversight for Divisions. The importance of support for staff was raised during the summit especially for members who have been part of an incident or are conducting an RCA/investigative process.

Other topics that were raised during the day related to data and a process for turning it into information, the establishment of steering groups to address training/ education and quality and safety themes, for example, medication safety, working environment, psychological safety human factors and joint working.

The Board was advised that the mandated NHS patient safety expert role will be appointed to in December and expressions of interest will be shared in the next few months to encourage staff to become involved in patient safety.

Attention was drawn to the next steps for the proposed approach to patient safety:

- It has been agreed to change the reporting and governance structure for patient safety and quality therefore the Trust is aiming to have the new structures and process in place in the New Year, February at the latest.
- Utilise the Care Delivery Board for Divisional and service line assurance.
- Utilise other functions within the current reporting structure to focus on Trust wide projects programmes and national risks.
- The Brilliant Basics approach will be used to develop overarching Trust wide patient safety projects and metrics for monitoring within the improvement system.
- Look at how the organisation wraps staff support around the overarching safety metrics and work with each department to develop bespoke local safety indicators.

- Liaise with the ACT Team to see if they are able to take on a strong role in respect to listening to concerns raised by children, young people and families.
- Review Mental Health/Community services indicators.

Louise Shepherd felt that it was fabulous to receive such positive feedback from staff following the event. The Board was advised that the Trust is going to align patient safety and quality with the work that the organisation has been conducting in respect to Brilliant Basics to ensure that the overarching approach is about empowering front line staff. It was reported that Brilliant Basics is being piloted in Surgery towards the end of 2020 and some of the learning from this will become part of the overall safety programme. Louse Shepherd thanked Nicki Murdock and Nathan Askew for leading on the patient safety and quality work.

The Chair noted that achieving full engagement, including children and young people, and embedding patient safety and quality is ongoing work.

Resolved:
The Board noted the update following the Trust Safety Day that took place on the 24th November 2020.

20/21/179 CQC Action Plan

The Board received the current version of the CQC Action Plan. It was reported that the Trust is making strong progress on closing actions in response to recommendations that arose from the last inspection. It was felt that Assurance Committees are being provided with the right level of information thus enabling them to carry out scrutiny of the actions that are assigned to them, in terms of monitoring.

Attention was drawn to a recent example of a discussion that took place during the Safety and Quality Assurance Committee around the action relating to the Trust's consent process and progress with compliance audits.

It was reported that the Trust is reviewing its consent process in three ways; **1**. A group has been formed to review the Consent Policy formally following new guidance published by the GMC which will be included in the policy. This will provide information on the changes to the consent process and inform how the audit tool that is being used to monitor compliance with consent has to be changed. **2**. Electronic consent is going to be rolled out across the Trust in the next two months. This will deal with a lot of the technical aspects of consent in terms of legibility and dates. **3**. Assurance around consent - The Trust is developing an audit tool based on the new GMC guidelines which will be issued to each department. There will be a mandated consent audit that will be performed on a six-monthly basis that will be reported via the Divisions.

Resolved:
The Board received the CQC Action Plan and noted the progress made towards closing actions in accordance with target dates set.

20/21/180 Serious Incident Report

The Serious Incident report was presented to the Board to provide an overview of the current position for incidents reported externally to the Strategic Executive Information System (StEIS) that met the Serious Incident criteria in the reporting period 1.10.20 to the 31.10.20. The report includes recommendations and

actions for improvements for StEIS investigations completed since the last reporting period. The following points were highlighted:

- There were zero Never Events reported during this period.
- There are seven incidents open at the present time which are on track to be completed.
- An update was provided on the two incidents that have been closed.
- There was one new incident reported on the 7.10.20 (2020/19349) that has an expected completion date of the 7.1.21. A 72-hour route cause analysis has been completed and the outcome of the investigation will be submitted to the Trust Board accordingly.

Kerry Byrne queried the monitoring process for ensuring improvement actions are introduced. It was reported that part of the gap in assurance is that action tracking is done at Divisional level with the governance teams. Going forward, the Medical Director and Chief Nurse will meet with Divisional teams on a monthly basis to review the actions from Serious Incidents, complaints, etc. to gain assurance that actions have been completed.

Resolved:

The Board received and noted the contents of the Serious Incident report for October 2020.

20/21/181 Weekly Corporate Report – Top Line Indicators

Corporate Report Divisional Updates:

Medicine

Safe:

- There were zero Never Events, zero clinical incidents resulting in severe, moderate or permanent harm. No grade 3 or 4 pressure ulcers and no hospital-acquired infections for MRSA. There has been one report of a patient with C Difficile. This patient has been taking multiple antibiotics due to be immuno suppressed. It was confirmed that Beatriz Larru is looking into this matter.
- Cleanliness score of 97.9%.
- 100% Sepsis patients treated within 60 minutes.

Caring:

- 7 complaints and 25 PALS responses. The Division is receiving an increasing number of complaints that are linked to the Tics and Tourette's patients in Neurology.

Effective:

- ED performance continues to meet the national standard of 96.8%.

Responsive

- RTT compliance remains challenging at 68%, however with the Division's intense focus on restoring capacity and expanding access to care, this has improved on the September position of 55%.
- Diagnostic compliance has improved to 98.8%.
- Consistent delivery of all national cancer standards.
- Waiting times are a challenge.

Well Led

- Long-term sickness rates have been reduced and mandatory training is at 89.9%

Community and Mental Health

Safe:

- Zero Never Events and zero pressure ulcers.
- It was reported that there has been an increase in medication risks, predominantly lost prescriptions related to the Royal Mail. The Divisional Pharmacist is undertaking work to look at alternative arrangement for sending prescriptions to families.
- Lack of Tissue Viability support has been resolved and the post has gone out to recruitment.

Caring

- There have been three formal complaints, one is due to the lack of a Tics and Tourette's service.

Effective

- The new outpatient schedule was launched on the 26.10.20.
- Additional Mental Health in Schools Teams are mobilising.
- Funding has been agreed for mobilising one team in Liverpool and two teams in Sefton.

Responsive

- There were no urgent and routine breaches of Eating Disorder waiting time targets.
- Liverpool Speech and Language Therapy waiting times remain above eighteen weeks, but position continues to improve.

Well led

- Staff turnover rate is at 9.7%
- NHS Cadets programme commenced with the Youth Forum and young people from across Liverpool and Sefton (Youth Violence).
- Celebration of World Mental Health Day took place on the 10.10.20.

Kerry Byrne queried the plan for the Tics and Tourette's service. The Board was advised that a business case has been drafted and shared with the Executive Team for comment. It was confirmed that the Trust has appointed a General Paediatrician who wants to develop a career in neurology.

Surgery

Safe:

- Zero Never Events, zero clinical incidents, zero hospital acquired infections.
- Business case has been approved to invest in the Major Trauma Service. This will enable recruitment and make the service sustainable.
- Business case approved for Safety and Governance role.

Caring:

- The Board was advised of a challenging patient who was admitted as a result of an emergency and had life changing injuries. This patient was autistic and very challenging but as a result of working across the entire

Division, this patient had a relatively safe passage and recovery from major surgery. This demonstrated how the surgical Division is pulling together to address complex patients.

Effective

- Theatre utilisation is under 90%.
- Cardiac surgery has been managed throughout the pandemic.
- Increase in children cancelled on the day of their elective admission for non-clinical reasons. The Board was advised that the Trust is due to appoint three new anaesthetists.

Responsive:

- Increase in waiting list size - number of patients waiting over 52 weeks to receive treatment.
- Teams are ensuring that all patients waiting over 52 weeks have a clinical review.
- Brilliant Basics is being introduced onto one of the wards in December 2020

Top Line Indicators – Trust level

Quality:

- 94% of Inpatients treated for Sepsis within an hour.

Caring:

- Friends and family scores are generally above 94% across the board.
- Friends and family result in Mental Health is at 90% which is down from September. It was reported that the number of responses has affected the overall score.
- *Play and Learning* – A positive meeting took place with the Head of the school and it was acknowledged that the school is able to provide a little more in terms of offering education in a safe way, taking into account Covid restrictions. From the Trust's perspective it needs to make sure that the right people are being asked for the right feedback, this was something that was fed back. A joint action plan has been developed to improve the feedback around learning. It was reported that the Play Team are going above and beyond to try and present to children of all ages the most activity that they can taking into account the restrictions due to the pandemic.

Effectiveness and Responsive:

- It was reported that there were two patients who had an operation cancelled and didn't get their operation re-booked within twenty-eight days. Work is taking place to ensure patients receive their treatment.

The Chair acknowledged the progress that has been made and thanked all those concerned.

Resolved:
The Board noted the updates provided by the Divisions, and the top line quality, safety, effectiveness and responsive indicators highlighted in the weekly Corporate Report metrics.

20/21/182 Digital Futures

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

- The Trust has won a number of national awards in the previous reporting period. In addition to this Alder Hey has been shortlisted by the Health Service Journal award for the work that has taken place on the Global Digital Exemplar programme and HIMMS accreditation.
- There has been a focus on digital inclusion which is being progressed with the Divisions. A deep dive is being conducted on the Trust's position in respect to this area of work. This has been flagged as part of the regional work.
- There has been a lot of progress with the Alderc@re Programme. This is the programme of work which will see a significant update to the Trust's Electronic Patient Record programme in 2021.
- It was reported that the Trust is the second highest user in Cheshire and Merseyside of virtual consultation. The Trust is expecting this to rise as a result of the new outpatient schedule and work in this area.
- The Board was advised of the progress of Telemedicine. It was reported that the Trust's Telemedicine robots have been mobilised at Arrowe Park Hospital to support children needing high dependency care opinions. This is an example of technology supporting other areas across the regional pathway.
- It was pointed out that performance against operational KPIs remains on track. Attention was drawn to a business continuity issue that occurred on the 25.11.20 around electronic records. It was confirmed that this matter has been resolved.
- The digital partnership with Liverpool Specialist Trust Alliance continues to progress especially with Liverpool Heart and Chest Hospital.

The Chair congratulated Kate Warriner and her team on their success in respect to being nominated and winning a number of awards.

Resolved:
The Board received and noted the operational updates and progress with technology and digital maturity programmes.

20/21/183 Weekly Corporate Report – Top Line Indicators

People

This item was addressed under agenda item 20/21/177.

20/21/184 Alder Hey People Plan

The Board was provided with a strategic update against the revised approach to the Alder Hey People Plan which focuses activities on three strategic areas; Wellbeing, Flexible Working and Equality, Diversity and inclusion. The following points were highlighted:

- The 2020 Staff Survey was launched w/c the 21.9.20. Staff have been encouraged to complete the survey and it was confirmed that there has been a 50% response to date.

- The Board was advised of the large piece of work that is taking place around e-rostering. It was reported that the Trust has awarded Allocate Software the contract to supply its E Rostering system and mobilisation of the project commenced on the 9.11.20. The E Rostering team are currently carrying out a data collection exercise and the system will be configured w/c 23.11.20. The Trust will be ready to start building areas from the 30.11.20. There is going to be a focus on getting doctors onto the system initially for the purpose of annual leave and rotaring. It was pointed out that it is going to be a big change, but the organisation has got the right infrastructure in place along with some funding from NHSI.

  Nathan Askew (NA) was invited to comment and reflect upon the E-rostering system that the Trust is implementing due to having experience of the system when working for another Trust. NA pointed out that it can be a really complex process when trying to move people from that cultural change of having their knowledge transferred onto computer-based system but felt that the transfer of all professions onto they system is the right way to do it. At the moment the Trust is focussed on safe staffing for nursing, this will enable the organisation to have a really transparent oversight of staffing levels and manage the staffing risks more centrally. NA drew attention to the importance of maintaining the system and adapting it to changing needs.

- It was reported that PDR figures are 75%.
- Mandatory training figures are slightly below the Trust's target of 90%, at 88%. The Trust is continuing to focus on this area of work.

SALS Update

The Board was provided with a brief overview of the origins, purpose and development of the Trust's Staff Advice and Liaison Service (SALS). It was reported that Alder Hey has been shortlisted by the Health Service Journal for the work that the organisation has done around SALS.

SALS is a single door service for all staff at Alder Hey. It is open 7 days a week, with drop in facilities available five days a week and phone/e-mail facilities available seven days a week, from 9:00am to 5:00pm. The service offers advice to staff, signposting and brief interventions to prevent staff from going off sick and to keep them well.

It was reported that the service has got busier during the pandemic with a total of 600 contacts to date. The SALS team shared the impact that the service had has had on staff via a number of videos as a result of three brave colleagues who agreed to share their experiences with the Board; Anne-Marie Greenwood, Maria Simpson and Emily Kavanagh.

The Chair thanked the SALS team for providing an update on the work that has taken place since the beginning of the pandemic, and thanked Anne Marie, Maria and Emily for sharing their stories with Board members.

Fiona Marston queried the communications process for promoting SALS to staff working from home. It was reported that members of the SALS team are meeting on a face to face basis, in a socially distanced manner, with staff who are on site and via Teams with staff who are working from home. It is felt that the reach of SALS is getting out to staff and the service is growing organically. Training is also being offered around the themes that are being reported.

Claire Dove highlighted the importance of having diversity within the team.

Fiona Beveridge asked as to whether the experience gained by SALS can help the organisation manage wellbeing in the long term, going forward. In particular, developing something that can be shared. It was pointed out that it is key to feed any learning back into the organisation to enable it to improve early intervention. Feedback on this question will be able to be provided as SALS progresses.

The Chair suggested that the team should conduct an evaluation once it has been up and running for twelve months and share the outcome with NHSE/I as it could have an impact across all health services. It was reported that SALS is being shared regionally.

EDI Task Force Action Plan

Claire Dove raised a number of points following the People Plan update; 1. The BAME Task Force group is going to review the questions in the Staff Survey. The questions are set nationally but it was felt that the Trust needs to have its own context on this. 2. Thought needs to be given about how the Trust works as a whole in 2021 in terms of staff working remotely, as this will link in with the Green agenda.

The Board received an update on the progress of the EDI Task Force following the second meeting. Claire Dove provided an overview of the topics that were discussed at the first meeting and highlighted the themes that have arisen as a result of the listening events that have taken place;

- Recruitment – Lack of diversity on interview panels.
- Overt racism between staff and teams.
- Lack of training and development for BAME colleagues.
- Lack of professional progress into high level roles.
- Lack of understanding of race.

It was reported that 'Black History Month' at Alder Hey was really successful and Claire Dove thanked Colin Beaver for his support in promoting this topic across the Trust.

During the second meeting the Task Force reviewed the Trust's nursing workforce data and its diversity. A piece of work has been completed in relation to this matter and meetings are to be scheduled with frontline recruitment staff at universities to discuss this subject. The Board was advised that following on from 'Black History Month' a campaign has been put together called 'A Face Like Mine' which is going to be rolled out across the Trust.

Claire Dove drew attention to an urgent issue that BAME staff are experiencing; overt racism which happens on a regular basis. This issue was highlighted when an urgent case came into A&E and the parents wouldn't allow a black member of staff to touch their child. A meeting has taken place with a number of clinical consultants who have advised that this sort of behaviour will not be tolerated moving forward. It was pointed out that a review of policies needs to take place and it was felt that it would be beneficial if Louise Shepherd could speak with frontline staff to see how the organisation can support them to address overt racism.

The Board was advised that an interim report will be shared during December's Board meeting. Claire Dove highlighted the importance of ensuring that the Trust continues to progress the recommendations that will be captured in the final report,

in order to make Alder Hey a safe and happy place for all. Louise Shepherd advised that there is a huge commitment to drive the next steps forward in order to address some of the shocking things that staff are experiencing.

Shalni Arora asked as to whether there is something that can be done in addition to having policies in place to raise awareness amongst staff about the issues their BAME colleagues are experiencing, and to empower staff to stand up for their rights. Claire Dove advised that the Trust is organising a wholesale training session with a facilitator to address race, early in January 2021. Fiona Marston felt that the Trust should have a key message stating that there is zero tolerance for racism at Alder Hey.

The Chair felt that the blogs that supported 'Black History Month' were really informative and educational, and thanked Claire Dove for the time that she set aside in which to create these blogs.

The Chair informed the Board of the keynote speech that Claire Dove gave at the Annual Members' Meeting on racism and advised that the Communications Team will be circulating the link to enable members to listen to it. The Chair felt that it would also be beneficial to share this link with the organisation during a staff briefing session.

Resolved:
The Board noted the updates under the People Plan agenda item.

20/21/185 Children's Network in Cheshire and Merseyside

The Board was provided with an update on the work that the Trust is doing across Cheshire and Merseyside with the Paediatric Network. Alder Hey is continuing with its commitment to leadership for children and young people across its ICS footprint. The main focus is on Cheshire and Merseyside, but it was pointed out that similar work is taking place across the North West and the organisation's core place.

A number of slides were presented to the Board on Alder Hey's priorities for children and young people and the Trust's action in Cheshire and Merseyside from an access to care perspective, addressing health inequalities and leadership and advocacy for children and young people.

The escalation plan was shared with the Board in order to provide assurance that Alder Hey has continued to lead the agreement of the collaborative Cheshire and Merseyside wide escalation plan. It demonstrates that the relationships across Cheshire and Merseyside and Alder Hey have become really positive and are enhancing all the time. The Escalation Plan also demonstrates how the Trust has aligned the escalation levels set out by Cheshire and Merseyside Hospital Cell so that there is a clear link from every single District General Hospital from Alder Hey as a tertiary centre into the hospital cell back and forth.

The Board was advised that the Paediatric Network has been in place for the last five years but there has always been uncertainty across the region around the mutual aid offer that Alder Hey has wanted to develop. As a result of the pandemic the network has been reinvigorated and engagement is now strong and consistent across all of the partners through lead clinicians and children and young people managers across the region. There has been a step change in attitude following discussions about Alder Hey's role, and the opportunities around advocacy for children and young people across the region. The network now looks to Alder Hey

for support and leadership and it is felt that this has become a tremendous foundation to continue with the workstreams that were described in the presentation.

The Board was advised of a venture that the Trust is embarking upon in respect to the regional digital offer from Alder Hey. This has been built upon following the progress with the Liverpool Neonatal Partnership; digitally enabled remote support across the site of Liverpool Women's Hospital and Alder Hey. The network looked at the possibility of developing a similar offer for critical care support for children and young people needing high dependency care across the region, and it was agreed that Alder Hey would work up an expression of interest and selection process for a single site District General Hospital (DGH) partner to pilot the virtual opportunity.

It was reported that Arrowe Park Hospital was the chosen partner due to having the strongest expression of interest. It was pointed out that there were four potential partners, which it is felt demonstrates a real interest in this area of work.

Work is taking place with Arrowe Park presently around scope and contract logistics. The Board was advised of the areas of work and opportunities that the two month pilot will cover; high dependency support, virtual daily ward rounds, develop support of the deteriorating child, acute support for surgical patients both in paediatrics and on the Neonatal Unit, acute support for medical speciality patients, aim for care closer to home, and exploring the possibility of DGH consultants joining ward rounds when one of their patients has been transferred to Alder Hey. It was pointed out that this is huge opportunity that the Trust would like to upscale across the region.

Louise Shepherd informed the Board that Alder Hey has been working alongside the Paediatric Network for five years offering support to help improve the health outcomes of patients across the region. As a result of the work that has taken place by Adrian Hughes and Dani Jones, along with the pandemic there has been a transformation with the galvanising of the paediatric community across Cheshire and Merseyside. Louise Shepherd thanked Adrian Hughes and Dani Jones for the work that has taken place along with the achievements.

Louise Shepherd reported on the paper that was submitted to the Health Care Partnership Board that advised of the next phase of development and the national priority that is being set via the National Children's Transformation Board for a long-term plan for children and young people. It was reported that there are going to be clear targets set around some of the interventions that need to be made in obesity and asthma.

NHSE has recommended that there be a clinical education and care triumvirate leading the effort across the system. It has been recognised by all concerned that this is a top priority for the Health and Care Partnership, going forward. The Health Care Partnership Board has requested £0.5m of the national funding that is available, and it was reported that there has been broad approval for this request. The Board was informed that work will commence with colleagues across the region to set out a very clear programme.

Resolved:
The Board noted the Children's Network in Cheshire and Merseyside update.

20/21/186 Alder Hey in the Park Campus Development Update

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

- It was reported that the principal budget remains the same.
- Phases 2 and 3 are over budget but work is taking place to reduce the costs.
- *Alder Centre* - This project is complete. The final overspend amounted to £230k which is being funded via the relocation budget.
- Work is taking place on a long-term strategy as staff return to Alder Hey post April 2021.
- *Clinical Hub and Dewi Jones Unit*- It was reported that the construction of these two buildings is progressing.
- *Neonatal Development* – The design for the building is being progressed and options for the ground floor are being addressed.
- The link for the Time Lapse Project was shared with Board members.

Resolved:
The Board received and noted the campus development update.

20/21/187 EU Exit Update

A presentation was submitted to the Board to provide an update on the UK's exit from the EU and Alder Hey's approach to this situation. Information was provided on the following areas:

- EU Exit overview.
- Department of Health and Social Care position.
- NHSE operational response.
- Local actions.
- Alder Hey's Escalation Plan/roadmap.
- Alder Hey's next steps.

A query was raised as to whether Alder Hey would receive any additional funding to support the Trust through this period. It was reported that the organisation has been asked to track additional expenditure and flag it with the Centre, but there hasn't been any communications relating to extra funds.

Fiona Beveridge advised the Board that new members of staff who are EU Nationals will require a visa and assistance with insurance fees and queried as to who will fund this and how much risk is the Trust exposed to. It was reported that the Trust is still waiting for clarification of figures in respect to the amount of EU National staff who will be joining the organisation. There are 64 EU Nationals working at the Trust at the present time therefore it is felt that exposure is very limited.

Fiona Beveridge queried the eligibility to treatment of non-UK residents. It was reported that the Trust has systems in place to capture any non-UK residents attending the hospital.

Resolved:
The Board noted the EU Exit update.

20/21/188 Board Assurance Framework

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

- All strategic risks with the exception of 4.1 had been the subject of substantive Board discussions today.
- The Risk Management Strategy has been considered by the Audit and Risk Committee. There have been a number of significant changes to the strategy therefore there is going to be a period of consultation to road test some of the tools. The Risk Management Strategy will be submitted to the Board for ratification in January.

20/21/188.1 **Action: ES**

- It was reported that a risk appetite is in the process of being compiled and will be submitted to the Board in March for ratification.

20/21/188.2 **Action: ES**

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

20/21/189 Board Assurance Committees

Audit and Risk Committee (19.11.20) – It was reported that the Trust is in a good position to deliver the Internal Audit Report by the end of 2021 despite putting it on hold.

RABD (23.11.20) – The committee discussed the progression of the Trust's Green Plan. Claire Liddy has agreed to work with Mark Flannagan from an innovation perspective.

SQAC (18.11.20) – **The Committee had a good discussion on the top five risks.** touched on UK's exit from Europe and discussed the impact of change from a safety and wellbeing perspective. The Committee noted the progress with the CQC action plan.

20/21/190 Any Other Business

There was none to discuss.

20/21/191 Review of the Meeting

The Chair felt that there had been a wide range of discussions during November's Board meeting, all highlighting the huge progress that is being made. The Chair drew attention to the Board's appreciation for the hard work of the Executive Team and staff members to restore services for patients. The Chair highlighted the importance of focussing on operational issues but felt that it is important to commence strategic discussions in the near future.

Date and Time of Next Meeting: 17th of December at 9:00am via Teams

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 17th December 2020							
07.07.20	20/21/93.1	Serious Incident Report	Compare recent Serious Incident figures against data from previous years to ascertain improvement.	Pauline Brown	17.12.20	On Track	**24.9.20** - A comparison of figures has been conducted against data from the previous year and included in the Serious Incident report. Kerry Byrne asked if a comparison of the last two to three years could be carried out to look at whether the Trust has more or fewer serious incidents. It was agreed to provide this information via a line graph in the next report. **22.10.20** This will feature in December's report. **ACTION TO REMAIN OPEN**
26.11.20	20/21/177.1	Covid-19 Assurance Plan – Progress Update	*Access and Restoration of Services* - Submit an update in December on safe waiting risk management in order to share the findings of the improvement work that is taking place, in association with an advisory company, for the three Divisions.	Adam Bateman	17.12.20	On Track	**13.12.20** - This item has been included on the agenda.
26.11.20	20/21/177.2	Covid-19 Assurance Plan – Progress Update	*Financial Framework Update* - Provide an update on the work that is taking place to mitigate the Trust's £2.4m risk	John Grinnell	17.12.20	On Track	**13.12.20** - This item has been included on the agenda.
26.11.20	20/21/177.3	Covid-19 Assurance Plan – Progress Update	*Financial Framework Update* - During the next regional call, query the detail of the incentives if the Trust exceeds its targets.	Rachel Lea	17.12.20	On Track	
Actions for the 28th of January 2021							
03.03.20	19/20/346	Key Issues/Reflections and items for information	Invite the new Nurse cohort from India to the Trust Board lunch and write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff.	Pauline Brown	28.1.21	On Track	This item has been deferred until further notice due to the Covid-19 crisis.
02.06.20	20/21/60.1	Freedom to Speak Up	Compile a breakdown of the issues that SALS have addressed during the current year.	Kerry Turner	28.1.21	On Track	

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
24.9.20	20/21/122.4	Phase 3 Covid-19 Response	*IPC Covid Assurance Framework* - Discuss the possibility of incorporating the IPC Covid Assurance Framework with the BAF – ES/NM/PB	Nicki Murdock/ Pauline Brown/ Erica Saunders	28.1.21		**22.10.20** - Discussions are taking place in terms of the shape of the integrated framework. An update will be provided in December following November's Safety Summit. **ACTION TO REMAIN OPEN**
24.9.20	20/21/123.1	DoS – Governance and Safety Rates	Provide an update a further update on the work that is taking place to address governance in the DoS.	Alfie Bass	28.1.21		
22.10.20	20/21/152.1	Covid-19 Assurance Plan – Progress Update and Incident Response	*Financial Update: 2020/21 Financial Plan and Phase 3 Framework* - Provide an update during January's Trust Board meeting on a breakeven model and strategic approach.	John Grinnell	28.1.21		
26.11.20	20/21/188.1	Board Assurance Framework	Submit the Risk Management Strategy to the Board for ratification in January.	Erica Saunders	28.1.21	On Track	
Actions for the 25th of February 2021							
26.11.20	20/21/177.4	Covid-19 Assurance Plan – Progress Update	Arrange for a Board strategy session to place in February.	Karen McKeown	25.2.31	On Track	
Actions for the 25th of March 2021							
26.11.20	20/21/188.2	Board Assurance Framework	Submit the risk appetite to the Board in March 2021 for ratification.	Erica Saunders	25.3.21	On Track	

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 17th December 2020

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

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

1. Introduction

Alder Hey continues to deal with the consequences of COVID-19 pandemic. Since the National directive to cease all elective activity from mid-February we have been managing the significant and adverse effect on capacity, productivity and waiting times. Our phase 3 restoration programmes continues to improve against the backdrop of high COVID-19 community prevalence, ongoing preparations for EU Exit and emerging winter pressures. We remain focused on reducing waiting times by restoring service capacity and improving productivity.

Nationally, restoration targets have been set as follows:

- In October 90% of last year's activity for both overnight electives and for outpatient/day case procedures.
- Diagnostics to achieve at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
- 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September.
- Full restoration of cancer services.

2. Summary of progress in restoring services

Our performance for restoration of services in August to November is as follows:

Service	NHSE Plan for October	Aug-20	Sep-20	Oct-20	Nov-20
Outpatients	100%	86%	87%	84%	94%
IP/DC	90%	84%	76%	87%	92%
Diagnostics	100%	73%	86%	82%	89%

Service	Aug-20	Sep-20	Oct-20	Nov-20
Outpatients	13,108	16,581	16,656	17,187
IP/DC	1,834	1,910	2,097	2,200
Diagnostics	1,303	1,700	1,651	2,018

Forward look

Service	Provisional	
Forward Look	w/c 7th Dec	w/c 13th Dec
Outpatients	97%	98.3%
DC/IP	96.6%	99.2%

The detail behind the trend and reasons for performance are set out in section 3. In **outpatients** we have seen robust performance reflective of the sustained focus on increasing Outpatient activity.

In **elective care**, we have exceeded the restoration target driven by additional weekend working and a sustained increase in Day Case activity levels.

The **diagnostic** standard performance has significantly improved from M7 to M8 and just short of the restoration target. Note the diagnostic restoration standard does not include all of the diagnostics standards that we currently report on via the DM01 standard.

Progress against restoration is tracked through a live-app and reported to Gold Command.

3. Restoration by service area

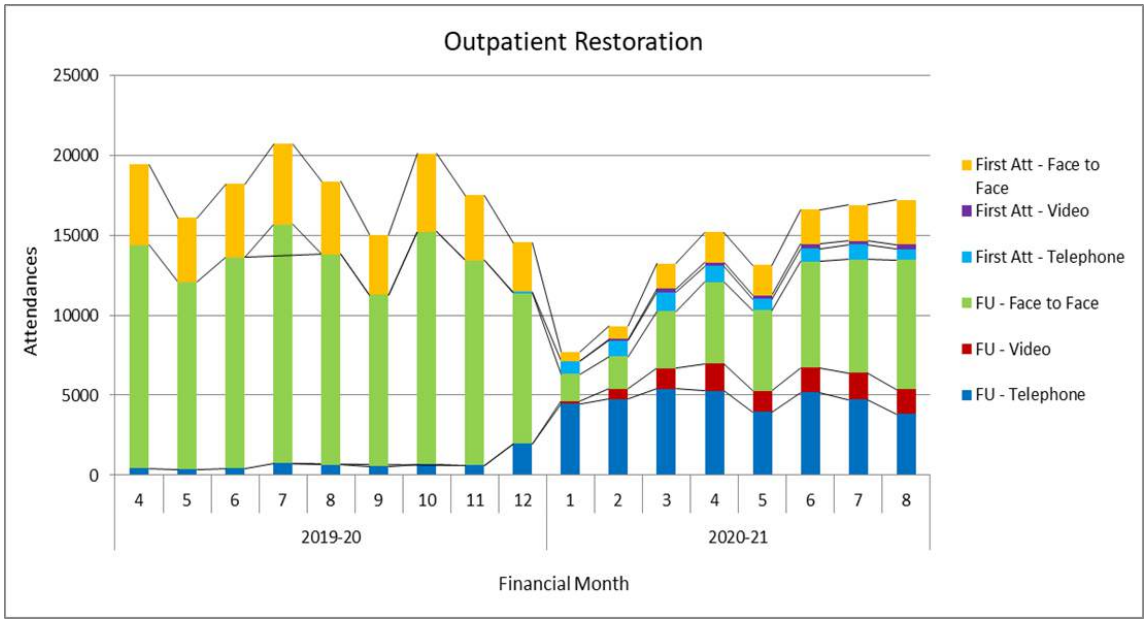
3.1 Outpatients

Our high-impact interventions continue to improve outpatient restoration. The aggregate levels of OPD activity are continuing to increase and we have provided an additional 531 consultations in November.

The clinical divisions continue to take additional actions to improve outpatient restoration including:

- Maximising the opportunities that digital and phone clinics create reflected by the revised templates which went live from 26 October.
- Continuing with extra weekend and evening sessions
- Working with specialties to increase patients numbers per clinic with agreed increases in ENT, Cardiology, Paediatric Surgery and Dental.
- Review of specialty use of attend anywhere for scope to expand virtual clinics
- Increased Nurse Led & Registrar clinics
- Developing different clinical pathways
- Cleaning of the department between clinics
- Total footfall, risk assessments to ensure safe passage through the department
- Extended sessions into evenings

The activity profile in the table shows the overall increased out turn for M8 relative to M7.

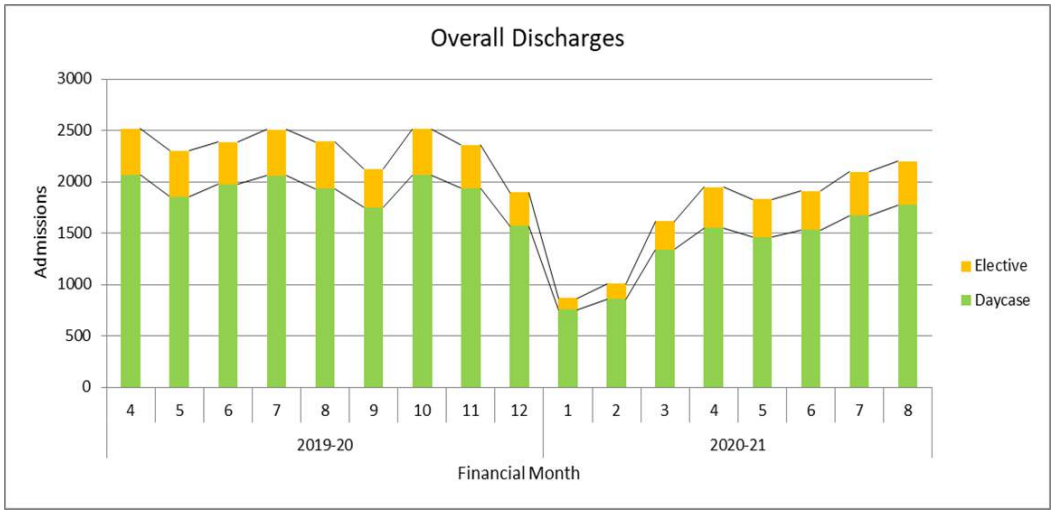


3.2 Elective & Day Case Activity

Elective activity restoration has exceeded restoration target for November. A fantastic achievement given the challenging conditions within which all the teams are currently operating. The teams continue to innovate and improve capacity and activity to further improve restoration:

- Focus on day case surgery improvement programme
- Additional Saturday theatre list commenced
- Pooling of lists

- Review cases per list to maximise utilisation
- Maintain PPE supply



3.3 Diagnostics

Restoration diagnostics have a target of 90% set against 7 of the 15 diagnostic measures that are used to make up the DM01 target. These are listed in the table below.

Diagnostic Intervention	DM01	Restoration
Magnetic Resonance Imaging	X	X
Computed Tomography	X	X
Non-obstetric Ultrasound	X	X
DEXA Scan	X	
Audiology - Audiology Assessments	X	
Imaging	X	
Cardiology - Echocardiography	X	
Cardiology-Electrophysiology	X	
Neurophysiology - Peripheral Neurophysiology	X	
Respiratory Physiology	X	
Urodynamics	X	
Sigmoidoscopy	X	X
Colonoscopy	X	X
Cystoscopy	X	X
Gastroscopy	X	X

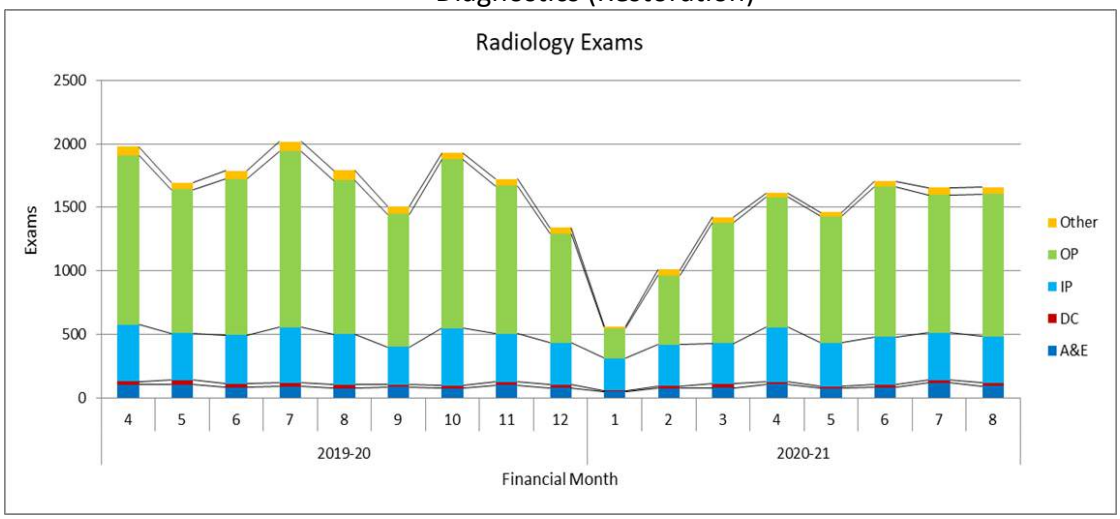
Against both the DM01 and the restoration standard good progress has been made with improving the performance to the extent that we are on the cusp of achieving both standards. DM01 has hit 97.1% against the 99% standard and Restoration Diagnostics has achieved 89% against the 90% standard. This is again a fantastic achievement with restoring services which has reduced the number of children waiting less than 6 weeks for a scan.
The Clinical, Radiology and Day Case Teams have worked tirelessly to improve access and work continues to reduce the waiting times. The teams have continued to improve access by

refining the suite of initiatives to maintain safety as these interventions are classed as Aerosol Generating and reviewing efficiency within the department. Work is in place to keep this improving performance in place for example:

- The department continues to develop plans for new smarter ways of working for increased resilience in Ultrasound and MRI to enable us to do more elective work within core hours and potentially extending week days to 8pm in those areas.
- Plans are in place to reinstate the second on call, if deemed necessary, for MRI and CT which will support IPC recommendations for donning / doffing over the winter if the tier system enters level 3 or above for the local area, this is due to attenders for trauma not having a known COVID status upon arrival.
- Decontamination team working patterns changed to reduce turnaround times for scopes
- Implemented a local Track & Trace system within Day Case to improve resilience
- Established a Task & Finish group to review diagnostic utilisation within Day Case theatres

Radiology and aggregate activity and performance against the 99% standard are presented on the following 2 tables.

Diagnostics (Restoration)

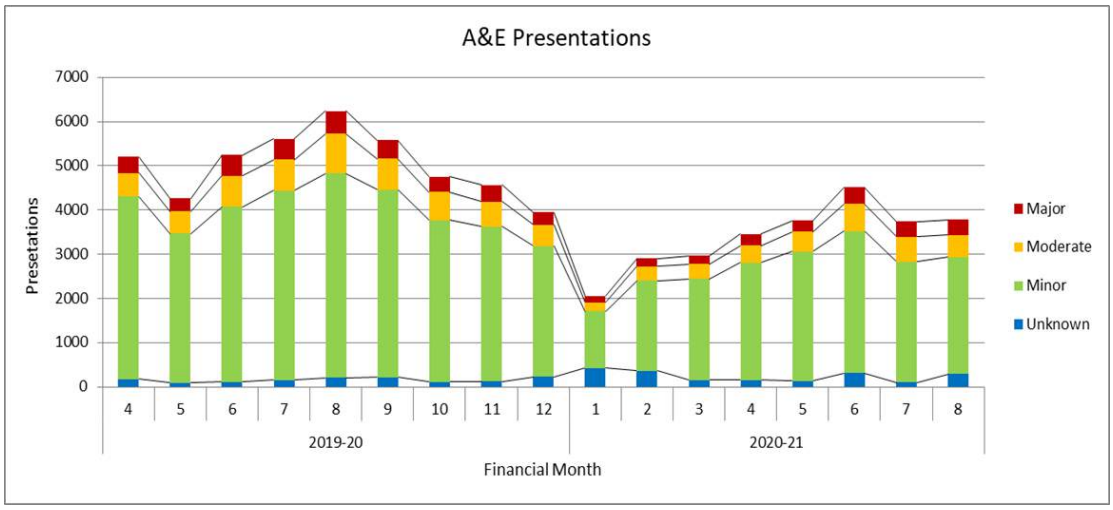


Diagnostics (DM01) Performance against 99% standard

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

3.4 ED attendances

ED performance for the year continues above the 95% standard despite the challenges of social distancing. Attendance continues to increase with increasing acuity as we progress through the winter period and is presented in the table below.



ED 4hr access standard performance:

Month	Total	Type 1
Apr-20	97.28%	97.28%
May-20	98.14%	98.14%
Jun-20	98.75%	98.75%
Jul-20	97.25%	97.25%
Aug-20	97.79%	97.79%
Sep-20	95.43%	95.43%
Oct-20	96.92%	96.92%
Nov-20	97.51%	97.51%

3.5 Cancer Performance

Throughout the pandemic we have maintained access to cancer care:

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%

3.1 New outpatient care: waiting list size and waiting times

Between July and November the number of patients on the outpatient waiting list (new patient) has reduced from 11,086 to 9,946. The number of children waiting over 52 weeks for a new appointment has been reducing however has plateaued following our review of waiting lists.

Date	Volume	Waiting Times 0-39	Waiting Times 40-51	Waiting Times 52+
01-07-20	11086	10405	610	47
01-08-20	10509	9913	558	37
01-09-20	10385	9608	734	29
01-10-20	10015	9142	835	30
01-11-20	9832	9010	469	24
01-12-20	9946	8454	968	31

Of the 31 patients waiting over 52 weeks, 4 families have. In community paediatrics there are no longer any children waiting over 52 weeks for treatment. In the Division of Surgical Care some improvement actions are in place to reduce the number of long wait patients. The number of specialties with patients waiting over 52 weeks has reduced from 8 to 5 (ENT, Pain, Neurosurgery, Orthopaedics and Dentistry). We have a shared goal between Executives and the Division of Surgical Care to achieve a material reduction in the number of outpatients waiting less than 52 weeks by 31 December 2021.

3.2 Inpatient care: waiting list size and waiting times

We are concerned that the number of inpatients waiting over 52 weeks is not reducing significantly; in response to this we have agreed a new set of progress metrics to track improvement. We continue to book treatment dates for all patients waiting over 46 weeks and ensure the majority are within the 52-week timescale.

Date	Volume	Waiting Times 0-39	Waiting Times 40-51	Waiting Times 52+
20-08-20	1144	873	181	90
01-09-20	1116	819	181	116
01-10-20	1126	841	170	115
01-11-20	1059	791	162	106
01-12-20	1088	794	145	117

Of the 117 long waiting patients, there are 26 families who have requested to delay treatment until post-COVID-19.

4. Conclusion

There has been significant progress in restoring services. We are working hard to ensure this translates into a reduction in the number of long wait patients. Access to care is most challenged in surgical specialties and our transformational projects in outpatients and the day surgery unit is built around working with specialty times to improve productivity, increase capacity and ultimately reduce waiting times for children and young people.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 17th December 2020

Paper Title:	**Infection, Prevention and Control Covid-19 Assurance Framework**
Report of:	Beatriz Larru, DIPC
Paper Prepared by:	Beatriz Larru, DIPC

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

Alder Hey Children's NHS
NHS Foundation Trust

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	All children admitted at Alder Hey (including emergency, planned and intrahospital transfers) have a SARS-CoV-2 testing done on admission. Results are recorded electronically in Meditech. The testing protocol is available on the COVID-19 hub. Link here Daily, patients and visitors are confirmed to meet the triple negative strategy- 1) neg symptoms, 2) neg test and 3) neg contact with a known COVID-19 case in the previous 14d.	At present, only HDU/PICU formally audit the completion of the triple negative strategy in Meditech.	Staff is regularly reminded about the importance of checking daily the triple negative criteria in patients and visitors with visual communications strategies.
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients	All new admissions are managed under the high or moderate-risk pathways and are isolated in a cubicle (where possible), until proven COVID-19 positive or negative by testing and clinical assessment. A cohorting plan is in place to optimise the use of beds during escalation of patient admissions. Patient Placement and Cohorting Guidance is available on the COVID-19 hub. Link here Discharge Planning Policy, Patient Transfer Policy, Rapid Discharge Plan for End of Life Care available through intranet (documents are hyperlinked). Rapid testing is available (if necessary) prior to transfer to other healthcare settings, including hospices and long-	Not all our inpatient facilities are isolation cubicles (approx. 30% are common bay areas). In times of high clinical demand, patients may need to be admitted to common bay spaces.	IPC nurses daily (M-F) review appropriate placement of patients, in particular those in common bay spaces. Rapid SARS-CoV-2 testing is available in the Trust if needed for patient allocation.

	term care facilities.		
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	The IPC team regularly performs audits in clinical areas to ensure compliance with IPC practices such as hand hygiene, PPE compliance or environmental cleaning.	Audit results are reported to the IPC committee but immediate feedback to clinical areas does not consistently happen.	PPE audits are being incorporated in the routine ward dashboards.
• monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	The nursing educational department has assigned PPE educators (practice facilitators or clinical educators) in each clinical area, to ensure PPE compliance and rapidly cascade any change in guidelines.	With the remobilisation of clinical services, many practice/clinical educators have been redeployed to their clinical duties.	The IPC team is now also participating in the PPE audits.
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	The Trust has an asymptomatic NHS staff testing program (started on 23-Nov-2020). Any positive test is rapidly communicated and followed by a Track & Trace team. If a cluster/outbreak of cases is detected, urgent incident meetings chaired by the DIPC or ID/micro on call are organised.	SARS-CoV-2 testing performed in the community are not automatically download in our records, relaying on staff to report to us their results.	Ward and line managers are frequently reminded about the process of Track & Trace.
• training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory	Educational sessions on SARS-CoV-2 transmission have been given to staff (Grand rounds). The Trust has an isolation policy approved by the IPC committee. Link to IP&C precautions here On induction, there is a specific module on IPC with content regarding isolation precautions. Regular IPC training is also part of the annual mandatory education for all staff.		IPC nurses review appropriateness of isolation precautions on daily (M-F) rounds.

training • all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work • all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Educational material regarding the relevance of hands-face-space is displayed across the trust and as Trust computer screen savers. Staff is reminded frequently (at least twice weekly) about importance of complying with hands-face-space as part of the Broadcast. PPE training has been performed in all clinical areas. Posters with detailed information on how to don and doff PPE are also displayed in clinical areas. PPE is readily available in all clinical areas with close supervision of adequate stocks by the Procurement department. The Procurement department has developed a predictor PPE usage model to anticipate potential shortages and seek alternative PPE where possible. The Procurement Operational Team manager is a member of the regional procurement who is cited on seeking emergency supplies when require The Trust has established a PPE workstream led by a Senior Manager which links together procurement, innovation, communication, education and clinical recommendations regarding PPE. A multidisciplinary clinical team regularly (weekly or biweekly) discussed and updates the PPE guidance in accordance with national guidelines and emergent scientific evidence. The PPE Guidance is available on the COVID-19 hub. Link here The PPE guidance for staff is communicated to all staff and	.	

• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens • that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. • ensure Trust Board has oversight of ongoing outbreaks and action	updated as changes occur and is available through the Trust's COVID-19 Hub, through Posters, Daily Operational Communications and Trust email. Link here. Any changes to PHE guidance are raised in the PPE workstream and the Clinical Advisory Group and are discussed in Operations Board and communicated to the Trust Board via the DIPC / Medical Director. Risks are documented in Ulysses under a specific COVID-19 section and reviewed through the governance structures. Link to Ulysses here. IPC risk assessments remain in place and continue to be reviewed and updated before and during the pandemic. A specific COVID-19 evaluation is now a standing agenda item at the IPC committee. The Trust CEOs approves and signs off all data submission by the daily nosocomial sitrep. The Trust CEO, Medical and Nursing director are frequently (3 times per week at least) updated on potential COVID-19 outbreak. Trust Board is updated about outbreaks and action plans by the DIPC.		

plans.			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Caring for COVID-19 patients forms part of the standard training for doctors and nurses. Extra / specific training has been provided for teams being requested to care for patients on PICU and other cohort areas. Alder Hey is a HCID centre designated by the Government.		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Detailed programme of cleaning processes in clinical areas has been devised and implemented. Designated domestic staff for COVID-19 wards trained appropriately including in use of PPE. Training logs are kept by Domestic Services manager. The COVID-19 hub has a list of cleaning regimes for all staff to access. Link		Regular training about SARS-CoV-2 transmission with the Domestic department is being offered by the IPC team.
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other	The DIPC/environmental director/ decontamination lead, have ensured terminal cleaning is in line with PHE Guidance, including RAG rated 'daily cleans' and 'discharge cleans'. Documentation is		All COVID-19 cleaning regimens (clinical and non-clinical areas) have been collated into a single

national guidance • increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance • Frequently touched surfaces e.g. door/toilet handles, patient call bells,	available on the COVID-19 Hub. Link In the outpatient department, two domestics are specifically supporting the cleaning due to the increase patient flow in this area. All cleaning protocols are in place as per PHE guidance Link All cleaning protocols have been reviewed and agreed by IPC, decontamination team and environmental services. Join audits in clinical areas are now taking place to ensure rapid identification of potential challenges and support form Ward Managers. Additional domestic staff have been employed to ensure frequency of cleaning is stepped up in all areas, including both clinical and public places.		document and is now available on the COVID-19 hub.

over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids.	A specific Office space cleaning SOP has been shared with all staff (both in clinical areas and offices).		
• electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	Cleaning wipes are easily accessible in all office spaces. Additional domestic staff have been employed to ensure frequency of cleaning is stepped up in all areas, including both clinical and public places.		
• rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Collection PPE bins for masks at the entrance of the hospital are regularly monitored by entrance staff to avoid overfilling.		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Standard protocol in place for infected linen, which complies with PHE guidance. Linen is sent to a national approved laundry facility. Link to Linen Management Policy here		
• single use items are used where possible and according to single use policy	Single use items used where possible.		
• reusable equipment is	Guidance on single use items form part of Medical Device and		

appropriately decontaminated in line with local and PHE and other national guidance • ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Equipment Management Policy (incorporating single use policy. Link here Decontamination of Reusable Medical Devices Policy. Link here Join audits performed by IPC/Decontamination/Environmental services, in clinical areas are now taking place to ensure rapid identification of potential challenges and support from Ward Managers. Optimization of ventilation across the Trust has been carried out by the Interserve Support Services. Installation of Bioquell isolation facilities has been done in PICU/HDU to ensure negative pressure capabilities. All cleaning protocols are in place as per PHE guidance Link		The outpatient department is exploring the purchase of mobile air cleaners to improve ventilation in areas where aerosol generating procedures are being performed.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship is maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	The Antimicrobial Stewardship (AMS) and Infectious Diseases (ID) team complete a ward round everyday Monday to Friday where all IV antibiotics prescribed for inpatients are reviewed, except Oncology and Critical Care. (Oncology and Critical Care are all reviewed in separate MDTs which occur 1-2 times per week). All IV antibiotics for inpatients at Alder Hey are reviewed by a specialist AMS clinician within 72 hours of initiation. We have reviewed on average 360 prescriptions per month which equates to on average 210 antibiotic episodes per month. We continue to report evidence of antibiotic consumption to the Infection Prevention and Control Committee and the Medicines Management and Optimisation Committee. Our Antimicrobial Prescribing Policy was updated in February 2020 and is available on the staff Intranet. LINK We continue to maintain our Antimicrobial and Infection Guidance webpage on the intranet: http://intranet/DocumentsPolicies/SitePages/Antimicrobials.aspx Our Outpatient Parenteral Antimicrobial Therapy (OPAT) service continues to help facilitate early discharge and admission prevention. We continue to see approximately 120 bed days saved directly related to OPAT which equates approximately to	Antifungal drugs are currently reviewed weekly or bi-weekly in Oncology, NICU, HDU and PICU.	We are currently in the process of establishing an Antifungal Stewardship Team which will be taken up by the AMS/ID Teams.

	£56k on average a month.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	Visiting guidance document. Reviewed and updated when changes are advised nationally and made available on public facing COVID-19 information hub. Link here. There is an escalation process for exceptions to the policy		
• areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	COVID-19 (suspected and positive) areas identified as PICU /HDU and within identified specific Pod areas. Signage in place on wards, audited on monthly IPC environmental audit.		
• information and guidance on COVID-19 is available on all trust websites with easy read versions	Signage is as provided in the Patient Placement and Cohorting Guidance is available on the COVID-19 hub. Link here:		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	It is standard practice for the transfer of patients (internal or external) to advise of any infectious diseases, as detailed in Sections 7.2, 7.3 and 7.4 of the Patient Transfer Policy. Link here		
• there is clearly displayed and written information available to prompt patients' visitors and staff	Information and guidance is available on COVID-19 information hub (Trust website). Numerous examples are provided throughout this document.		

to comply with hands, face, space advice.	Child friendly content on Public COVID19 Information Hub.		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 cases to minimise the risk of cross-infection as per national guidance • staff are aware of agreed template for triage questions to ask • triage undertaken by	ED have an established triaging system as patients enter the department and allocate to different areas in the department. COVID-19 risk factors have been added into it. Prior to outpatient appointments and attendance to the Medical Day Unit, patients and families are screened for symptoms suggestive of COVID-19. The clinical questionnaire is designed for paediatric patients and includes an extensive list of symptoms associated with COVID-19 infection in children. Outpatient appointments in which a high-risk aerosol procedure could be performed, are also offered a pre-appointment SARS-CoV-2 test 72-48 hr. Pre-operative patients have a SARS-CoV-2 test 72-48hr prior to the procedure. The testing protocol is available on the COVID-19 hub. Link here:	Reporting of high-risk contacts with a known COVID-19 case in hospital visitor relays on self-reporting.	Daily confirmation that patients and visitors meet the triple negative strategy, 1) neg symptoms, 2) neg test and 3) neg contact with a known COVID-19 case in the previous 14d.

clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors	Face coverings are given to all visors and patients at the entrances of the hospital alongside a pamphlet with general information on how to prevent SARS-CoV-2 transmission. (age-appropriate face covering sizes are available).		
• face masks are available for patients with respiratory symptoms	Patients with respiratory symptoms are encouraged to wear a FR type II surgical mask during transport or in common clinical areas if clinically appropriate.		
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Physical screen barriers have been installed to better separate patient/visitors in common bay areas.		
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	Barriers are in placed in all reception areas and between desk in communal office spaces.		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Any patients that develop COVID-19 symptoms whilst in hospital are re-tested immediately and appropriate cohorting is implemented according to the Patient Placement and Cohorting		

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Link here: Patients who display symptoms are treated as positive despite a negative test.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas • all staff (clinical and non-clinical) have appropriate training, in line with latest	Patients in the moderate or high-risk pathways are admitted into isolation cubicles or designated areas in HDU/PICU. Hospital areas (both clinical and non-clinical) have been assessed by Health & Safety. Their reports have been shared with ward,	Not all our inpatient facilities are isolation cubicles (approx. 30% are common bay areas). In times of high clinical demand, patients may need to be admitted to common bay spaces.	Rapid testing capacity is available in the Trust to facilitate patient allocation.

national guidance to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely • a record of staff training is maintained • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited	line managers for cascade to all staff. Clear signage on maximum number of staff occupancy s displayed in all staff communal areas and offices. Standard Mandatory training log. Local training (e.g. for domestics / yellow helpers) is provided relative to the job they are required to undertake. PPE training has been performed in all clinical areas. Posters with detailed information on how to don and doff PPE are also displayed in clinical areas. Guidance for appropriate use of PPE is provided via the COVID-19 Hub and includes generic guidance plus a number of appendices which provide detailed information including 'donning' and 'doffing' PPE. Link here. A separate page on the Hub is also dedicated to PPE Training. Link here All staff have a training record on ESR. Additional PPE training is captured on a separate spreadsheet that was developed during the initial Trust response to Covid-19. Instruction on how to safely re-use or do extended use of PPE are included in the PPE Guidance on the COVID-19 hub. Link here. Any incidents of PPE usage are documented in Ulysses under a specific COVID-19 section and reviewed through the governance structures. Link to Ulysses here. If incidents are related to PPE compliance, they are also reported to the Clinical Lead for PPE. PPE audits are routinely performed in clinical areas by clinical educators and IPC. PPE Observers have been identified on each ward to support and		

• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe	advise staff on appropriate PPE selection and usage, and to monitor compliance with the right processes. At the entrance of hospital and clinical areas, there is a hygienic station with hand hygiene facilities, respiratory masks and general information on how to prevent SARS-CoV-2 transmission. The station based at the entrance of the hospital are supported by volunteers M-F between 9am-5pm. Signage on 2 metres safe physical distance is displayed in all hospital areas (clinical and office areas). Posters on face-hands-space are commonly displayed in all hospital areas (clinical and office areas). A PPE Handbook has been provided to staff (link here) which includes reminders about the “5 moments” of hand hygiene. The		

standard infection control precautions • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	IP&C Team undertake audit of the ward areas to ensure compliance with these standard infection control precautions. Paper towels are available in toilet facilities across the Trust. Hand hygiene posters are displayed in toilets across the Trust. A communication has been issued to staff advising on how to launder scrubs and uniforms. Link here In house testing is available for any staff/household member with COVID-19 symptoms. Turnaround time for staff results is 24-48 hr. The information for staff testing is available on the COVID-19 hub under Staff Testing FAQs. Link here Regional and local data on COVID-19 rates are shared weekly with	Positive SARS-CoV-2 tests performed in the community are not automatically communicated to our microbiology results.	We relay in staff and line managers to alert the Tracing team. Regular communication is sent to war and line managers to remind them of this.

• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals) • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. • robust policies and procedures are in place for the identification of and management of outbreaks of infection	the IPC/Micro/ID teams and in the PPE clinical advisory group. PHE prediction modelling for national COVID-19 rates is shared weekly with the pre-operative and anaesthesia teams to guide PPE in theatres. If a cluster/outbreak of cases is detected, urgent incident meetings chaired by the DIPC or ID/micro on call are organised. The Trust policy on how to respond to positive SARS-CoV-2 testing in patients and staff, including hospital onset infections and potential outbreaks is available in the COVID-19 Intranet Hub. LINK		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate	All clinical areas in the Trust have restricted access as mandate for healthcare facilities with paediatric patients.	Due to very low number of patients regularly admitted in the Trust with COVID-19, no designated area of the Trust is	Patients in the moderate and high-risk pathways are prioritised for admission into in

low/high) by other patients/individuals, visitors or staff • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Trust has 70% single rooms which supports isolation when required. Cohorting considered with agreement IPC/ID when required and according to the Patient Placement and Cohorting plan. Link here: Single patient cubicles and cohorting plan in place. In common bay areas, patients' beds are separated > 2 metres and physical screen barriers have been installed. This is part of business as usual and is recorded in Meditech by the IPC team once communicated to the appropriate area.	only used for COVID-19 patients.	isolation rooms.

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • ensure screens taken on admission given priority and reported within 24hr. • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes	SARS-CoV-2 tests are sent to a local accredited laboratory for testing. There are three deliveries per day to the referral laboratory. In house rapid tests can be undertaken by qualified Biomedical Scientists. SARS-CoV-2 tests are results are rapidly communicated by email to ID/Micro/ Tracing team. Results are also telephoned back to clinical areas as soon as they are available. Patient testing is routinely performed on admission and pre-procedures as per PHE guidance. Symptomatic staff and household members are tested within the Trust as per PHE guidance. Rates of positive cases are reviewed weekly or biweekly by the clinical advisory group. A screening panel for a variety of respiratory viruses is undertaken on symptomatic patients where clinically relevant.	Turnaround of results cannot be guaranteed within 24 hours. This is challenging when we require urgent results for emergency patients.	Rapid testing facilities are available in the Trust and can be used in a limited number of patients (after approval by ID/Micro).

place			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC mandatory training is provided for all staff. An IPC Team is available (Monday – Friday) to support and provide advice in all aspects of IPC Out of hours this is the ID Consultant on call.		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Updates are communicated as required and latest guidelines are available on the COVID-19 hub The Trust has established a group led by a Senior Manager and an Infectious Diseases Consultant to ensure the use of PPE within the Trust is compliant with PHE guidance. The PPE guidance for staff is regularly communicated and is available through the Trust's COVID-19 Hub. Link here.		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Isolation Policy (link here) and Waste Management Policy (link here) are in place for handling infectious waste.		
• PPE stock is appropriately stored and accessible to staff who require it	PPE stock is overseen and distributed by Procurement department. A PPE Supplies work stream 2 weekly discusses the availability of PPE. In the event of shortage out of hours, an emergency supply is available for staff to access via the bleep		

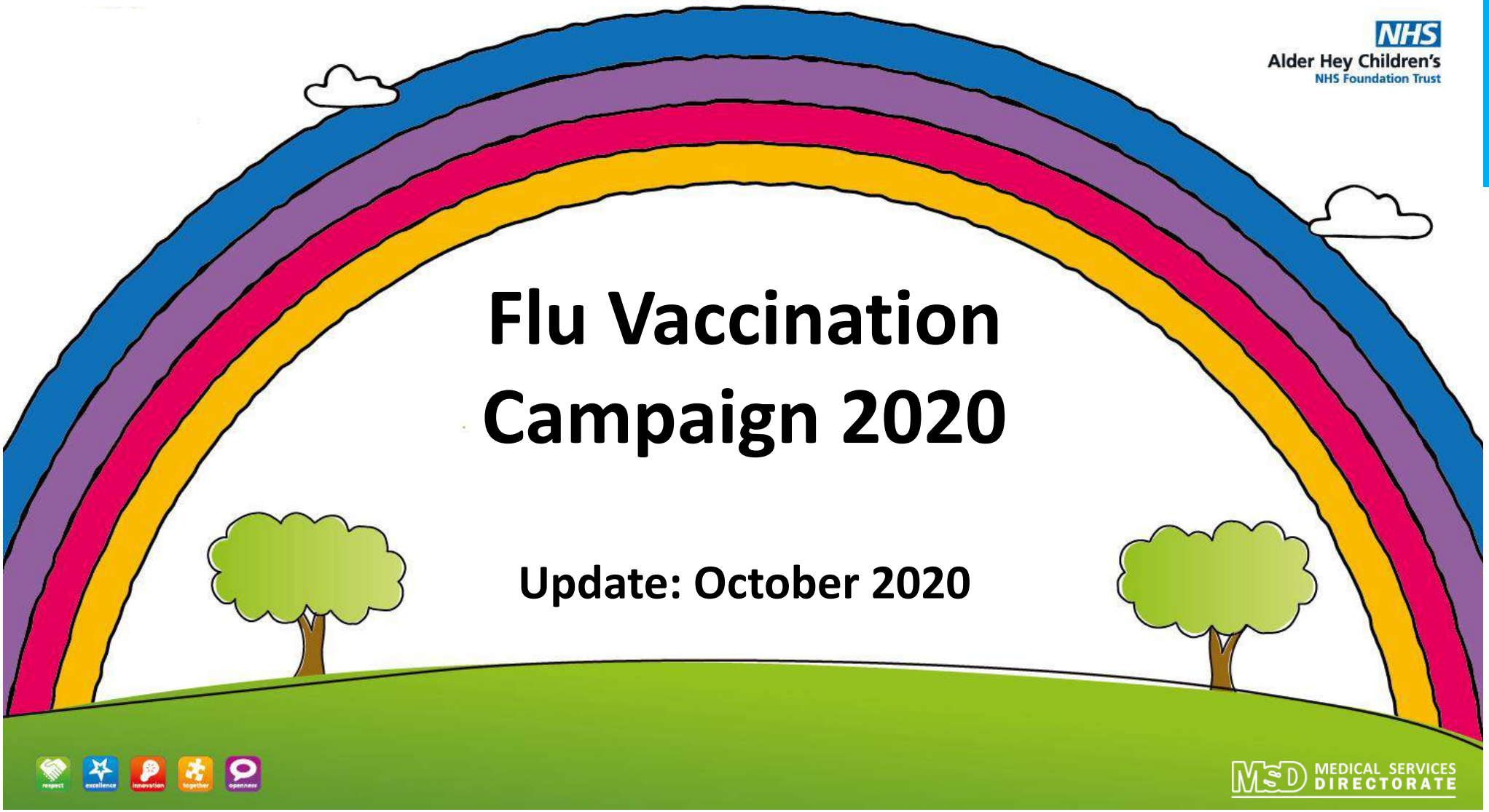
	holder.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported • that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	The HR led wellbeing team are in regular contact with staff who are shielding. Specific advice for vulnerable groups and staff who are 'shielding' is provided through the COVID-19 Hub. Link here. COVID-19 secure risk assessments have been conducted by Health and safety and Line mangers for BAME and shielding staff returning to work. A Staff Advice and Liaison Service is in place to provided additional psychological support to any staff member who needs it. Link here There is specific guidance to BAME staff with a risk assessment for a managers and self-assessment available Fit testing training has been recorded and held centrally.  COVID19-PPE-FIT-TESTING-Master-May2		

• staff who carry out fit test training are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation • for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods. • for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	A process to guarantee competencies for fit-testing is in place. Staff are given clear instructions on only using FFP respirators for which they have been successfully tested. Fit testing training has been recorded and held centrally. A flow-chart of different alternatives after failing FFP respirators is available in the Trust. Staff who have not successfully been fit-tested with any alternative, have been redeployed and excluded from any area undergoing high-risk aerosol generating procedures.		To minimise mistakes, staff is also given a sticker with the mask information they have been tested with.

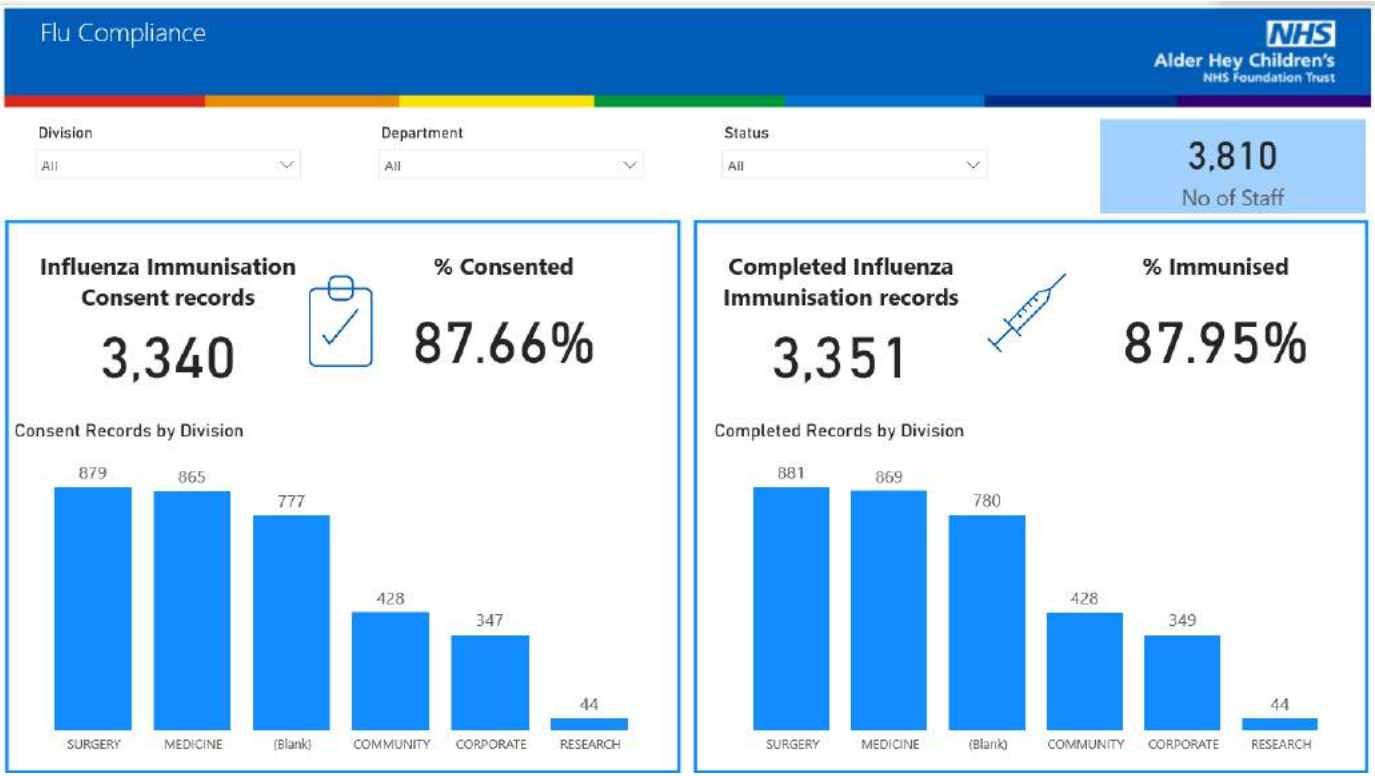
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board • consistency in staff	Staff testing system is in progress and is available through the COVID-19 hub. Link here A clear policy for wearing masks at all times has been adopted by the Trust to minimise confusion.		

allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance • all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone • staff are aware of the need to wear facemask when moving through COVID-19 secure areas. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Clear signage exists in breakrooms and kitchens to ensure 2 metres safe distancing while eating. Clinical and non-clinical hospital areas have been assessed by Health and Safety to ensure that meet requirements for COVID-19 secure areas. A clear policy for wearing masks at all times has been adopted by the Trust to minimise confusion. Staff absence is categorised into COVID related and non-COVID related and is reported to the H&WB Team who monitor all staff absence and support them to access testing. Staff support Link here Staff testing positive are given advice on isolation from a clinician and the H&WB Team follow up the individual to provide the necessary support to return to work when appropriate.		

• staff who test positive have adequate information and support to aid their recovery and return to work			


NHS
Alder Hey Children's
NHS Foundation Trust
Flu Vaccination Campaign 2020
Update: October 2020
respect
excellence
innovation
together
openness
MSD MEDICAL SERVICES DIRECTORATE

Progress

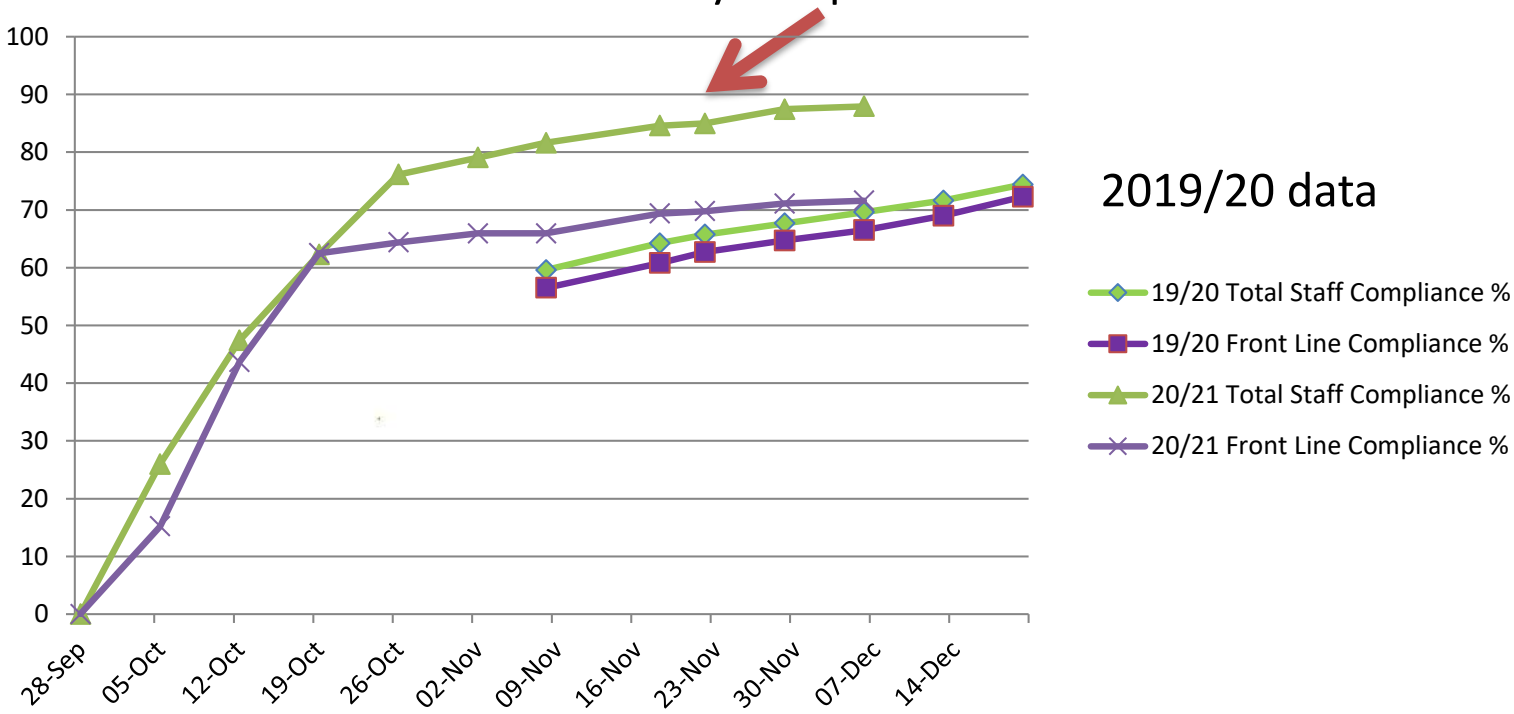


(*figures from 07/12/2020)

MSD MEDICAL SERVICES DIRECTORATE

Progress

This years campaign data demonstrates progress above and in advance of last years position



(*figures from 07/12/2020)

MSD MEDICAL SERVICES DIRECTORATE

Challenges

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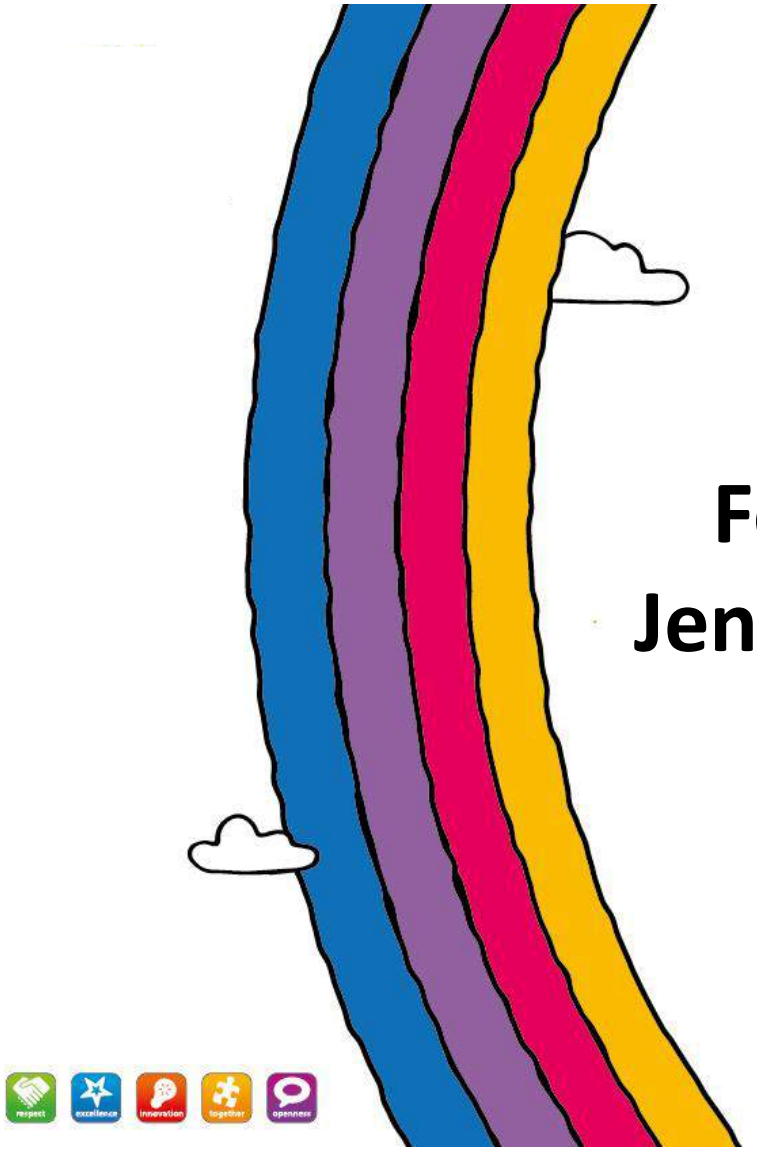
- Have most staff that would have it had it?
- Flu jab in advance of COVID vaccination – flurry of requests now we have ended the campaign
- Many staff working from home and didn't come in to get it
- Operational resources required to support COVID vaccination service



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NHS Foundation Trust

For more information contact Jennie.Williams@alderhey.nhs.uk

MSD MEDICAL SERVICES DIRECTORATE

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 17th December 2020

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

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

1. Purpose

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

2. Summary.

There are currently **27** risks identified on the COVID 19 risk register including **3** high risks (references 2138, 2188, 2182), same as previous reporting period, the risk profile and risk heatmap is outlined at appendix 1.

Number of closed risks removed from the risk register = **7** (table 3)

Number of new open risks = **0**

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

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

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

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

Number of open risks with reduced risk scores = **2** (table 4)

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

3. Themes

3.1. Access to services

There are **2** high COVID- 19 related risks within this theme.

"Risk of not seeing C&YP who need treatment, the associated risk of late or no presentation and associated potential for harm.(risk ref. - 2178).* When first identified in May 2020 this risk was rated as 4x5 = 20, but it is currently rated 3x3 =9. 111 First roll out well underway in C&M; regional assessment passed to enable go live of 111 First in NMersey in Nov. C&M Paed Network model for 111. First prioritised and supported with additional U.Care funding. Local CAS in NMersey to be staffed exclusively by GPs which will ensure greater paediatric experience. All combined, it is hoped that the paediatric response through 111 First will be improved; to be tested through Go Live in NMersey during Dec/Jan - update in February 2021. Late presentation report 1st Nov 20 showed 2 incidents related to delay in presentation - one no harm and one minor, non permanent harm in November, no harm incidents reported since.

" *Risk of delay in imaging and subsequent delay in treatment*" (risk reference - 2143). At the time of identification in April 2020 the risk rating was 5x3=15, currently rated at 4x3=12. The reduction is due to the contingency plan being enacted and robustely implemented and monitored.

"*Risk of patients breaching 18 weeks referral to treatment target (CHAMS)"* (risk ref. -1560). This risk was first identified in 2018 and at that time was rated 3x3=9. It increased significantly at the start of the Pandemic; April 2020, to a rating of 3x5=15. However, at time of reporting the risk has decreased to 3x3=9. This reduction is due to robust controls and ongoing actions for example, weekly MDT meetings to monitor waiting times, in addition to single site session therapies

"*Risk of delay in access to Theatre will result in suboptimal outcome for children and Young people*" (Risk ref. – 2228), rating 3x3=9 since first identified in July 2020, although activity continues at pace and is near pre-COVID levels.

"Risk that complex neurodisability patients who require aerosol generating procedures (AGPs) physical condition will deteriorate further over time", (risk ref. - 2287) Risk rating 4X3=12. The identified control is that virtual appointments are in place via 'attend anywhere'. Regular meeting now in place with stakeholders. Small number of children have returned to school.

"*Risk to Operational Delivery Network function as pandemic impacts on the ability of providers within the North West Congenital Heart Disease Network to continue to provide normal services*", (risk ref 2285, risk rating 4x3=12. This risk was first identified in September 2020. There are 6 clear controls in place, but these are not sufficiently robust to enable reduction in the risk rating. For example, North West Congenital Heart Disease Network is actively monitoring backlogs across the all age service (level 1 & 2). Surgical/Interventional/Electrophysiology waiting lists and capacity including outpatient backlogs. Data is being shared on a monthly basis with Regional Commissioners and Central NHS England Team. Patient listed for surgery/intervention and electrophysiology procedures are being triaged regularly. Clinical prioritisation of outpatient's services being done across some services. Inconsistency around clinical prioritisation across the Network. Level 1 service not currently using Royal College of Surgeons classification as recommended by NHS England

3.2. Resource

One of the highest scoring risks, currently rated as 4x5=20, *(risk reference - 2182).* "*Risk of Insufficient financial resource to meet demand".* Financial gap remains for M7-12, further plan has been submitted to NHSI and awaiting outcome. Cost reduction programme has been activated and mitigations underway to reduce the gap in 20/21.

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

"Risk that front line nurse availability to work will be significantly compromised during winter 2020 the second COVID peak and that compliance with national nursing standards for safe staffing levels on wards and departments will not be met (RCN / PICS / BAPM / QNIC / NQB) and / or the ability to have beds / services will be significantly affected" (risk reference 2138). This risk has reduced from 20 (5x4) to 16 (4x4) since the last reporting period. Staffing ratios set and agreed; signed off by Executive team, associated QIA and EA completed, presenting winter staffing plan to CCG at CQRM on 18th December. Retired nurse being contacted centrally by region to return to support workforce. Workstream meeting running and effective and feeds into Gold Command. Active recruitment campaign underway; action. The expectation is that this risk will reduce further in the next reporting period.

"*Risk of short- and long-term negative effect on staff mental wellbeing"*(risk ref – 2181), which when first identified was a was a high risk 3x5=15 , but as the result of progress with actions to mitigate, this risk has been reduced to high moderate 4x3 =12.there are numerous controls and additional actions to mitigate this risk. For example, Care first - online Employees Assistance programme, Clinical Health Psychology service support for staff, spiritual care support, Regional resilience hub.

3.4. Infection to CYP, families and our staff.

"*Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained".* (risk ref.- 2082), 5x3 =15 This risk has continued to be managed effectively in 'real time' to keep both patients and staff safe", despite dependency on external supplies and the challenges this has presented. No concerns about supplies at time of reporting.

There were 3 risks in this theme closed during this reporting period
2119 2142 2201 – refer to table 3.

Appendix 1

1. Risk Register Profile – 11th December 2020 (Total 27)

Table 1

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk				No risk rating
1	2	3	4	5	6	8	9	10	12	15	16	20	25	
0	**0**	**0**	**0**	**0**	**5**	**2**	**8**	**4**	**5**	**1**	**1**	**1**	**0**	**0**
0 (0.00%)			**5 (15.62%)**			**24 (75%)**				**3 (9.37%)**				**(0.00%)**

Note* 3 high risk refs = 2138, 2180 & 2182

2. Risk Register Heat Map – 11th December 2020

Table 2

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

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

Table 3 Closed risks

Risk reference	Risk description	Target
2119	Risk of Patients acquiring COVID 19 whilst an inpatient at the Trust	5
2199	Risk to ODN (function due to the impact of COVID 19 on providers within the ODN or on the ODN team.	8
2161	Due to not having an e-roster system in place and the ESR system not being set up to automatically calculate these payments, there is a risk that pay will not be calculated accurately for the affected employees.	9
2142	Catering staff may become unwell contracting corona virus, and the potential consequence of this to short- and long-term health	6
2141	Inability to collect blood from the blood issue fridge and/or incorrect administration of blood and blood products.	4
2201	Staff contracting COVID due to non-compliance with safe social distance	5
2020	Alcohol based hand sanitizer has the potential to cause static electricity when in contact with metal surface.	**4**

Table 4 Number of risks with reduced risk scores = 2

Risk reference	Current Score	Target score
Risk 2138	16 (↓20)	
Risk 2143	12 (↓15)	5

END

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 17th December 2020

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

1. Purpose of the report

The purpose of this report is to provide the Trust Board with an overview of open and closed incidents reported externally to the Strategic Executive Information System (StEIS), that met the Serious Incident criteria, in this reporting period (1st November – 30th November). There were no new reported serious Incidents reported during this reporting period.

2. Summary

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

Section 2 incident Investigations completed- shows summary of 2 incident investigations, which were closed and completed on time.

Section 3 open ongoing investigation - shows there are 6 open incidents currently under investigation, previously reported to Board, that meet the SI criteria,

Moderate Harm incidents reported
There were no moderate harm incidents reported in this reporting period.

Section 1

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

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

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

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

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

Section 2 Incident investigations completed

Table 3

StEIS Reference	Incident	Duty of Candour
2020/13420 **Reported 05/07/2020**	Patient swallowed magnets while inpatient on ward (magnets taken from make-up pallet, 2 small and 2 larger magnets). Patient in Mental Health crisis in inappropriate care setting **&** Ligature cutters not in place in line with Trust policy – Patient in Mental Health crisis in inappropriate care setting	Completed - Compliant

Recommendations

1. To provide feedback to the staff involved in the incident, including a copy of the report.
2. A Task and Finish group is being established to agree a clinical pathway going forward for these groups of patients, through the Suicide Prevention Group.
3. To formalise access to "as required debrief' sessions to support staff health and well being
4. Ensure all staff are made aware of and supported to access available health and wellbeing support
5. To formalise partner arrangements re external role of paid carers through formal governance procedures
6. To ensure environmental risk assessments are completed for identified areas based on patient need
7. To develop designated 'safer' area for patients at risk of self-injury, violence and or aggression
8. To clarify and rectify Meditech 6 issues associated with access to Crisis Care/CAMHS/AED information to support communication sharing and patient care
9. To review and embed admission guidance for Looked After Children as per recent Standard Operating Procedure
10. To implement a TNA for 4C to identify staff training needs associated with Mental Health Awareness and Self Harm

1. To develop policy/ procedure and SOP to support transparent policy for staff (internal and external) – partnership arrangements to be formalised on patient admission. Interim guidance to be developed
2. Training for ward staff on role for CAMHS/Crisis team liaison
3. Project team to develop/ lead on environmental changes
4. To clarify and rectify Meditech 6 issues associated with access to Crisis Care/CAMHS/AED information to support communication sharing and patient care
5. To review and strengthen the clinical pathway for CYP presenting with additional challenging behaviours that include suicidality, and self-injury via task and finish group.
6. To review and embed admission guidance for LAC as per recent SOP
7. To develop a TNA to support delivery of appropriate training for clinical teams
8. Input and comments have been sought from both social workers around closer scrutiny of the preadmission process and journey of

each child as well as the management of appropriate discharge for each individual child is required
Expected investigation completion date - 13/11/2020 (Completed & submitted on agreed date)

Table 4

StEIS Reference	Incident	Duty of Candour in line with regulation 20
2020/13501 Reported 24/07/2020	Suspension of treatment for patients with Tics, Tourette Syndrome and Paediatric Acute onset Neuropsychiatric Syndrome (PANS/PANDAS).	Completed - Compliant

Recommendations

1. To provide feedback to the staff involved in the incident, including a copy of the report.
2. To consider a Communications Strategy at an early stage of any change to service provision and ensure that the appropriate CCGs are fully sighted on the reasons behind this.
3. To further develop the new appraisal training [for medical staff] to identify a 'doctor in difficulty' and ensure that there is a process for escalation to the Responsible Officer to provide oversight across the Trust [through the use of a new drop down menu to alert the Responsible Officer]
4. To further develop the job planning process within the Trust through the recently introduced Job Planning Group, to involve representatives from Human Resources and Medical Staffing.
5. To review and communicate the escalation process for situations where there are concerns about a staff members clinical practice.
6. A Task and Finish group is being established to agree a clinical pathway going forward for these groups of Neurology patients, specifically those with Tourette Syndrome.
7. To await the findings of the commissioned external review of practice.

Actions for Improvement:

1. To provide feedback to the staff involved in the incident, including a copy of the report.
2. To share this learning with the Care Group Service Manager within Medicine and other clinical divisions.
3. To finalise the new appraisal training and launch this within the Trust
4. To utilise the Job Planning Group to support clinicians in the review of their workload
5. To progress a pathway for patients with Tourette Syndrome in collaboration with the CCG and service users.
6. To ensure that the escalation process is clearly documented within the appraisal and job planning processes
7. The Trust will actively co-operate with members of the BPNA who will be on site during 21 and 22 October 2020 as part of the external review. The findings of which will be used to review the current service provision and consider improvements to the governance arrangements within the specialty.

Expected investigation completion date - 09/11/2020 (Completed & submitted on agreed date)

Section 3 : Open ongoing investigations

Table 5

StEIS Reference	Date reported	Incident	Agreed date of completion
2020/15939	21/08/ 2020	Removal of Kidney	11/01.2020
2020/16208	26/08/ 2020	Patient death, following posterior vault expansion for an atypical presentation of multiple suture synostosis (i.e. patient did not appear to have any of the classic craniosynostosis syndromes)	14/12/2020
2020/16210	26/08/2020	Patient death following catastrophic and irreversible brain haemorrhage.	17/12/2020
2020/608	07/01/2020	Misdiagnosis of the grading of a tumour in 2011 - Diagnostic incident ,including delay, meeting SI criteria	30/11/2020
2020/18368	04/09/2020	Teeth replanted in incorrect sockets (UR1 &UR2)	22/12/2020
2020/19439	12/10/2020	Inappropriate clearance of C-Spine	07/01/2020

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 17th of December 2020

Paper Title:	**Q2 complaints position**
Report of:	**Nathan Askew, Chief Nurse**
Paper Prepared by:	Liz Edwards, Head of Clinical Audit & NICE guidance

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ■
Background Papers and/or supporting information:	This paper provides an overview of the performance and themes from the complaints service in Q2. It should be noted that during the pandemic the service has been fully functional to support our children, young people and their families. It is recommended that a full review of the complaints function, process and reporting in undertaken to improve the experience for families and to improve assurance to the board regarding the management of complaints. The review will include how the organisation learns from complaints and demonstrates the impact at a complainant and organisational level.
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

Complaints and PALS Report

1. Introduction

This report provides an overview of formal complaints and informal PALS concerns received and completed between 01 July and 30 September Q2 2020.

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

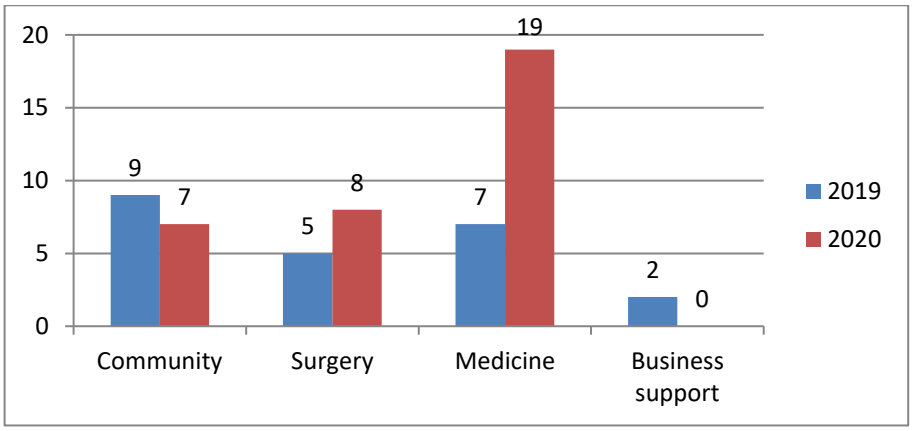
2. Formal complaints received in Q2 2020

34 complaints were received during this period, a slight decrease of 1% (37) on same period last year.

It is important to note that the Covid 19 pandemic continued to have significant impact on services during this period. Where a new complaint was received and clinicians were unable to respond in a timely manner due to COVID, there was an internal agreement to review investigative and response timescales on a case by case basis.

This unprecedented time impacted on the Trust's ability to progress some face to face meetings with complainants and in some cases caused a delay in finalising written responses. However, the ability to raise concerns and complaints was not compromised and the Trust provided a full service at all times.

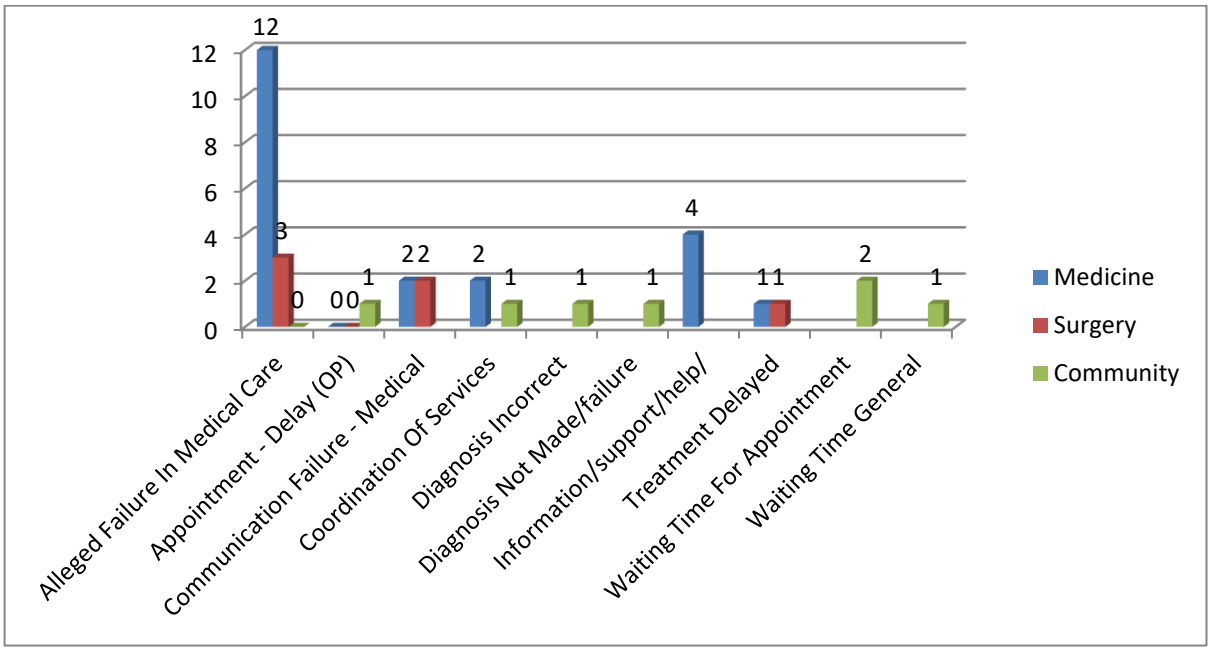
2.1 Formal complaints received in Q2 2020 by Division



20.5 % of total complaints were received within Community & Mental health, 56% within Medicine, 23.5% within surgery

Complaints are categorised by subject using the NHS Digital complaints categorisation system. Each complaint may raise several issues and all concerns expressed by patients are categorised within the record but only the primary issue is used within this report to monitor key trends.

2.2 Category by Division



The Division of Medicine received a number of formal complaints involving the specialty of Neurology, with the main theme being around the cessation of a service for patients with Tourettes Syndrome. The specialty and Divisional leadership team continue to work to mitigate parental concerns regarding the discontinuation of treatment regimens for some patients however the volume of parents now making contact has led to a review of our current processes as PALS contacts in particular are taking over 72 hours to resolve due to their complexity.

Complainants are raising common themes within their complaints and several have referred to an online petition regarding the commissioning of a service for this patient group. The medicine division are working with each case to provide a tailored response and assessing each child's clinical need.

3. Complaints performance

Please see tables below regarding our performance in acknowledging and responding to complaints over this quarter. Future reports will include a 12 month rolling run chart to demonstrate improvement in the service and to support the identification of changes/trends.

The Trust's performance with acknowledging receipt of complaints within three working days continues to site at 100% each month.

The table below shows the Trust's performance responding to complaints within 25 working days. There has been a sustained improvement due to an improved process of proactive monitoring and communicating compliance with timeframes with our Divisions.

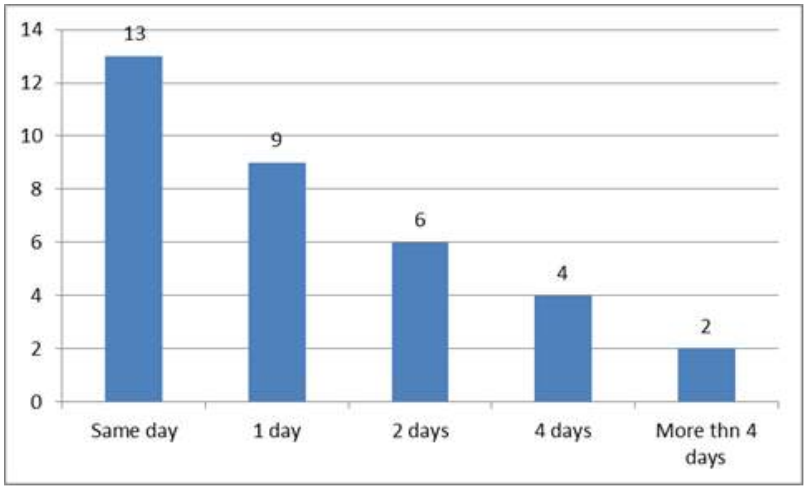
3.1 Report against three day acknowledgement

The Trust has three working days to formally acknowledge a complaint; this can be in an email or by phone. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes providing a named contact for the complainant (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwatch Advocacy

In Q2 82% of complaints received were acknowledged within 3 days - 38% on the same day. On 2 occasions the acknowledgement was delayed by more than 4 days, 1 occasion due to an administrative oversight and in the other case, there was some uncertainty around the eligibility of the complaint which was addressed.

The process for acknowledging complaints within the time frame is currently under review and it is expected that performance against this metric will improve.

Figure 2 – Days taken to acknowledge receipt of complaint



3.1 Responses within 25 working days

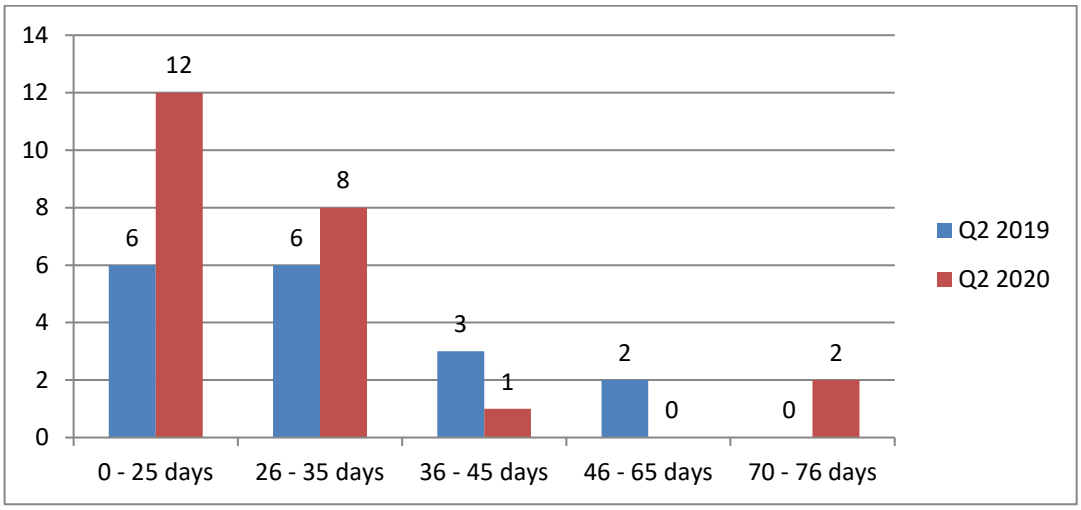
The graph below shows the timeframes the Trust has responded to a formal complaint within Q2.

Of the 34 complaints received during this period, 13 have ongoing investigations.

23 complaints were responded to during Quarter 2. The response times are illustrated in figure 3 and demonstrates that 52% of complaints were responded to within 25 days during this period

Delays in completion of responses have been a result of complex complaints and on occasions cross divisional complaints. On occasions, there has been a delay caused by the need for repeated quality checks to ensure that all aspects of the complaint have been included in the response with a comprehensive and clear explanation. Additionally the impact of the Covid pandemic has continued to cause delays within the process.

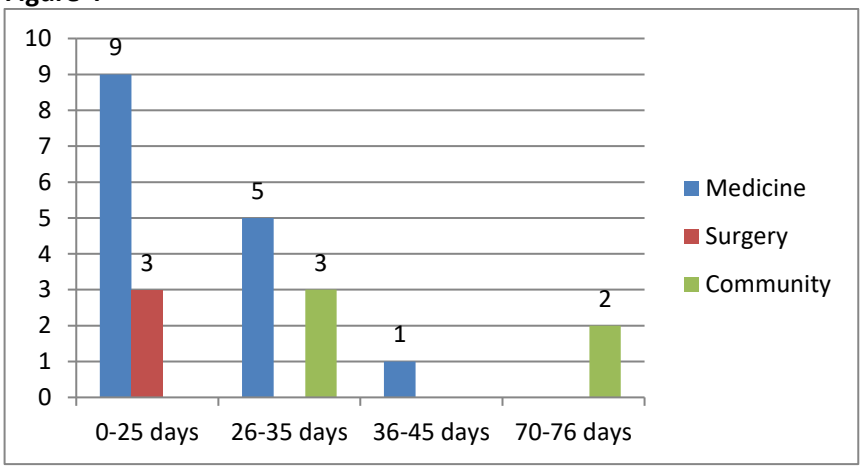
Figure 3 – days taken to respond to complaint



The complaints response process will be reviewed at improvement in response times is essential to ensure that we are meeting the needs of families who are not satisfied with our service. There will be additional emphasis on the role of the Associate Chief Nurse within each division to meet the turnaround times for complaints.

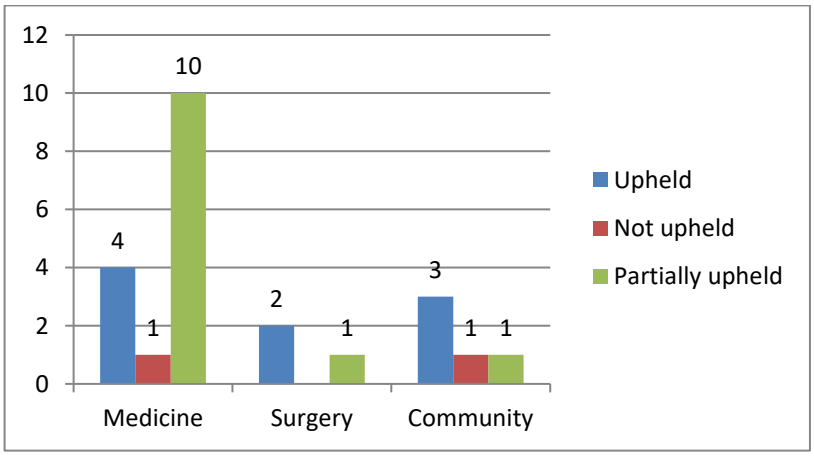
Individual Divisional performance is demonstrated in Figure 4 below

Figure 4



3.2 Outcome of complaint

Please see the chart below which shows complaints closed during Q2 by Division and outcome.



The majority of our complaints are either fully upheld or partially upheld. These provide rich sources of learning for the organisation, the complaints teams will continue to work on sharing the learning with clinical teams and the wider organisation.

4. Parliamentary and Health Service Ombudsman

There were no referrals to the Parliamentary & Health Service Ombudsman during this period.

5. Actions and learning from complaints

These include

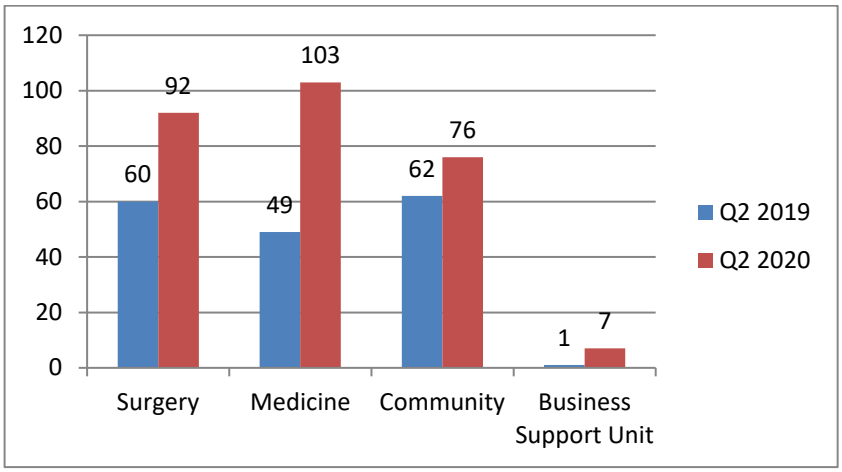
- Review of content of letter summarising outcome of assessment, with amendments mutually agreed with parent
- Review of services available to children with Tourette's Syndrome & tics
- Process in place to manage delays in receiving appointments as a result of the Covid pandemic
- Review of programme for commemorating the end of treatment in Oncology
- Development of a revised Standard Operating Procedure for children being escorted to and collected from theatre, which will include guidance on process for checking that medication is prescribed via an appropriate route prior to leaving the recovery area.
- Children and young people attending CAMHS are 'matched' to clinicians with the skills and experience to support them with the individual difficulties they present with.
- Training for staff on completing neurodevelopmental histories.
- A full review of the ASD pathway with the aim of reducing waits for diagnostic assessments to 18 weeks by the end of March 2021
- Development of a more comprehensive referral form and associated training so that referrers understand exactly what to look for prior to making a referral

6. Informal PALS concerns

In Q2 2020 – **278** PALS contacts were received, significantly increased from Q1 (172) but a decrease against same period last year 342. This decrease in contacts is due to the impact of the Covid pandemic and a reduced volume of patients accessing our services. It is important to note that the PALS service has been fully operational during the pandemic.

6.1 PALS by Division - The following table indicates the number of PALS contacts received by Division in Q2 2020

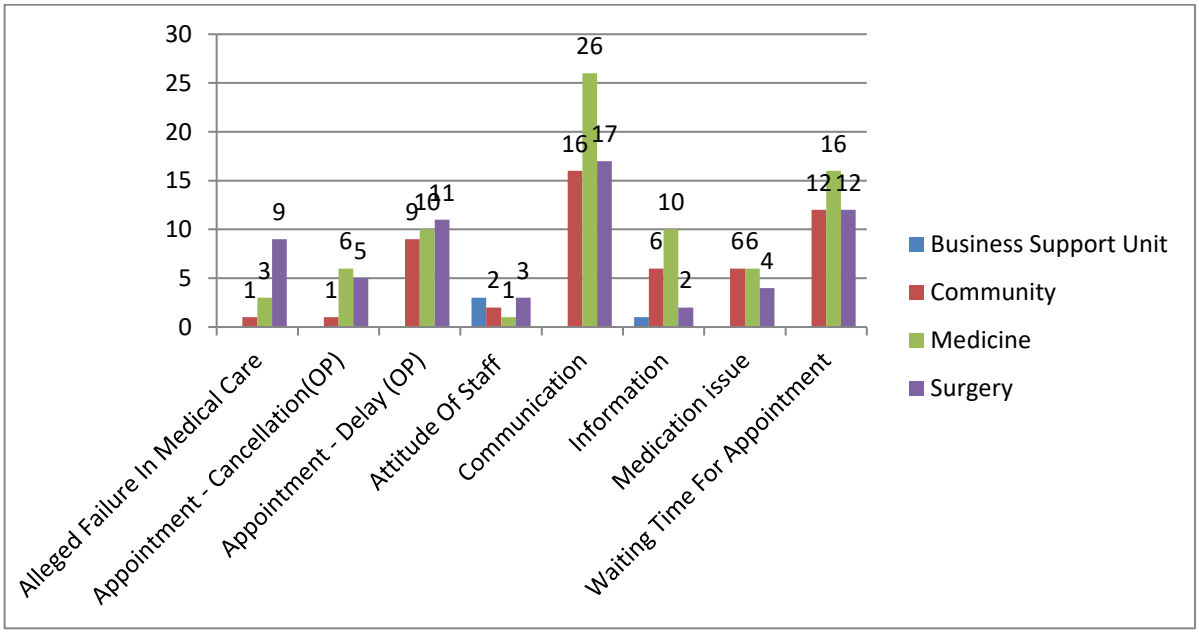
Figure 5



6.2 Main PALS categories

The table blow shows the main categories of PALS contacts by Division for Q2 2020

Figure 6



The main issues identified within Q2 relates to communication, appointments management –waiting times.

PALS and complaints are communicated and fed back to senior staff at the three Divisional Integrated Governance meetings to ensure appreciation of current trends are fully disseminated and actions can be taken to look at specific areas of concern. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month

7. Compliments

There is currently no centralised process for the recording of compliments received about care our children, young people and their families receive within the Trust. This is a missed opportunity to balance the feedback that is received about the care that we provide. A review of this aspect of the service will be undertaken in Q4 with a new process implemented to capture positive feedback.

8. Conclusion

The board are asked to note the content of this report and support a review of the complaints management procedure and process to ensure a more robust level of assurance moving forward and to improve the performance of this service for our children, young people and their families.

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report November 2020

How Did We Do?

Executive Summary **Month: November** **Year: 2020**

Alder Hey Children's NHS

Delivery of Outstanding Care

Safe

- Incident reporting up to a yearly high
- 40% increase in medication errors although all resulted in minor harm
- First Patient Safety summit took place in November

Highlight

- 0 incidents resulting in moderate harm and above
- 0 never events
- 0 category 3 and above pressure ulcers
- Year high report of 397 clinical incidents resulting in no harm
- Year high report of 108 clinical incidents resulting in near miss
- 0 hospital acquired COVID infections

Challenges

- 1 Hospital acquired MSSA .PIR underway to determine cause
- 8 medication errors reported resulting in minor harm
- There was a 40% increase in medication incidents reporting in November. Nine incidents caused minor harm due to wrong infusion rate, wrong dose, disconnected infusions, a drug not being available and an adverse drug reaction. Action underway includes development of a quiet prescribing space, review of the electronic prescribing system, education and support for prescribers and a review of stock levels. Medication errors will be the focus of a Patient Safety Summit in January 2021.

The Best People Doing their Best Work

Caring

- Complaint numbers remain high in comparison to the rest of the year. PALS numbers still remain lower than this time last year
- The low number of Friends and Family responses continues to disproportionately affect the overall score

Highlight

- 99% of all respondents via Family and Friends test in Community recommended the Trust
- 95% of all respondents via Family and Friends test in inpatient areas recommended the Trust.

Challenges

- Complaints in November were at 17 which is the 3rd highest total of the year and reflects the COVID impact and the ongoing Neurology service issue.

Delivery of Outstanding Care

Effective

The timeliness of care in the Emergency Department remains very good with 97.1 % of patients attending the Emergency Department for treatment receiving care within 4 hours.

With the exception of one patient, all patients who had an operation cancelled in October were rescheduled to receive treatment in November.

Highlight

- Timeliness of care in the Emergency Department
- Was not brought rate

Challenges

- One patient waited over 28 days following cancellation

Delivery of Outstanding Care

Responsive

We have made significant progress in the month of November in restoring services which will support an improvement in access to care. Most notably, provisional figures indicate outpatient consultations have reached 94% restoration, with daycase and inpatient activity at 92% of the pre-COVID-19 level.

The number of patients waiting over 52 weeks remains similar to prior month at 148 patients. We have seen real improvements in community paediatrics and at the beginning of December there are no patients waiting over 52 weeks in this specialty. In several specialties in the Division of Surgical Care there are patients with a waiting time greater than 52 weeks. Specialty-based improvement plans are in place and are being monitored weekly at the Access to Care meeting.

All patients who have waited over 52 weeks have received a clinical review.

Referral to treatment times against the 18-week standard remain challenging but has improved for the fourth consecutive month to 59%.

Our feedback from families in November remains positive in areas around receiving information to make choices about care; being treated with respect; knowing their planned date of discharge and knowing who is in charge of their care. We are starting to see an improvement in satisfaction with patients involved in play as play activities have increased at ward level in response to shielding play staff returning to work. CYP access to learning remains a challenge as we seek to re-introduce education but comply with COVID regulations. We are also reviewing our FFT question set around learning as the policy excludes some CYP even though we are asking everyone about access thus reflecting lower compliance overall.

Highlight

- Referral to treatment times (18 weeks) improving
- Timeliness of cancer care
- CYP involved in play continues to slowly improve

Challenges

- Number of patients waiting over 52 weeks for treatment
- Referral to treatment times in surgical services

The Best People Doing their Best Work

Well Led

In Month 8, the Trust is reporting a £0.7m deficit which is £0.3m ahead of the month 8 plan. The year to date performance is now a £2m deficit which is line with the plan.

November 's elective and daycase activity were 92% of last year's level which is slightly above the 90% target. November's outpatient activity was 94% of last year's level which is below the 100% target although this is expected to improve by the freeze date.

The mandatory training levels have dropped further to 72.4% which is below the target. It is essential that this is improved and the target is achieved in future months.

The PDR deadline has now passed and the target of 90% achievement has been exceeded.

Sickness has decreased in the month and is now 5.6%.

Highlight

- Financial performance
- PDR completion

Challenges

- Sickness Levels
- Mandatory training

Game Changing Research and Innovation

Research and Development

Recovery Programme

- Setup and Delivery of Urgent Public Health (COVID-19) studies ongoing
- Continued reactivation of suspended research studies underway
- New academic and commercial research underway

Visibility

- Newsletter, Divisional Briefing, Research Clinic

Partnerships

- Joint research and innovation projects underway
- Commercial research unit plans approved and underway

Highlight

- Sustained increase in activity levels

Challenges

- COVID-19 impact on portfolio

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Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis - A&E
0	0	0	11	0	79.17 %
Nov 2020	Nov 2020	Nov 2020	Nov 2020	Nov 2020	Nov 2020

Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
80.77 %
Nov 2020

CARING

Friends & Family: Overall Percentage Recommended Trust
93.69 %
Nov 2020

EFFECTIVE

ED: 95% Treated within 4 Hours
97.09 %
Nov 2020

RESPONSIVE

31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	All Cancers: 31 day wait until subsequent treatments	Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	Diagnostics: % Completed Within 6 Weeks
100 %	100 %	100 %	97.10 %
Nov 2020	Nov 2020	Nov 2020	Nov 2020

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	RTT: Open Pathway: % Waiting within 18 Weeks	Waiting Greater than 52 weeks - Incomplete Pathways	Waiting List Size
100 %	59.02 %	148	10826
Nov 2020	Nov 2020	Nov 2020	Nov 2020

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
110503	324.53	72.41 %		5.58 %
Nov 2020	Nov 2020	Nov 2020	Nov 2020	Nov 2020

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm (D)	99.8%	99.2%	99.0%	99.8%	100.0%	99.6%	100.0%	100.0%	98.9%	99.1%	100.0%	100.0%	100.0%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss (D)	70	43	72	72	49	39	49	59	86	54	50	82	107		No Threshold	
Clinical Incidents resulting in No Harm (D)	296	221	342	335	236	138	260	286	381	318	339	317	396		No Threshold	
Clinical Incidents resulting in minor, non permanent harm (D)	89	92	88	82	62	48	57	89	92	83	71	71	90		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	2	4	1	0	1	0	0	6	1	0	0	0		No Threshold	
Clinical Incidents resulting in severe, permanent harm (D)	0	0	1	0	0	0	0	0	0	2	0	0	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0	✔
Medication errors resulting in harm (D)	3	3	0	2	2	1	5	7	6	2	8	2	11		<=3 N/A >3	✔
Pressure Ulcers (Category 3) (W)	1	0	0	0	0	1	0	0	2	0	0	0	0		0 N/A >0	✔
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Never Events (W)	0	1	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis - A&E (D P)	84.2%	76.7%	83.9%	86.5%	83.3%	60.9%	95.5%	96.2%	79.2%	77.3%	85.2%	74.1%	79.2%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	93.8%	87.5%	87.5%	88.2%	88.9%	93.8%	87.5%	90.9%	88.5%	85.2%	86.1%	94.3%	80.8%		>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	1	0	0	0	0	1	1	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA (D)	1	0	0	2	0	1	0	0	1	4	1	0	1		No Threshold	

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust W	91.6%	92.2%	94.3%	94.3%		96.9%	94.2%	94.9%	94.6%	93.8%	90.6%	94.7%	93.7%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust D	80.9%	80.8%	88.0%	87.6%		96.1%	92.9%	92.3%	90.7%	91.5%	84.4%	92.1%	89.2%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust D	94.1%	91.9%	92.0%	91.8%		100.0%	100.0%	95.2%	95.2%	92.3%	89.1%	94.7%	98.8%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust D	95.9%	95.9%	97.1%	95.7%		94.4%	90.8%	93.3%	97.0%	95.1%	92.4%	94.5%	95.5%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust D	89.1%	73.1%	90.7%	80.0%		100.0%	90.9%	100.0%	100.0%	82.4%	92.3%	89.7%	91.3%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust D P	94.5%	95.7%	95.6%	96.1%		97.4%	96.9%	96.6%	96.0%	95.7%	94.1%	95.5%	93.9%		>=95 % >=90 % <90 %	✔
Complaints W	15	8	10	10	9	8	6	10	5	20	11	19	15		No Threshold	✔
PALS W	105	67	124	114	74	45	44	86	105	105	77	98	72		No Threshold	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%		<=3 %	N/A	>3 %	
ED: 95% Treated within 4 Hours	D	79.2%	85.6%	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%		>=95 %	N/A	<95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	44	36	20	41	36	6	5	3	7	18	17	19	20		<=30	N/A	>30	✔
28 Day Breaches	W	2	7	10	4	7	24	1	2	0	0	8	2	1		0	N/A	>0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	96.7%	96.5%	97.3%	97.8%	96.4%	91.5%	93.2%	94.1%	99.3%	95.9%	95.4%	95.4%	95.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	97.6%	98.5%	98.7%	97.6%	98.1%	100.0%	97.7%	94.1%	98.5%	97.9%	96.0%	98.3%	98.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	92.6%	90.2%	90.5%	89.6%	91.1%	87.3%	95.5%	95.8%	98.5%	93.2%	97.1%	96.7%	97.8%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	98.3%	96.8%	98.0%	97.6%	96.1%	88.7%	90.9%	90.8%	91.1%	99.3%	98.3%	100.0%	99.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	93.9%	91.2%	95.6%	92.5%	94.2%	60.6%	78.4%	64.7%	72.6%	81.5%	82.3%	83.3%	84.9%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	68.3%	85.4%	85.4%	78.0%	79.2%	74.6%	61.4%	84.0%	83.0%	78.1%	75.4%	88.3%	71.9%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.3%	92.0%	92.0%	86.7%	66.7%	58.1%	45.9%	39.6%	43.1%	48.2%	54.2%	59.0%		>=92 % >=90 % <90 %	
Waiting List Size	W	12,827	12,879	12,885	12,895	12,162	11,046	10,909	11,248	11,022	11,402	11,000	10,941	10,826		<=12899 N/A >12899	✔
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	5	15	52	82	149	127	145	145	148		0 N/A >0	
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	100.0%	99.7%	100.0%	100.0%	100.0%	42.8%	67.0%	81.9%	82.9%	78.9%	91.8%	96.4%	97.1%		>=99 % N/A <99 %	
PFI: PPM%		99.0%	99.0%	99.0%	95.0%	99.0%	99.0%	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	98.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	-205	358	-172	-488	693	0	0	0	0	0	0	-358	325		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-115	624	3,126	3,820	300	1,287	1,792	3,503	936	-483	4,518	187	-1,733		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	77,896	75,657	76,536	76,536	90,030	107,738	111,270	107,221	107,221	107,763	108,756	109,084	110,503		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	1,387	1,479	1,439	30	6,889	3,146	-692	1,342	1,825	1,077	2,492	-792	748		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-39	-89	394	-627	-709	-1,433	691	-312	-340	-291	-1,160	20	492		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-1,552	-1,031	-2,005	110	-5,487	-1,713	1	-1,029	-1,485	-786	-1,333	414	-916		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W	1,406	1,331	1,245	1,181	954	11	0	0	0	0	-349	-398	-456		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W	451	360	430	409	322	0	0	0	0	0	49	9	10		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W	1,923	1,747	2,061	1,930	1,565	0	2	5	2	4	-61	-183	36		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W	22,066	17,837	23,884	21,026	17,980	160	270	1,017	1,342	1,324	1,058	-1,161	1,736		>=0	N/A	<0	✔
PDR	W	89.3%	89.3%	90.1%	90.1%	90.1%	90.1%	1.3%	5.4%	13.4%	20.7%	29.5%	62.6%	124.8%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	W	69.7%	63.8%	82.7%	90.6%	95.1%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	W	91.5%	92.1%	94.3%	95.1%	93.2%	92.1%	90.8%	91.0%	90.5%	90.6%	89.3%	88.6%	72.4%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.7%	6.5%	5.8%	5.7%	6.2%	5.9%	5.3%	5.0%	5.2%	5.0%	5.2%	6.0%	5.6%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.9%	2.0%	1.7%	1.7%	2.3%	1.6%	1.0%	0.9%	1.0%	1.1%	1.4%	1.8%	1.4%		<=1 %	N/A	>1 %	
Long Term Sickness	D	3.8%	4.5%	4.1%	4.0%	4.0%	4.3%	4.3%	4.1%	4.1%	3.9%	3.8%	4.2%	4.2%		<=3 %	N/A	>3 %	
Temporary Spend ('000s)	D	928	833	775	974	1,514	990	740	565	934	946	1,015	1,061	1,365		<=800	<=960	>960	✔
Staff Turnover	D	10.0%	10.3%	10.7%	10.7%	10.4%	10.0%	10.0%	10.1%	9.8%	11.3%	11.0%	10.7%	10.4%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	96.2%	91.6%	90.6%	92.8%		92.2%		95.6%	90.3%	91.3%	94.2%	94.2%			>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	82.0%	100.0%	100.0%	97.7%				100.0%	85.6%	97.0%	93.8%	90.0%			>=85 %	N/A	<85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

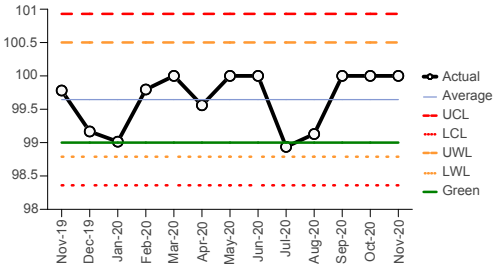
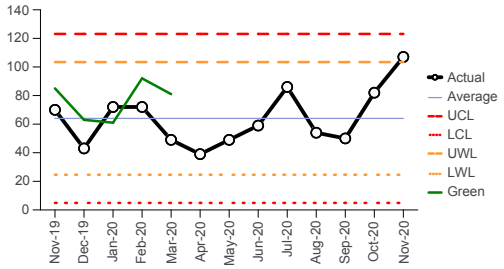
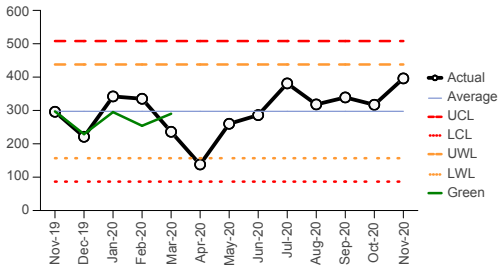
		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	167	172	166	165	146	21	23	43	47	50	61	66	71		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	45	46	46	46	42	21	19	20	25	27	28	34	37		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	5	6	3	1	0	4	3	3	1	3	4	1	4		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	6	3	0	1	0	1	0	0	1	2	0	2	1		>=1	N/A	<1	✔
Number of patients recruited	W	1,180	1,094	982	917	665	407	537	560	134	508	413	665	832		>=100	>=86	<86	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

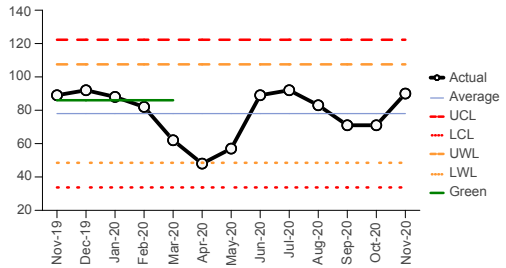
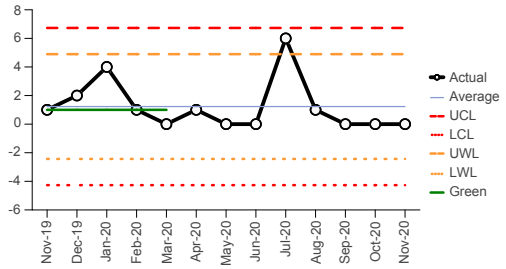
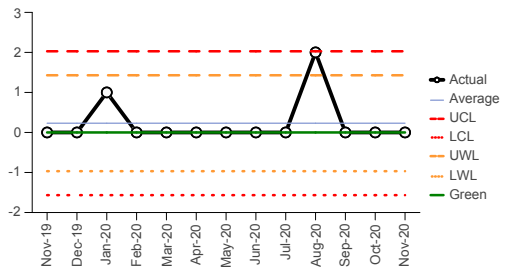
	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	100 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nicki Murdock **Committee:** SQAC	107	No Threshold		
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	396	No Threshold		

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

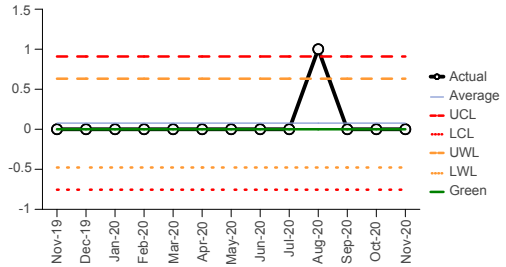
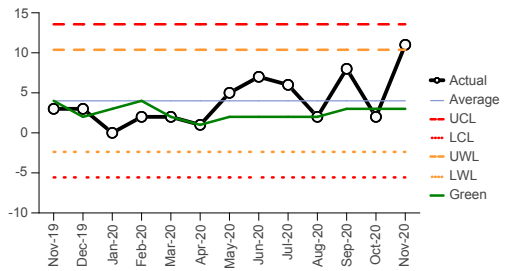
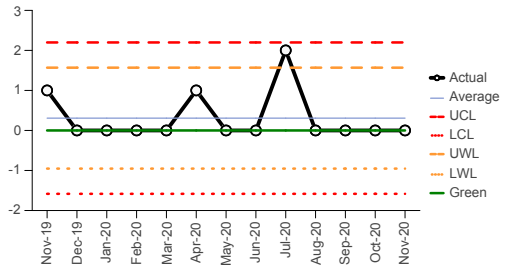
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	90	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

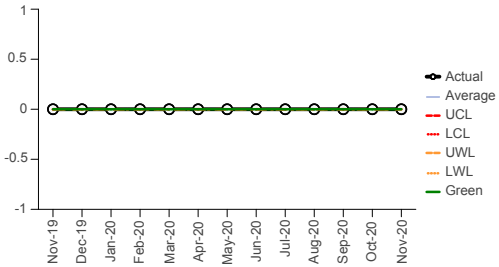
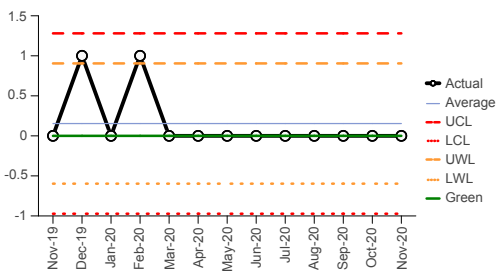
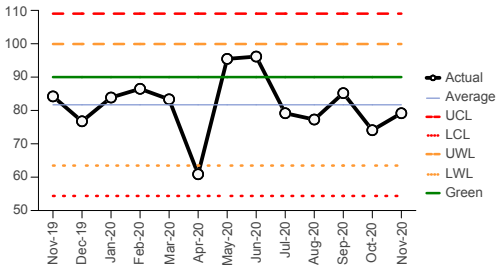
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 19 - Mar 20, on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 20/21 aim is less than 27 annually for the trust. **Exec Lead:** Nicki Murdock **Committee:** SQAC	11	R >3 A N/A G <=3		There was a 40% increase in medication incident reporting in November. Eleven incident reports describe 9 incidents caused minor harm due to wrong infusion rate; wrong dose; disconnected or incorrectly set up infusions; a drug not being available and 2 adverse drug reactions. Action underway includes development of a quiet prescribing space, review of the electronic prescribing system, education and support for prescribers and a review of stock levels. Medication errors will be the focus of a Patient Safety Summit in January 2021.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 20/21 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	79.17 %	R <90 % A N/A G >=90 %		Five patients did not receive antibiotics within 60 minutes. Three of these were due to difficult intravenous access. Of the remaining two; one received antibiotics within 4 minutes and one had an incident form completed due to no clear reason for delay'

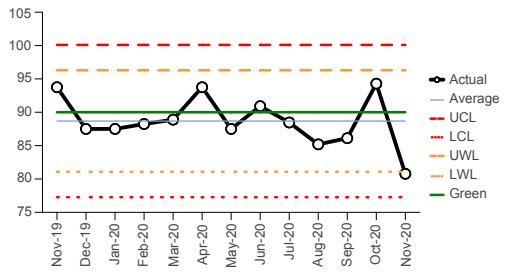
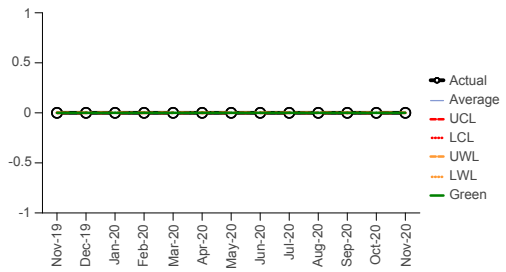
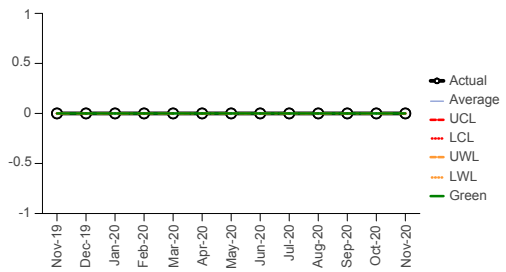
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

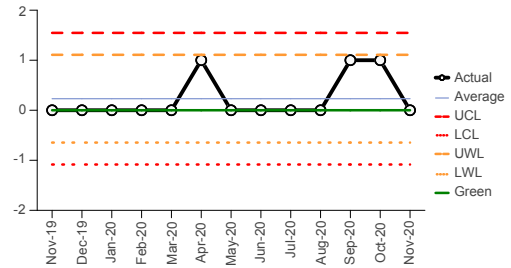
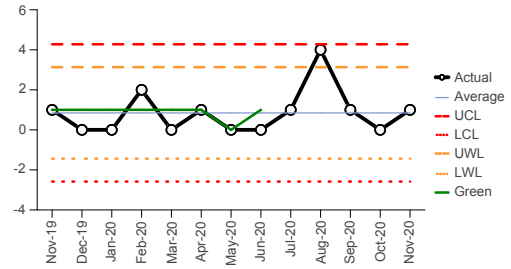
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 20/21 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	80.77 %	R <90 % A N/A G >=90 %		Contact made to ward managers, incident report completed and reviews taking place. Two cases with no justifiable reason for delay in IVAB. Three cases where treatment >60mins were having either clinical procedure and/or required sepsis bundle management. In these three cases the patients received good care and management from the nurses and clinicians.
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 20/21 is zero. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

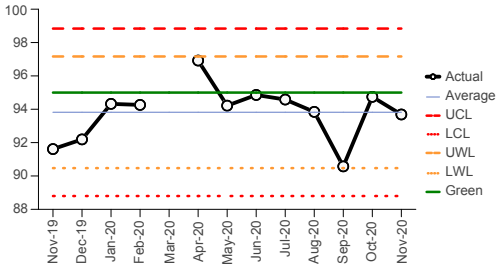
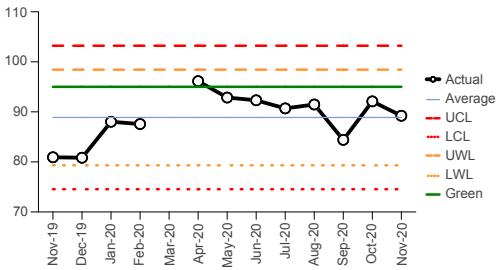
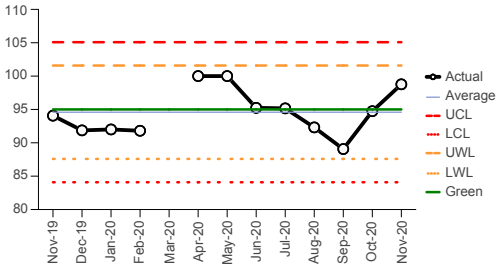
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	93.69 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 1% from October 2020. Response channel is predominately made up via SMS (73.4%) and surveys after online consultations (26.3%). In November 2020, Medicine had a total of 805 responses with 31 negative (5.09%), Surgery had a total of 618 responses with 18 negative (2.9%). Community had a total of 215 responses with only 7 negative (3.3%).
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	89.22 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 2.9% from October 2020. There were 204 responses for November 2020, 49 less than October 2020 – 100% response via SMS. 16 (7.84%) responses were either poor or very poor. Comment analysis has identified two negative trends in November. Out of 144 comments about how we could improve, 16 (11.1%) mentioned staff attitude and 13 (9.02%) mentioned long waiting times as a key issues.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.77 %	R <90 % A >=90 % G >=95 %		No Action Required

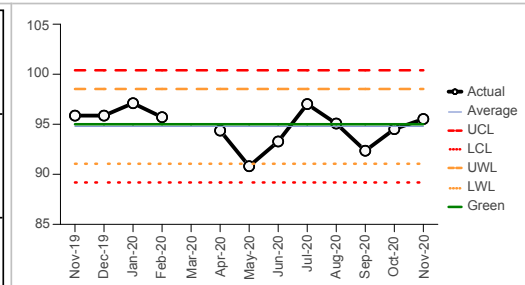
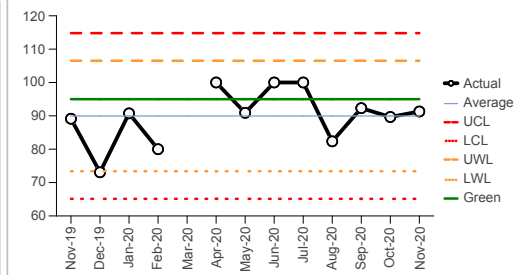
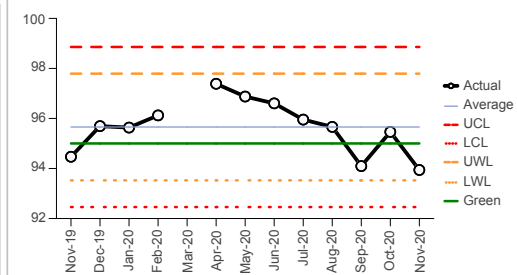
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.52 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	91.30 %	R <90 % A >=90 % G >=95 %		The percentage has increased by 1.6% since October 2020. There were 23 completed surveys, with two very poor responses in this area. These two very poor responses account for 8.7% of overall percentage. Comment analysis on the two negative responses relates to the Crisis Team. Both comments identified a feeling of lack of compassion, understanding and active listening in this area.
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	93.94 %	R <90 % A >=90 % G >=95 %		The percentage has decreased by 1.6% since October 2020. There were 1221 completed surveys, with 44 poor or very poor responses in this area. Out of 518 responses to the question of how we could improve, 7.7% (40) identified waiting times as the main concern. Another trend was identified around efficient communication regarding appointments and cancellations. This trend was also identified through the Patient Helpline.

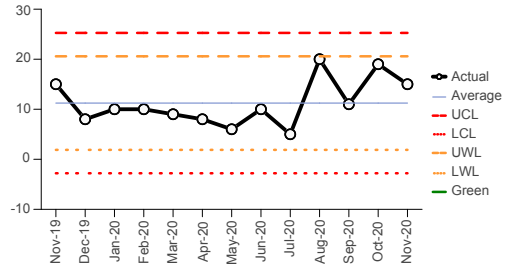
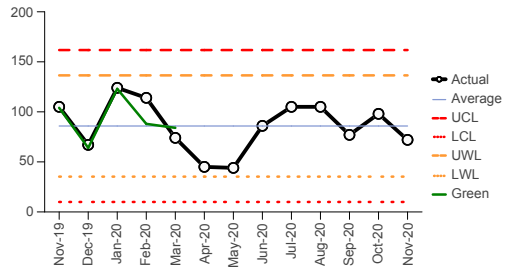
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

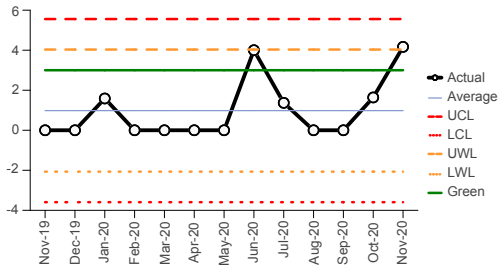
	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	15	No Threshold		Total 17 complaints. Community –6 complaints, appointment delays, explanation of treatment was inadequate, medication delayed, treatment delayed, diagnosis delayed, attention to detail. Medicine had 7 complaints for alleged failure of medical care, the theme being neurology due to lack of communication and appointments. Surgery had 4 complaints for failure of nursing care
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	72	No Threshold		67 PALS which is low in comparison to last year mainly relating to the helpline picking up and dealing with many calls that would have progressed to a PALS.

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

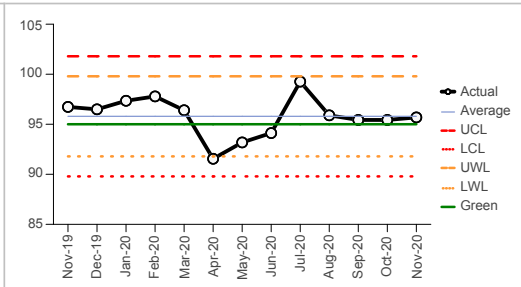
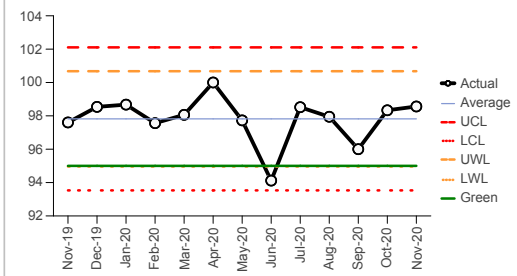
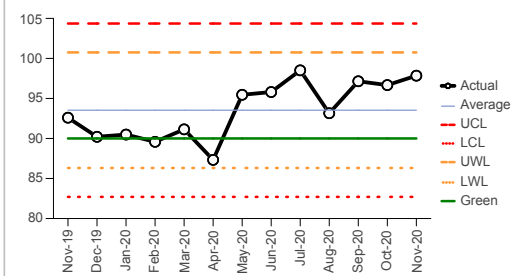
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Nicki Murdock **Committee:** SQAC	4.17 %	R >3 % A N/A G <=3 %		

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

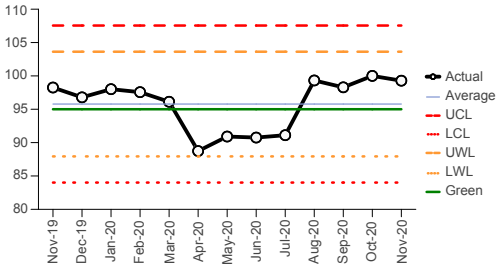
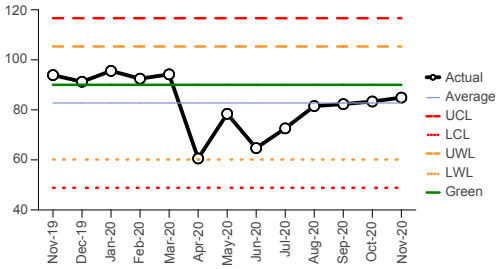
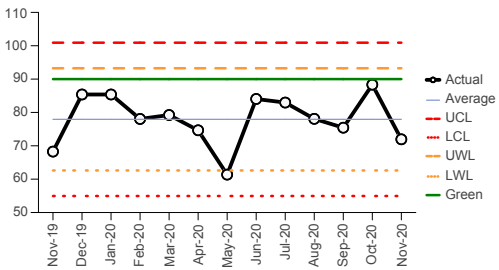
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.68 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 20/21 is 100%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.56 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	97.84 %	R <85 % A >=85 % G >=90 %		No Action Required

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.28 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	84.89 %	R <85 % A >=85 % G >=90 %		Percentage of patients that report engaging with play this month was 84.9%, an increase of 1.6% compared to October 2020. Percentage increase following a positive trend since May 2020. There has been an increase in the number of volunteers able to go up to the ward to engage in Play activities. The number of Play staff having to shield has been reduced, increasing the team's capacity. A further increase in the overall percentage is expected next month with the introduction of the Arts for Health programme under Play activities and FFT data.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	71.94 %	R <85 % A >=85 % G >=90 %		November 2020 has shown a decrease in the percentage of inpatient children / families reporting involvement in learning/teaching (71.9%) compared to October 2020 (88.3%). There is currently a review of the resumption of group-based teaching within the main classroom which has been prohibited due to infection control since March 2020. There are patient/families that are ineligible for learning who are still being asked if they are involved. A discussion is set to be had around the true accounting for these responses.

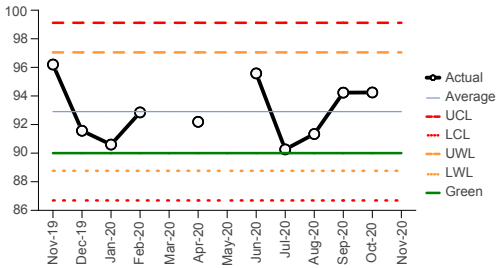
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

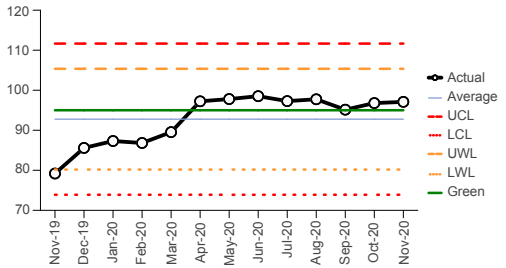
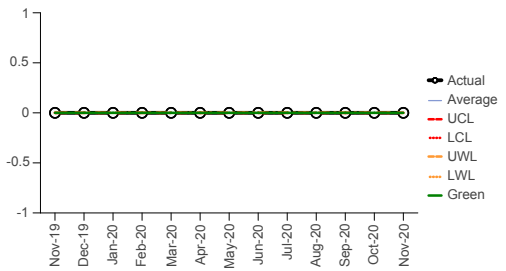
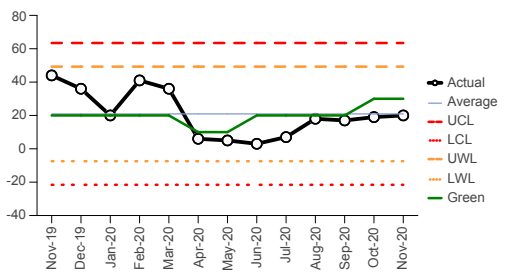
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC		R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

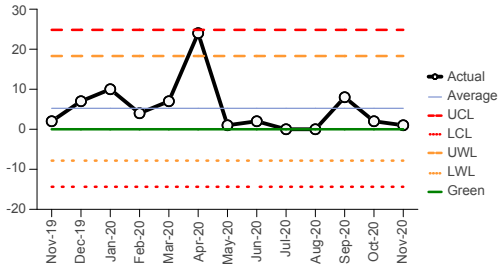
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	97.09 %	R <95 % A N/A G >=95 %		No Action Required
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	20	R >30 A N/A G <=30		No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

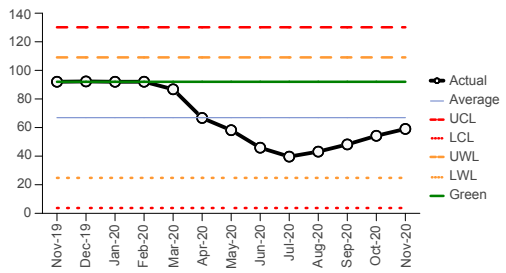
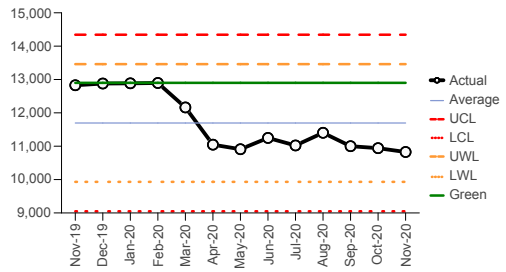
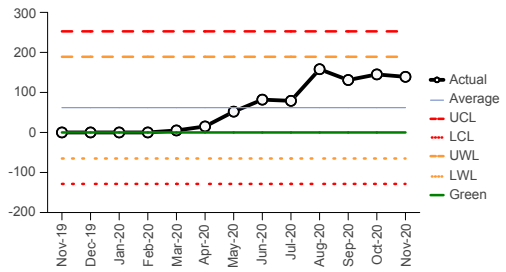
	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national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

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

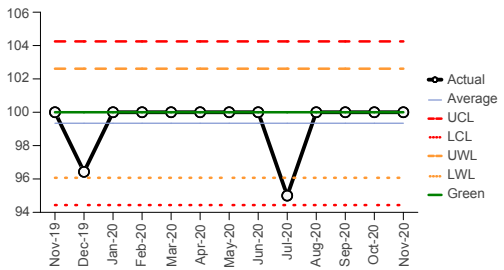
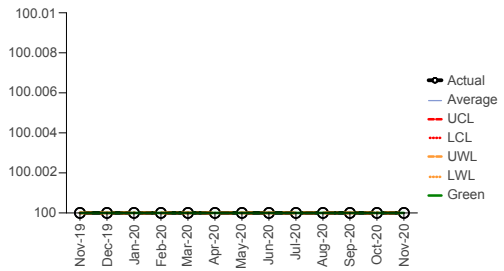
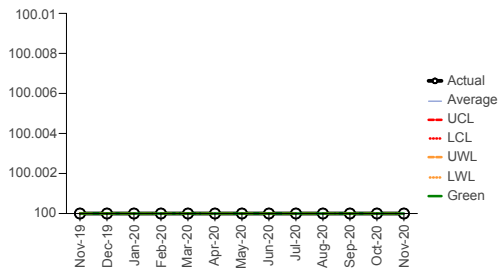
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	59.02 %	R <90 % A >=90 % G >=92 %		Performance continues to improve after 4 consecutive months of deterioration. As phase 3 activity improves and increases the RTT performance will also continue with this trajectory.
Waiting Times	**Waiting List Size** W National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	10826	R >12899 A N/A G <=12899		No Action Required
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Adam Bateman **Committee:** RABD	148	R >0 A N/A G 0		All patients waiting > 40 weeks continue to be clinically reviewed and >52 weeks dated in a chronological order. This is for OP & IP activity and is reliant on AH being able to maintain elective activity through the winter/covid 2nd wave. Plans continue to be refined to mitigate this. We are completing a deep dive into the management of waiting lists which will improve the way we currently manage and report on all patients on our PTL.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

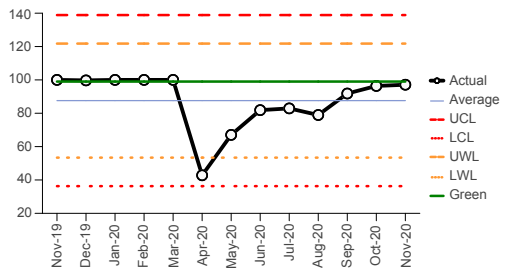
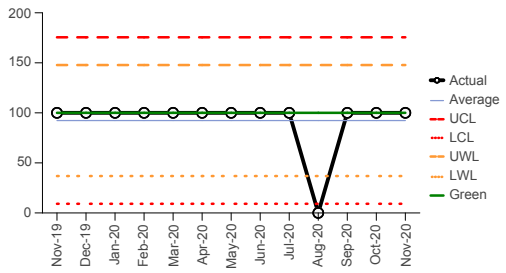
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	97.10 %	R <99 % A N/A G >=99 %		Whilst still adhering to social distancing and IPC guidelines, Radiology has seen their activity returning to between 85-90%, week on week, of pre-Covid 19 capacity. Fluctuations in unplanned activity have resulted in variations of activity
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

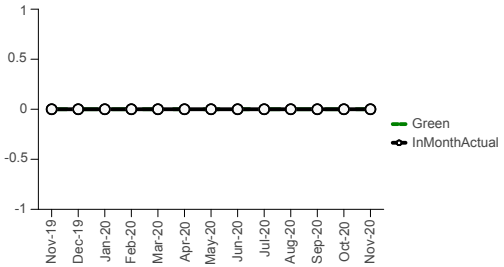
The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

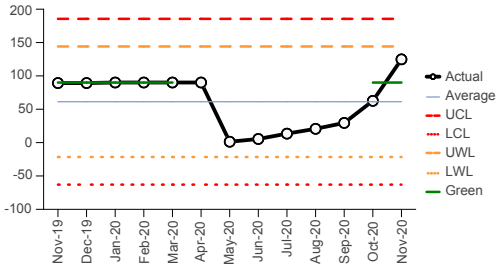
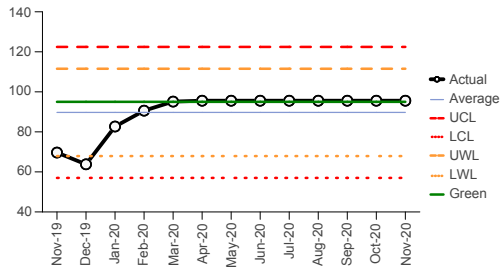
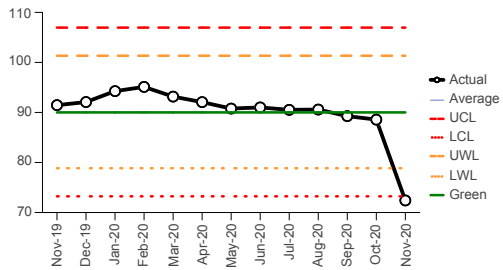
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	124.80 %	R <85 % A >=85 % G >=90 %		Following the official window close date of 31st of October 2020, PDR compliance continues to rise slowly, regular emails to divisional leads followed up by full breakdowns of their areas by individual are sent to allow managers to address any outstanding appraisals.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	95.56 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	72.41 %	R <80 % A >=80 % G >=90 %		Mandatory training has seen another small decrease this month, practical topics such as Resus and Moving and Handling continue to struggle as well as a large number of staff who had multiple topics expire at the end of November. All staff who's compliance is less than 80% have received an individual email alerting them to their current compliance and instructions to improve this.

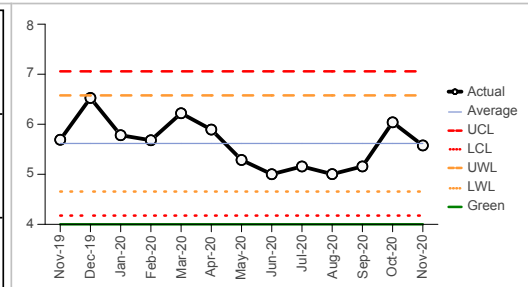
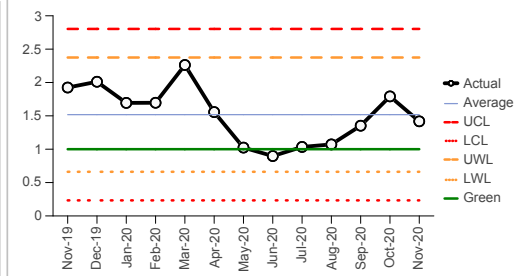
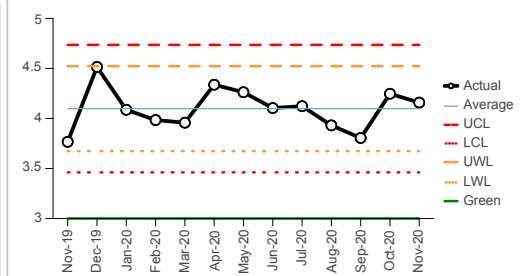
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.58 %	R >4.5 % A <=4.5 % G <=4 %		Sickness has reduced in November by 0.4% but still remains above the Trust target of 4%.The HR team are working in collaboration with Divisions to support manager with staff absences in partnership with the SALS Team who are providing support and guidance to managers and employees. The Wellbeing team as of October have been aligned to divisions to further support staff and managers with sickness absence. The numbers of staff absent due to COVID-19 is also reducing and we have successfully facilitated the return to work of staff advised to shield during the national lockdown in November.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.42 %	R >1 % A N/A G <=1 %		
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.16 %	R >3 % A N/A G <=3 %		

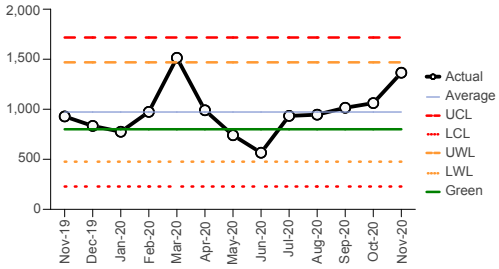
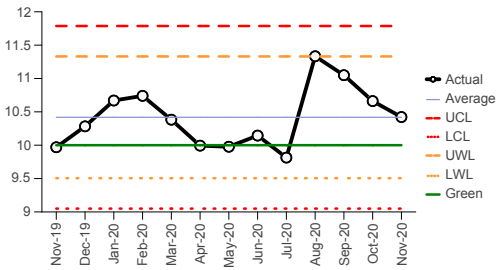
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1364.99	R >960 A <=960 G <=800		Temporary staffing costs have seen an increase following on amendment to rates of pay for NHSP shifts for nursing and health care assistants. This was further to a review of rates of pay across the system to ensure we were equitable. We are are continuing to work with NHSP to ensure we have the right support in place throughout winter
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.42 %	R >11 % A <=11 % G <=10 %		Turnover has continued to reduce, since a peak in August due to a number of temporary COVID support staff leaving. There were 17 leavers in November; the majority of leavers being in the Division of Medicine (7) The Nursing staff group saw the highest number of leavers (6).

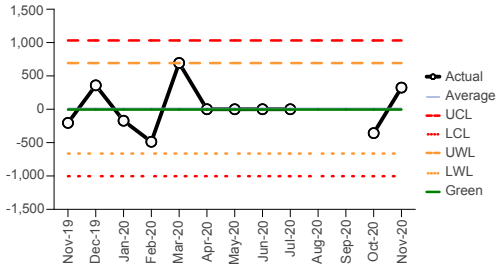
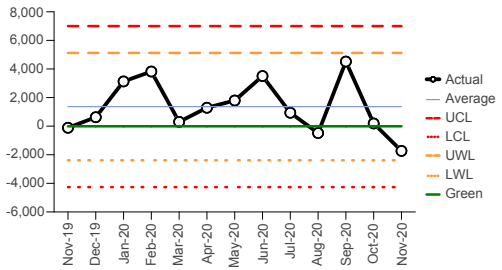
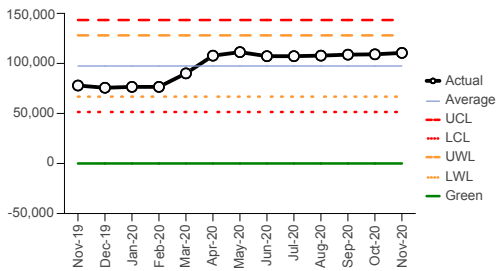
The Best People doing their best Work

16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	325	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-1,733	R <-10% A >=-10% G >=-5%		Total capital expenditure for November was £3.9m which exceeded the in-month plan by £1.7m. This reduced the year to date capital slippage to £8.7m
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	110,503	R <-20% A >=-20% G >=-5%		No Action Required

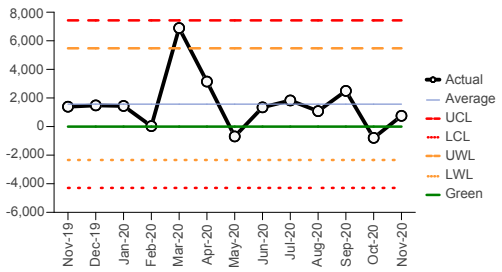
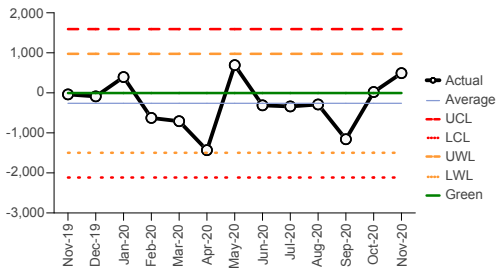
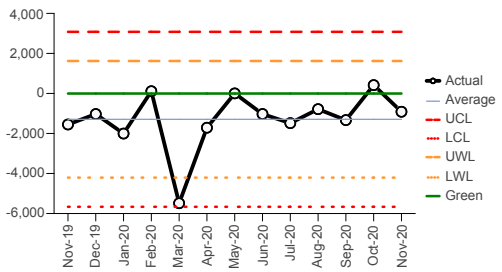
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	748	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	492	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-916	R <-20% A >=-20% G >=-5%		The non pay expenditure exceeded the plan in month 8 by £0.9m. This related to a budget realignment into pay which was backdated to month 7.

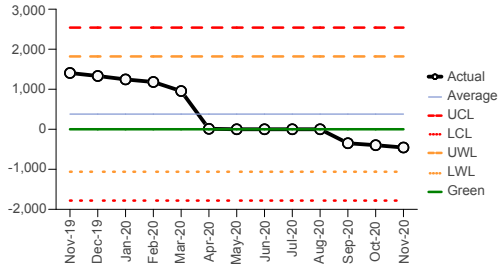
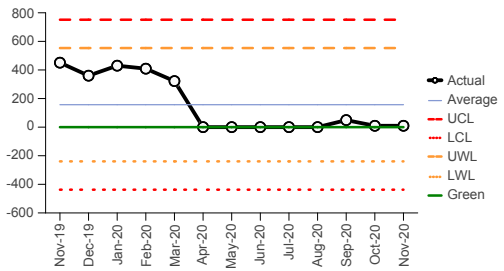
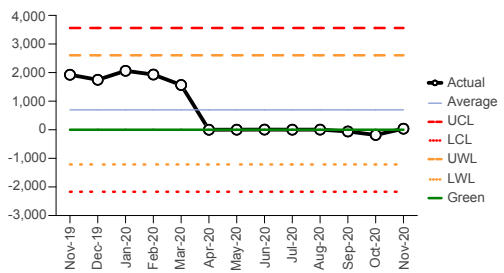
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-456.00	R <0 A N/A G >=0		Non Electives continue to be affected by the impact of COVID, below Planned and Last Years levels.
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	9.50	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	36.10	R <0 A N/A G >=0		No Action Required

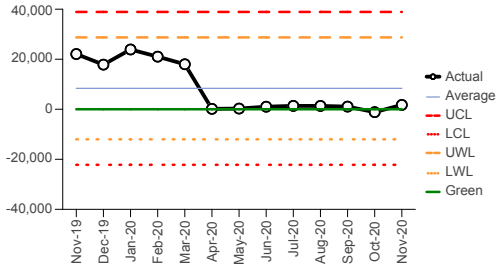
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1735.99	R <0 A N/A G >=0		No Action Required

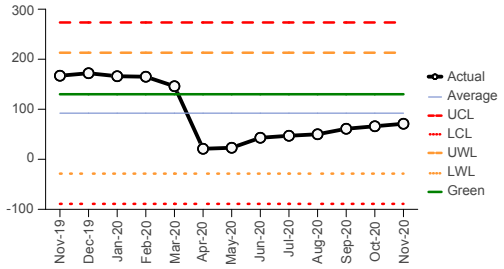
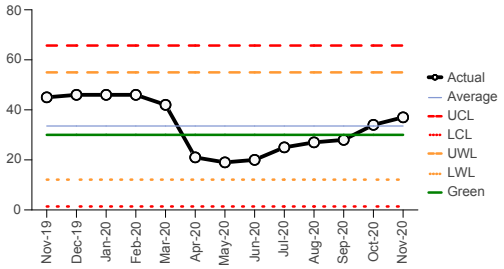
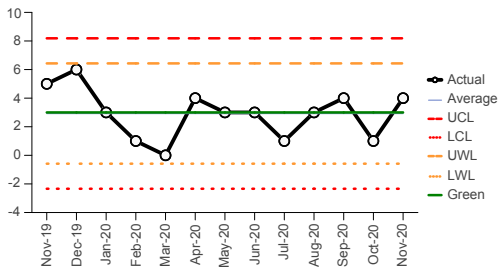
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

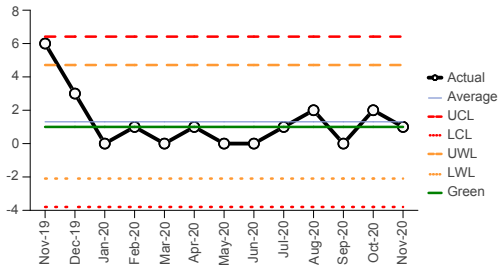
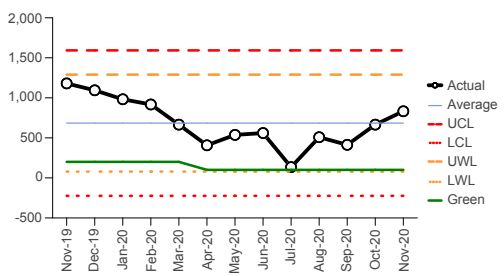
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	71	R <111 A >=111 G >=130		The process of ensuring that 1) the necessary preconditions to safely restart suspended studies are in place and 2) prioritisation of these studies according to level of urgency is ongoing and activity levels continue to increase.
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	37	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	4	R <2 A >=2 G >=3		No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

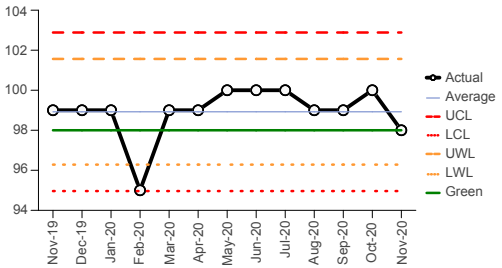
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	1	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	832	R <86 A >=86 G >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

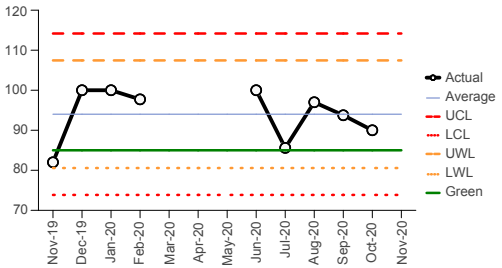
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	11	35	49	No Threshold
Clinical Incidents resulting in No Harm	D	75	123	181	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	13	18	52	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	0	11	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	0	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		75.0%	90.0%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	1	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	4	7	4	No Threshold
PALS	W	17	29	20	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			4.2%	<=3 % / N/A / >3 %
ED: 95% Treated within 4 Hours	D		97.1%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	3	17	No Threshold		
28 Day Breaches	W	0	0	1	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		96.9%	95.3%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		100.0%	98.1%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		100.0%	97.2%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		100.0%	99.1%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		84.4%	85.0%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		62.5%	74.8%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	64.4%	81.0%	53.4%	>=92 %	>=90 %	<90 %
Waiting List Size	W	755	1,778	8,216	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	0	147	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		100.0%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks	W		97.7%	87.5%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	270	153	47	No Threshold
Income In Month Variance (£'000s)	W	155	561	1	No Threshold
Pay In Month Variance (£'000s)	W	30	338	-73	No Threshold
Non Pay In Month Variance (£'000s)	W	85	-746	120	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		-421	-35	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	24	-16	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		140	-104	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	819	510	-1,381	>=0	N/A	<0
PDR	W	122.0%	144.8%	148.1%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	100.0%	96.0%	94.1%	>=95 %	>=90 %	<90 %
Mandatory Training	W	81.9%	69.1%	67.5%	>=90 %	>=80 %	<80 %
Sickness	D	4.2%	5.0%	6.0%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.3%	1.7%	1.3%	<=1 %	N/A	>1 %
Long Term Sickness	D	2.9%	3.3%	4.7%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	212	239	505	No Threshold		
Staff Turnover	D	9.0%	7.0%	8.3%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	100.1%	93.2%	94.4%	>=90 %	>=80 %	<90 %

Medicine Division		
SAFE	Zero Never Events; Zero clinical incidents resulting in severe, moderate or permanent harm. No grade 3 or 4 pressure ulcers. No hospital-acquired Infections For MRSA and C Difficile.	**Highlight** • Cleanliness score of 96%. • Pharmacy OP time for complex patients 100% • Zero never events, hospital-acquired infections (MRSA, C. difficile) for over 12 months. **Challenges** • 75% Sepsis patients treated with 60 min
CARING	7 complaint and 29 PALS responses.	**Highlight** • Relatively low number of complaints **Challenges** • Increasing numbers of complaints that are linked to the Tics and Tourette's patients in neurology
EFFECTIVE	ED Performance continues to meet the national standard 97.1 %. The Emergency Department continues to be responsive to the challenges of Covid and seeks to continue to improve its resilience for winter	**Highlight** • Emergency Care Performance • Improved theatre utilisation • Zero 28 day breaches **Challenges** • WNB rate has continued to remain high at 11.3% but has improved against the last 5 months
RESPONSIVE	RTT compliance continues to improve at 81% (against 68% in October) with the Division's intense focus on restoring capacity and expanding access to care. There continue to be no patients waiting over 52 weeks for treatment. Diagnostic compliance has improved to 97.7% and has narrowly missed the 99% standard,	**Highlight** ▪ Consistent delivery of all national cancer standards ▪ Continued recovery of the diagnostic target ▪ Pathology turnaround times **Challenges** ▪ OP imaging reporting times
WELL LED	The Division of Medicine remains 153k underspent. There is a focused effort to control expenditure through significant reduction in temporary pay spend and also address agreed spends through historically approved business cases. Medical Appraisals are at 96% and Mandatory training is at 69.1 %.	**Highlight** • Safer staffing fill rates • Reduced long term & short sickness rate **Challenges** • Sickness rates overall • Finance • Mandatory training

Alder Hey Children's NHS
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Medicine

D Drive W Watch P Programme

SAFE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	25	20	34	28	16	13	19	17	29	19	16	28	35		No Threshold
Clinical Incidents resulting in No Harm (D)	76	70	135	93	70	33	64	76	104	75	93	66	123		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	16	23	24	19	7	12	13	19	26	21	16	11	18		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	0	1	0	0	0	0	0	2	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	1	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	0	2	0	1	0	1	5	3	2	0	4	0	0		No Threshold
Medication Errors (Incidents)	21	22	48	30	15	13	25	29	26	23	18	24	32		No Threshold
Pressure Ulcers (Category 3) (W)	1	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	3	2	3	1	2	1	1	0	0	2	2	0	0		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	90.0%	100.0%	100.0%	100.0%	88.9%	100.0%	83.3%	92.3%	100.0%	84.6%	91.7%	100.0%	75.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	1	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	1	0	0	0	0	0	1	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	3	1	1	1	0	1	1	1	0	2	0	0	0		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Cleanliness Scores	97.4%	98.3%	97.8%	97.6%				98.5%	97.7%	97.8%	98.0%	98.0%	96.0%		>=90 % >=80 % <80 %
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.	99.7%	100.0%	99.9%	99.8%	99.7%	99.3%	99.3%	99.6%	99.8%	99.8%	99.8%	99.8%			>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	58.5%	58.5%			55.7%	55.7%	57.4%	60.0%	63.8%	63.8%	63.8%				>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	50.0%	62.0%	47.0%	53.0%	58.0%	65.0%	65.0%	64.0%	78.5%	84.0%	77.3%	85.0%			>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	92.0%	89.0%	84.0%	88.0%	67.0%	67.0%	69.0%	100.0%	100.0%	100.0%	100.0%	100.0%			>=90 % >=80 % <90 %

CARING

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Complaints (W)	1	2	7	5	4	7	2	6	1	11	7	8	7		No Threshold
PALS (W)	38	21	45	44	34	13	18	21	32	49	27	25	29		No Threshold

EFFECTIVE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Referrals Received (Total)	1,933	1,825	2,012	1,957	1,545	834	990	1,428	1,658	1,558	2,266	2,003	1,691		No Threshold
ED: 95% Treated within 4 Hours (D)	79.2%	85.6%	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	9.3%	7.0%	4.0%	3.8%	2.7%	0.2%	0.8%	1.1%	1.5%	0.8%	2.0%	0.8%	1.0%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	9.6%	8.5%	8.3%	8.0%	7.4%	8.2%	8.4%	7.5%	7.8%	8.3%	7.0%	7.9%	7.8%		No Threshold

Medicine

D Drive W Watch P Programme

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
ED: Number of patients spending >12 hours from decision to admit to admission W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised W	79.3%	78.9%	80.7%	85.8%	76.2%	73.9%	76.7%	75.4%	82.0%	82.1%	81.0%	83.9%	82.2%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	4	1	2	5	0	1	2	0	0	3	2	1	3		No Threshold
28 Day Breaches W	1	0	0	0	0	0	1	2	0	0	3	2	0		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	42	26	22	41	67	175	1	2	12	55	20	33	20		No Threshold
OP Appointments Cancelled by Hospital %	13.9%	15.1%	12.8%	15.3%	25.8%	46.0%	21.7%	15.5%	13.0%	11.3%	12.1%	11.1%	12.2%		<=5 % N/A >10 %
Was Not Brought Rate W P	10.0%	11.8%	9.1%	10.6%	11.0%	7.6%	9.1%	11.7%	12.1%	12.6%	12.4%	12.0%	11.3%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	11.8%	14.2%	11.3%	14.3%	14.9%	15.9%	14.0%	14.6%	15.2%	13.6%	16.3%	12.8%	13.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	9.4%	11.0%	8.5%	9.6%	10.1%	6.0%	8.1%	11.0%	11.5%	12.4%	11.7%	11.7%	10.6%		<=14 % <=16 % >16 %
Coding average comorbidities	4.69	4.80	4.82	5.07	5.25	5.58	5.50	5.47	5.39	5.32	5.17	5.31	5.43		No Threshold

RESPONSIVE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Convenience and Choice: Slot Availability	85.6%	82.7%	95.9%	89.6%	66.7%										
IP Survey: % Received information enabling choices about their care W	96.1%	94.6%	95.5%	97.1%	95.0%	95.0%	100.0%	81.5%	100.0%	95.6%	92.9%	92.9%	96.9%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	96.6%	97.7%	98.9%	97.6%	98.1%	100.0%	100.0%	88.9%	96.8%	97.8%	100.0%	97.2%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	87.1%	92.7%	86.4%	83.5%	91.2%	90.0%	97.1%	85.2%	100.0%	93.3%	95.2%	88.9%	100.0%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	98.3%	92.7%	97.7%	97.1%	95.0%	87.5%	97.1%	85.2%	90.3%	100.0%	97.6%	100.0%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D	91.0%	90.4%	94.4%	92.9%	93.1%	60.0%	74.3%	63.0%	77.4%	80.0%	88.1%	77.8%	84.4%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	68.1%	81.6%	81.6%	78.2%	76.1%	77.5%	68.6%	77.8%	87.1%	82.2%	76.2%	63.9%	62.5%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	94.4%	94.2%	94.0%	92.2%	88.1%	68.8%	60.1%	46.3%	40.6%	45.0%	55.5%	68.0%	81.0%		>=92 % >=90 % <90 %
Waiting List Size W	3,317	3,420	3,043	3,495	3,361	3,381	3,266	2,791	2,484	2,420	2,151	1,916	1,778		
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Waiting Times - 40 weeks and above	3	1	2	9	14	90	121	127	147	181	137	81	63		
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks W	100.0%	99.7%	100.0%	100.0%	100.0%	39.1%	64.9%	82.1%	84.6%	77.9%	91.4%	96.2%	97.7%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	90.9%	89.8%	90.2%	91.0%	86.1%	90.3%	90.4%	90.0%	90.4%	92.7%	89.7%	90.0%	90.6%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	99.8%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	92.0%	82.0%	85.0%	88.0%	95.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	85.0%	81.0%	86.0%	90.0%	86.0%		98.0%	98.0%	97.0%	97.0%	98.0%	93.0%	98.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	87.0%	92.0%	89.0%	95.0%	75.0%	100.0%	98.0%	97.0%	81.0%	69.0%	71.0%	74.0%	72.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	89.0%	82.0%	64.0%	86.0%	84.0%	16.8%	63.6%	62.6%	82.4%	59.1%	98.0%	98.8%	100.0%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks						11.6%	17.2%	35.4%	88.2%	77.8%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

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Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks						21.6%	70.7%	83.8%	86.4%	95.0%	92.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	100	501	124	-361	-81	-2,544	-1,842	-1,048	278	-1,111	-1,201	-264	153		No Threshold
Income In Month Variance (£'000s)	W	678	869	1,315	80	271	-2,416	-2,220	-1,103	347	-1,170	-622	-647	561		No Threshold
Pay In Month Variance (£'000s)	W	150	-28	15	-67	-297	59	99	92	196	62	-211	-143	338		No Threshold
AvP: IP - Non-Elective	W	1,026	944	816	827	612	0	0	-2	1	1	-222	-333	-421		>=0 N/A <0
AvP: IP Elective vs Plan	W	136	96	135	108	89	0	0	0	0	1	24	7	24		>=0 N/A <0
AvP: OP New		1,335.00	1,093.00	1,443.00	1,133.00	856.00	1.00	4.00	2.00	-1.00	9.00	-462.00	-20.00	21.00		>=0 N/A <0
AvP: OP FollowUp		4,026.00	3,186.00	4,284.00	3,648.00	3,609.00	2.00	7.00	4.00	15.00	8.00	1,256.00	650.00	723.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	1,054	1,025	1,203	1,088	982	0	1	2	0	4	15	-5	140		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	6,650	5,410	7,163	6,073	5,594	3	11	6	17	19	542	149	510		>=0 N/A <0
PDR	W	87.8%	87.8%	87.1%	87.1%	87.1%	87.1%	3.1%	10.7%	12.1%	23.0%	21.8%	60.2%	144.8%		>=90 % >=85 % <85 %
Medical Appraisal	W	69.8%	65.1%	84.1%	91.5%	94.9%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%		>=95 % >=90 % <90 %
Mandatory Training	W	91.8%	91.6%	94.1%	94.6%	93.1%	92.3%	91.9%	91.6%	91.3%	91.3%	89.9%	90.2%	69.1%		>=90 % >=85 % <80 %
Sickness	D	5.6%	6.1%	5.8%	6.3%	6.0%	5.6%	4.8%	5.4%	5.6%	5.1%	5.0%	5.8%	5.0%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	2.2%	2.2%	1.9%	2.0%	2.4%	1.6%	0.9%	1.0%	0.9%	1.0%	1.4%	2.1%	1.7%		<=1 % N/A >1 %
Long Term Sickness	D	3.4%	3.9%	3.9%	4.3%	3.6%	4.0%	3.9%	4.4%	4.7%	4.1%	3.6%	3.7%	3.3%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	242	222	250	265	347	201	157	108	167	217	266	235	239		No Threshold
Staff Turnover	D	9.7%	9.5%	9.9%	9.8%	10.0%	9.7%	9.2%	8.3%	7.6%	7.6%	6.7%	6.8%	7.0%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	97.2%	90.7%	91.6%	94.6%		96.5%		97.7%	96.4%	94.9%	94.9%	93.2%			>=90 % >=85 % <90 %

Surgery Division

SAFE	• No clinical incident resulting in moderate, semi-permanent harm or severe, permanent harm or catastrophic death • 11 medication errors resulting in harm. 4>2<11 • Increase in medication errors 38>36<67 • Increase in clinical incidents resulting in near miss 24<35<50 • Increase in clinical incidents resulting in No harm 147 > 141>148<181 • Increase in clinical incidents resulting in minor, non-permanent harm 51>39<41<52 • No cat 3 or 4 pressure ulcers. • No never events. • One Hospital acquired- MSSA	**Highlight** • Continued increase in patients treated for sepsis within 60 mins 75%<86.7%<90% **Challenges** • Increase in medication errors
CARING	• Decrease in formal complaints from 7>2<9>4 • Reduction in PALS from 33>22<29>20 • Overarching themes include: perceived lapses in clinical care, access to care within anticipated time frames and communication within teams and across specialities and divisions.	**Highlight** **Challenges** • Providing access within a timely manner for elective patients
EFFECTIVE	• Further reduction in referrals received 2565<3015 >2574>2,280 • WNB rate remains consistent 10.7%>9.5%<9.8% • CCAD cases <30<31>27 • Reduction in cancelations on the day of the admission 15<18>6 • Reduction in clinic cancelation <6 weeks' notice 52<58>38 • 0 patients waited over 28 day to be rescheduled for their elective procedure having been previously cancelled on the day	**Highlight** • Theatre utilisation remaining consistent 88.6%<89.1%>88.9%>89.9%>88.8% • Reduction in cancelations on the day **Challenges** • Increase in patients readmitted to PICU within 48 hours 0%<1.6%<4.2% • WNB rate
RESPONSIVE	• Patients who noted that they were treated with respect 94.7%<98.8%<98.1% • Patients knew their planned date of discharge 97.7%<100%>97.2% • Patients noted that they knew who was in charge of their care 98.5%<100%>99.1% • Reduction in patients noted they were involved in learning 75.2%>98.8%<74.8%	**Highlight** • Increased weekend theatre sessions both Inpatients and Day Case theatres **Challenges** • Increase in waiting list size 7840>7737<8129<8216 • Slight reduction in patients waiting over 52 weeks to receive treatment, remains a challenge 121<135<143>139
WELL LED	• Increase in number of PDR's completed • Reduction in mandatory training with plans to address in high volume areas 88.0%>87.1%>67.5% • Reduction in staff turnover 9.6% >8.8% >8.3%	**Highlight** • Increase in staff who have received their PDR. • Reduction in both long term and short term sickness resulting in overall improvement in sickness rates 7%>6.2% **Challenges** • Management of long term sickness 4.8%

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SAFE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	32	17	28	29	22	18	19	30	42	26	24	35	49		No Threshold
Clinical Incidents resulting in No Harm (D)	143	110	145	166	115	76	95	114	175	147	141	148	181		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	52	47	39	40	38	22	26	48	48	51	39	41	52		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	2	3	0	0	1	0	0	4	1	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	3	1	0	0	2	0	0	4	4	1	4	2	11		No Threshold
Medication Errors (Incidents)	55	27	43	38	38	16	22	34	61	36	38	36	67		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	1	0	0	2	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events (W)	0	1	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	100.0%	60.0%	57.1%	80.0%	88.9%	88.9%	91.7%	88.9%	83.3%	85.7%	75.0%	86.7%	90.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	1	0	0	2	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	1	0	0	2	0	1	0	0	1	4	1	0	1		No Threshold
Cleanliness Scores	97.6%	98.0%	99.1%	96.3%				97.9%	98.4%	96.0%	98.2%	98.0%	97.9%		>=90 % >=80 % <80 %

CARING

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Complaints (W)	8	5	1	2	3	1	2	2	0	7	2	9	4		No Threshold
PALS (W)	35	19	29	30	20	13	7	37	39	33	22	29	20		No Threshold

EFFECTIVE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	0	0	1	0	0	0	0	2	1	0	0	1	3		No Threshold
% Readmissions to PICU within 48 hrs (W)	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%		<=3 % N/A >3 %
Referrals Received (Total)	3,317	2,838	3,724	3,637	2,813	1,371	1,780	2,252	2,827	2,581	3,159	2,984	2,332		No Threshold
Theatre Utilisation - % of Session Utilised (W)	85.6%	83.6%	89.7%	88.5%	86.2%	66.4%	68.1%	86.6%	88.6%	89.1%	88.9%	89.8%	88.8%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	40	35	18	36	36	5	3	3	7	15	15	18	17		No Threshold
28 Day Breaches (W)	1	7	10	4	7	24	0	0	0	0	5	0	1		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	57	11	29	41	140	194	2	0	16	70	52	58	38		No Threshold
OP Appointments Cancelled by Hospital %	12.2%	12.9%	14.0%	13.0%	28.6%	55.9%	30.2%	17.3%	14.8%	11.8%	11.1%	10.9%	11.6%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	11.1%	12.6%	9.3%	9.6%	10.7%	9.6%	10.4%	7.8%	9.2%	10.3%	10.7%	9.5%	9.7%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	11.4%	11.9%	9.3%	10.5%	11.2%	9.9%	11.3%	8.9%	11.2%	11.6%	12.4%	10.0%	10.2%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	10.9%	13.0%	9.3%	9.3%	10.4%	9.6%	10.0%	7.3%	8.5%	9.9%	10.1%	9.3%	9.5%		<=14 % <=16 % >16 %
Coding average comorbidities	4.09	4.20	4.11	3.96	4.21	5.23	4.87	4.16	4.09	4.61	4.45	4.33	4.26		No Threshold
CCAD Cases	27	26	33	28	36	21	26	24	29	23	30	31	27		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		99.0%	98.7%	99.0%	89.2%	64.6%												
IP Survey: % Received information enabling choices about their care	W	97.2%	97.6%	98.5%	98.2%	97.5%	87.1%	88.7%	97.8%	99.0%	96.0%	96.2%	96.2%	95.3%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	98.2%	99.1%	98.5%	97.5%	98.0%	100.0%	96.2%	95.7%	99.0%	98.0%	94.7%	98.8%	98.1%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	96.1%	88.7%	93.1%	93.2%	91.1%	83.9%	94.3%	98.9%	98.1%	93.1%	97.7%	100.0%	97.2%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	98.2%	99.3%	98.2%	97.9%	97.0%	90.3%	86.8%	92.4%	91.3%	99.0%	98.5%	100.0%	99.1%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	95.7%	91.7%	96.4%	92.2%	95.0%	61.3%	81.1%	65.2%	71.2%	82.2%	80.5%	85.7%	85.0%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	68.4%	87.7%	87.7%	77.9%	81.7%	71.0%	56.6%	85.9%	81.7%	76.2%	75.2%	98.8%	74.8%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	93.6%	94.5%	93.5%	94.4%	89.0%	69.0%	59.6%	47.8%	40.3%	43.2%	46.8%	50.6%	53.4%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,166	8,088	8,651	8,238	7,567	6,655	6,630	7,186	7,431	7,840	7,737	8,129	8,216				
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	0	7	31	60	137	121	135	143	147		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	66.7%	53.3%	100.0%	100.0%	100.0%	87.5%		>=99 %	N/A	<99 %

WELL LED

		Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	-65	154	-569	-142	-1,187	-4,228	-3,714	-1,774	-1,985	-1,541	-1,988	-488	47		No Threshold		
Income In Month Variance (£'000s)	W	556	541	-184	367	-503	-4,173	-4,172	-1,908	-1,964	-1,428	-1,460	15	1		No Threshold		
Pay In Month Variance (£'000s)	W	-194	-18	58	-343	-240	-132	-111	30	65	34	-454	-69	-73		No Threshold		
AvP: IP - Non-Elective	W	380	387	429	354	342	0	0	2	-1	-1	-127	-65	-35		>=0	N/A	<0
AvP: IP Elective vs Plan	W	309	264	294	301	232	0	0	0	0	-1	25	3	-16		>=0	N/A	<0
AvP: OP New		2,715.00	2,272.00	2,923.00	2,507.00	2,003.00	3.00	3.00	5.00	8.00	10.00	-690.00	-1,260.00	-621.00		>=0	N/A	<0
AvP: OP FollowUp		7,136.00	5,766.00	7,883.00	7,138.00	5,627.00	1.00	3.00	6.00	11.00	17.00	-679.00	-1,598.00	-345.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	867	720	856	842	581	0	1	2	1	0	-77	-178	-104		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	11,416	9,330	12,520	11,113	8,783	4	6	11	18	28	-1,802	-3,571	-1,381		>=0	N/A	<0
PDR	W	93.3%	93.3%	94.3%	94.3%	94.3%	94.3%	0.0%	1.1%	17.1%	24.7%	35.5%	57.8%	148.1%		>=90 %	>=85 %	<85 %
Medical Appraisal	W	67.7%	65.2%	84.1%	89.7%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%		>=95 %	>=90 %	<90 %
Mandatory Training	W	89.9%	91.1%	93.0%	92.9%	92.1%	90.6%	88.5%	89.6%	89.1%	89.3%	88.0%	87.1%	67.5%		>=90 %	>=85 %	<80 %
Sickness	D	5.9%	7.1%	6.3%	5.8%	6.3%	6.5%	6.8%	5.8%	5.8%	6.0%	6.0%	6.9%	6.0%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.8%	2.2%	2.0%	2.0%	2.2%	1.6%	1.5%	1.1%	1.4%	1.4%	1.6%	1.9%	1.3%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.1%	4.9%	4.3%	3.8%	4.2%	4.9%	5.3%	4.8%	4.4%	4.7%	4.4%	5.0%	4.7%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	484	388	343	397	504	457	321	204	310	332	286	446	505		No Threshold		
Staff Turnover	D	10.0%	10.5%	10.7%	11.1%	10.7%	10.5%	9.8%	9.4%	9.7%	9.6%	9.6%	8.8%	8.3%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	95.5%	91.7%	89.4%	91.9%		90.3%		94.4%	86.8%	89.1%	93.6%	94.4%			>=90 %	>=85 %	<90 %

Community & Mental Health Division

SAFE	Lessons learnt from incidents include: • Parent informed that their child had been discharged from the ASD pathway for failure to attend an assessment appointment by Axia (external provider of assessments) Lesson: Referrals to Axia are now being sent in batches of 10 to enable them to arrange timely appointments and assessments. • Email sent in error to the parent of a discharged child whose name is the same as the member of staff the person intended to send the email to. Lesson - IG policy summary has been shared and all staff reminded on the importance of checking emails	**Highlight** • Zero incidents resulting in moderate or severe harm • Zero incidents resulting in death • Zero Pressure Ulcers (Category 3 and above) • Approx. 300 Self testing kits distributed to staff • Tissue viability nurse post out to advert **Challenges** • Main incident themes relate to medication incidents (delays in receipt of prescriptions) and booking of incorrect appointments. The OPD team have developed an improvement action plan for increasing ePPF compliance which will support improvements in correctly pending future appointments.
CARING	Lessons learnt from complaints: • Wait for ASD diagnosis and wait for ADHD clinic appointment Lesson: When Trust staff are liaising with families following a PALS concern, it is important for them to keep parents/carers up to date so that they are aware that there concern is being addressed • Child with Tourette's Syndrome with no identified clinical lead, under mental health and Paediatric Neurology Teams Lesson: For children and young people who are being jointly managed, joint appointments should be organised to ensure care is better co-ordinated	**Highlight** • Reduction in PALS (18) compared to last month (33) • 13 compliments recorded in month • 19 excellence reports records • 98% positive FFT scores for Division **Challenges** • Increase in formal complaints (6) compared to last month (1). • Division pro-actively converting informal concerns to formal complaints to ensure appropriate investigation/actions taken and lessons learnt (4 x ASD/ADHD, 1 x Speech & Language Therapy and 1 x Rainbow Centre).
EFFECTIVE	First 4 weeks of new outpatient department schedule completed and roll out of visual display boards in OPD Additional investment agreed to support extension of Intensive Support Team pilot	**Highlight** • Crisis care continue to provide 24/7 provision with an increasing number of calls to the service **Challenges** • Routine referral turnaround time remains a challenge at 18 days – challenge board created to describe actions to improve this and monitoring via Divisional Board
RESPONSIVE	Improvement in RTT for Community Paediatrics to 64.3% Improvement in RTT for Specialist Mental Health Services to 70.4% (Ref to Partnership) with an improvement in referral to Choice also (72.2%)	**Highlight** • No breaches report for urgent and routine Eating Disorder waiting time compliance. • Launch of new ASD and ADHD dashboards, improving the ability for the service to monitor the patient pathway

	Improvements in waiting times for all community therapy services in Sefton and achievement of SEND key performance indicators	**Challenges** • Continued focus on reduction in ASD and ADHD referrals from pre April 2020 cohort in line with agreed trajectories • Was not brought (WBN) rates increased in Community Paediatrics, review of data underway but initial feedback is this is linked to the numbers of long waiting children & young people booked into clinics in November. Staff now calling all families/carers in advance to support attendance.
WELL LED	Joint Pathological Demand Avoidance Statement agreed with Parent Carer Forums, Education & Social Care partners (10 years). Young people from Camhelions attended Divisional Board to discuss experiences of being part of interview panels. Camhelions awarded funding from NHSE/I to launch "Health Champions" and support messages to young people regarding Covid-19.	**Highlight** • Medical appraisal at 100% • Continued reduction in staff turnover to 9.1% • Flu Vaccine compliance in the division increase to 64% **Challenges** • Increase in sickness to 4.1%, just over Trust target (Short term absence decreasing) • Reduction in mandatory training compliance to 81.9%

Alder Hey Children's NHS
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Community

D Drive W Watch P Programme

SAFE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	6	2	8	5	5	4	6	6	8	4	8	15	11		No Threshold
Clinical Incidents resulting in No Harm (D)	62	30	46	57	42	29	92	84	83	73	88	82	75		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	9	11	6	10	4	4	3	10	6	5	9	11	13		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)	8	9	1	2	6	6	7	6	11	10	20	33	26		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores			100.0%					78.3%	100.0%		98.8%	98.8%			No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	7	8	8	8	8										No Threshold
CCNS: Supported early discharges from hospital care	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%							No Threshold
CCNS: Prescriptions	21	32	15	22	17	16	12	15							No Threshold

CARING

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Complaints (W)	5	1	2	3	2	0	2	2	4	2	2	1	4		No Threshold
PALS (W)	21	20	44	36	18	19	19	26	29	22	26	33	17		No Threshold

EFFECTIVE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Referrals Received (Total)	933	771	917	949	795	433	464	613	871	633	854	971	834		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	11	18	18	19	17	0	0	4	25	25	18	2		No Threshold
OP Appointments Cancelled by Hospital %	12.8%	12.8%	10.9%	11.3%	18.3%	24.3%	11.8%	6.4%	6.4%	10.5%	10.2%	9.9%	11.0%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) (W)	11.4%	11.7%	9.7%	9.5%	9.6%	9.3%	10.2%	11.5%	10.6%	10.5%	6.9%	11.7%	16.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	10.4%	13.5%	11.1%	10.2%	10.8%	13.0%	14.8%	14.3%	15.1%	13.6%	13.9%	13.4%	14.8%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	13.3%	14.1%	12.5%	11.7%	9.1%	9.3%	12.5%	11.7%	8.8%	12.3%	9.1%	14.9%	21.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	9.4%	11.3%	9.6%	7.8%	8.2%	13.2%	13.3%	11.0%	14.7%	14.0%	17.5%	15.1%	19.5%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	14.2%	16.5%	9.5%	13.1%	24.9%	26.1%	22.4%	28.3%	25.7%	23.6%	9.0%	12.8%	13.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	11.5%	15.4%	12.3%	11.9%	12.1%	13.6%	15.8%	16.0%	15.8%	13.9%	13.1%	13.2%	13.9%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	71.0%	77.9%	92.6%	76.8%	82.5%	90.5%	91.2%	85.7%	87.6%	75.6%	91.4%	107.8%	91.0%		No Threshold
CAMHS: Tier 4 DJU Bed Days	238	278	340	256	296	322	386	360	380	328	384	470	382		No Threshold
Coding average comorbidities	3.00		3.00		5.00	3.00	3.00		2.00	6.00		4.50	3.33		No Threshold
CCNS: Number of commissioned packages	10	10	10	10	10	9	9	9							No Threshold

RESPONSIVE

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1	1	1	1	1	1		1	1	1		2		No Threshold
CAMHS: Referrals Received	342	259	354	383	315	110	163	258	262	258	356	348	414		No Threshold

Alder Hey Children's NHS
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Community

D Drive W Watch P Programme

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
CAMHS: Referrals Accepted By The Service	176	151	207	230	169	67	93	143	154	147	268	193	231		No Threshold
CAMHS: % Referrals Accepted By The Service	51.5%	58.3%	58.5%	60.1%	53.7%	60.9%	57.1%	55.4%	58.8%	57.0%	75.3%	55.5%	55.8%		No Threshold
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%								>=96 % N/A <96 %
RTT: Open Pathway: % Waiting within 18 Weeks W	76.5%	74.3%	76.3%	75.1%	69.3%	44.3%	42.5%	34.0%	32.3%	38.1%	40.1%	48.9%	64.4%		>=92 % >=90 % <90 %
Waiting List Size W	1,344	1,371	1,191	1,161	1,234	1,010	1,013	1,184	1,032	1,109	1,051	795	755		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	5	8	21	22	12	6	10	2	1		0 N/A >0
CAMHS: Crisis / Duty Call Activity						288	422	413	550	494	516	598	718		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks W	49.6%	49.0%	58.3%	59.6%	58.6%	53.0%	53.6%	49.3%	44.0%	53.2%	59.1%	68.8%	70.0%		>=92 % >=90 % <88 %
ASD: Completed Pathways	104	65	68	59	54	24	24	80	106	105	66	82	39		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	57.7%	66.2%	80.9%	74.6%	68.5%	83.3%	70.8%	53.8%	61.3%	69.5%	68.2%	96.3%	87.2%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) P			87.5%	100.0%	90.9%	69.2%	90.0%	87.5%	100.0%	100.0%	100.0%	94.4%	94.4%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) P			100.0%	100.0%		66.7%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals W	169	107	109	102	131	107	134	149	188	122	144	146	151		No Threshold
CCNS: Number of Contacts D	1,094	863	821	830	986	748	859	812	1,083	803	1,035	1,038	877		No Threshold

WELL LED

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	22	-9	-58	-65	165	-92	-27	175	-26	0	-70	369	270		No Threshold
Income In Month Variance (£'000s) W	34	26	104	91	330	-30	-64	139	-49	-44	96	397	155		No Threshold
Pay In Month Variance (£'000s) W	15	-30	-90	-87	412	18	131	-29	-64	-98	-31	-81	30		No Threshold
AvP: OP New	591.00	452.00	552.00	531.00	454.00	0.00	1.00	3.00	1.00	1.00	180.00	118.00	107.00		>=0 N/A <0
AvP: OP FollowUp	2,878.00	2,196.00	3,079.00	2,766.00	2,760.00	1.00	10.00	5.00	0.00	8.00	665.00	645.00	713.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan W	3,470	2,650	3,631	3,298	3,214	1	11	8	1	9	835	759	819		>=0 N/A <0
PDR W	90.1%	90.1%	91.3%	91.3%	91.3%	91.3%	2.1%	9.8%	16.6%	23.1%	41.3%	73.4%	122.0%		>=90 % >=85 % <85 %
Medical Appraisal W	78.8%	51.5%	69.7%	91.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %
Mandatory Training W	93.5%	94.1%	96.7%	95.9%	94.7%	93.8%	93.0%	92.8%	92.1%	92.0%	91.4%	91.7%	81.9%		>=90 % >=85 % <80 %
Sickness D	6.0%	6.5%	4.9%	4.7%	6.3%	4.0%	3.5%	2.7%	2.5%	2.7%	3.7%	4.0%	4.2%		<=4 % <=4.5 % >4.5 %
Short Term Sickness D	2.1%	2.0%	1.2%	1.1%	2.8%	1.4%	0.8%	0.5%	0.7%	0.9%	1.2%	1.5%	1.3%		<=1 % N/A >1 %
Long Term Sickness D	3.9%	4.5%	3.7%	3.5%	3.5%	2.6%	2.7%	2.2%	1.8%	1.9%	2.5%	2.6%	2.9%		<=3 % N/A >3 %
Temporary Spend ('000s) D	104	120	135	148	183	122	47	21	189	194	169	173	212		No Threshold
Staff Turnover D	11.1%	11.6%	12.2%	12.2%	11.2%	10.6%	11.7%	11.8%	11.0%	11.0%	10.4%	9.7%	9.0%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) W	100.3%	96.7%	101.0%	94.1%				96.2%	99.5%	99.8%	99.8%	100.1%			>=90 % >=85 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF ICP (compliant) • All patients screened for potential COVID 19 prior to hospital visit using telephone triage • CRF ward compliant with all standards on Trust Dashboard • Good uptake from Staff for Flu vaccine • All Areas have been certified Covid Secure	**Highlight** • Mandatory Training > 98% • GCP training 97% • ANTT compliance 100%-CRF Ward –additional training places for CRD nurses secured **Challenges** • All Covid RAs complete for CRD some amber actions to complete • Keeping ward a covid risk free area with Oxford F/U's and flu vaccine sessions
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience	**Highlight** • X 0 Complaints • New Children's PRES developed for 20/21 • Positive results from last survey reported **Challenges** • More work to do on local patient internal audits • Collation of survey questionnaires from patients
EFFECTIVE	• Studies selected based on best possible outcomes for children and young people. • No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients. • Clinicians encourage children and young people to make informed decisions about participating in studies.	**Highlight** • Project restart on track current portfolio at 53% • Overall Recruitment figures for UPH studies second highest • X 12 UPH studies open within Trust • Successful completion of Pilot of Lateral Flow Testing (LAVA study) **Challenges** • CRF housekeeping • Project restart to meet NIHR ambition of 80% • Reduced clinical space on CRF ward due to social distancing measures affects patient activity • Staffing for LAVA study • Releasing delivery workforce capacity to allow the opening of new studies
RESPONSIVE	• All Staff Risk Assessments completed as required • New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local providers to offer joint training programmes.	**Highlight** • COVID secure certificates received • Agile working implemented to reduce footfall • A.H supporting the wider system with Covid UPH activity • HCW study recruitment target achieved • Partnership working with external partners **Challenges** • Staff working offsite to support adult vaccine studies • Last minute requests for external support • Effective clinical space to deliver HCW study clinics
	• PDR compliance increased to 79% • LTS absence rates have improved staff are supported through line managers and staff	**Highlight** • Long Term Shielding Staff have returned. • Division supporting staff with Flexible working

WELL LED	support. • Engagement with partners in relation to upcoming starting well initiatives.	**Challenges** • Sickness levels higher this month. • Increased numbers of staff having to self-isolate with local increased infection rates • Late requests for help can be challenging

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

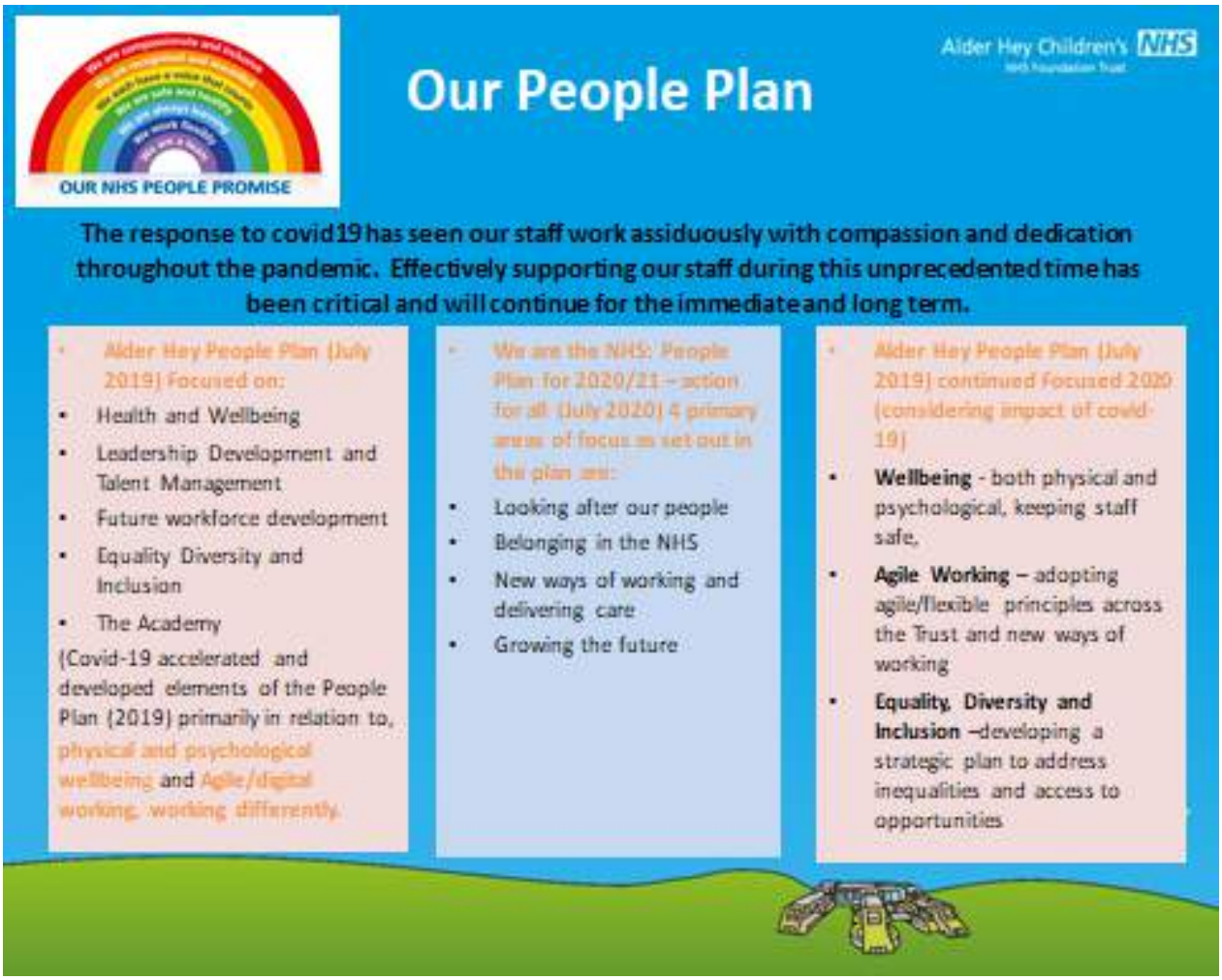
Thursday 17th December 2020

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

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

1. Purpose

The purpose of this paper is to provide the Board with a strategic update on the People Plan against the revised approach to the Alder Hey People Plan which focuses on three strategic areas; Wellbeing, Flexible Working and Equality, Diversity & Inclusion. In addition we are continuing to deliver the wider Alder Hey People plan and respond to the requirements of the national NHS People Promise.



2. Wellbeing

The focus on staff wellbeing remains of paramount importance and in light of our experiences during COVID 19, responding to staff's psychological and wellbeing needs is now even more crucial and essential for Alder Hey to be able to deliver first class, compassionate care. The SALS team continue to provide support and guidance across the organisation.

In December 2020 the Health and Wellbeing steering group is being relaunched, led by the SALS team. The steering group will bring together stakeholders from across the organisation into a collaborative focusing on improving the working lives of staff across the organisation.

The SALS team have applied for funding to support the training and development Mental Health First Aiders with a dedicated focus on our nursing and AHP workforce. The aim of this is to ensure we have local champions and support available for the staff groups with the highest areas of mental health related absences.

2.1 Leadership

The OD team have continued to build and develop the leadership support hub to provide leaders and managers with access to advice & guidance along with opportunities to request support for self or team including coaching/ mentoring and team interventions.

As part of the development of the in house coaching and mentoring framework to provide access to support across the Trust during November ten individuals successfully completed a four day Workplace Wellbeing Coaching course in partnership with the organisation Raw Horizons. These coaches will be working across the organisation supporting staff to focus and prioritise their health and wellbeing through the use of wellbeing approaches and techniques.

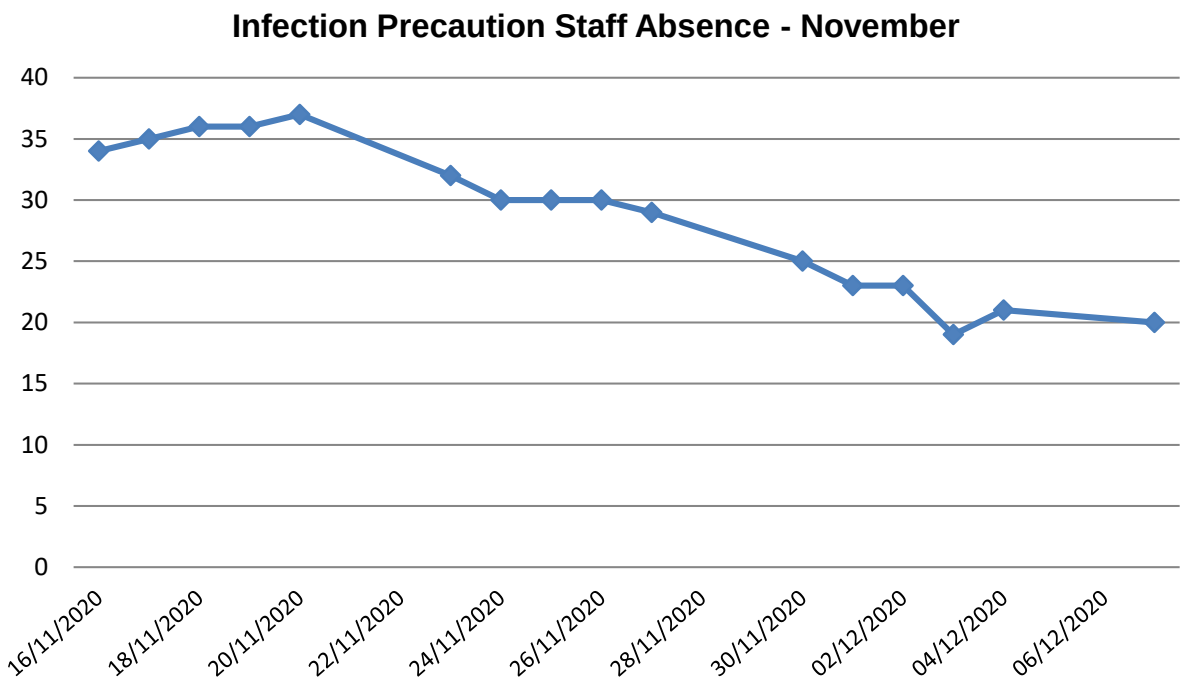
In addition work is continuing to support the development of the coaching framework through the national apprenticeship in coaching which will enable a sustainable, continuous development pipeline of new coaches within a cost effective framework.

2.2 Staff Availability

Table 1 - Sickness position 7th December 2020

Reason	Trust	
	%	No of Staff
Non Covid Related Sickness	5.23%	204
Covid Related Sickness	0.54%	21
Absence Related to Covid - not inc sickness	0.95%	37
Absence Related to Covid Inc Sickness	1.49%	58
All Absence (total of above)	6.72%	262

Following the changes to lockdown measures in England as of 2nd December 2020 and the return to the tier system, staff that were being advised to 'shield' during November due to being classified as Extremely Clinically Vulnerable are being supported to return to work. There are 13 members of staff absent due to shielding measures and the HR team are continuing to support teams across the Trust to facilitate return to work plans and support for these staff, ensuring that the necessary risk assessment and adjustments are put into place. In addition we are continuing also to support and facilitate home working were possible and temporary redeployment into alternative roles were appropriate.



The graph above demonstrates a downward trajectory in regards to staff absent due to self-isolating as a result of contact for Test and Trace services or household infection. As we move through winter the HR department will continue to monitor absences and support staff and managers to respond to any staffing concerns..

In response to the role out of testing across Liverpool as part of the city wide testing pilot and the role out of patient facing testing, the anticipated increase in COVID-19 related absences has not occurred and COVID-19 related absences are not adversely impacting our staffing levels. We will continue to monitor and assess the impact in order to provide support to managers and teams across the Trust

2.3 Staff Communication and Engagement

The Staff Survey 2020 closed on 27th November 2020 with a total response rate of 51% compared to 62% in 2019, however this is still to be verified by our survey provider. As a result of COVID-19, the national survey has been amended to include additional questions about staff experience during the pandemic. As in previous years, all staff received a survey and the HR and OD teams worked locally with managers to support and encourage all staff to tell us their stories and give us their feedback.

Table 2- Staff Survey Responses by Division

Directorate	Completion Rate
IM&T	76%
Corporate Other Department	73%
Finance	70%

Alder Hey in the Park	66%
Human Resources	63%
Nursing & Quality	63%
Research & Development	61%
Community	58%
Medicine	50%
Surgery	45%
Facilities	33%
Total	**51%**

3. Flexible Working

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

During December a Trust wide survey has been launched to gather information and feedback from staff and managers on their experiences of working flexibly and feedback from this session will be utilised to developing training and guidance for managers. On 8th December the flexible working task group launched its first management session with mangers from teams across the organisation to understand what support and guidance is needed moving forward and in January a number of sessions will take places focusing on managing teams and performance remotely. We will also be hosting events for staff working from home to support them to work differently and ensure providing the necessary resources to facilitate flexible working.

As part of a review being led by the Director of HR and OD into corporate estates a plan is being drawn up to facilitate flexible working options in the long term and looking at how the office space across the Trust is utilised effectively.

A detailed update is being provided to Strategic Executive committee at the end of December and further information on actions and next steps will be provided in January 2021.

3.1 E- Roster

In November 2020 the trust purchased the Allocate Healthroster system (E-Roster). Workshops and process mapping sessions have been taking place with the identified Phase 1 managers and key stakeholders during November. The system is undergoing configuration in early December for our Medical staff for the management of Annual leave, Study leave & Sickness. Training will be offered during December by the Allocate team with handover of the process to the Trust E-Roster team taking place from January 2021.

The facilitation, configuration and development of the rosters for Phase 1 of the system roll out will take place during January 2021 with the aim of having the first Healthrosters published on 28th January with the first live payroll taking place in April 2021. During February 2021 Phase 2 of the programme will be launched and the remaining roll out plan is currently being finalised.

4. Equality, Diversity & Inclusion

A Taskforce, commissioned by the Trust Chair and led by Claire Dove OBE, commenced in October 2020, and will be responsible for a focused review of process and practice relating to EDI, with a view to recommending and implementing specific actions to improve EDI across the organisation. This will specifically focus on looking at access to jobs and opportunities, the role the Higher Education Institutions play in increasing diversity and how we use apprenticeships. As part of this group a task and finish group focusing on Recruitment has been established with stakeholders from across the Trust

5. Apprenticeships

In response to COVID-19 the majority Apprenticeships have been able to continue with the support from the apprenticeship team and line managers with those deferring working with providers to return to education.

In order to facilitate the continued delivery of Apprenticeships programmes, delivery of learning has moved online with providers and Tutors redesigning delivery models by being innovative and the adoption of technology. This has included ensuring staff had access to the relevant equipment and resources to continue to access learning and the provision of additional support programmes for those requiring support utilising IT and technology by our specialist Functional Skills Tutor.

Throughout the pandemic we have been able to work in collaboratively with line managers to ensure we continue to drive forward the Apprenticeship agenda with an additional 37 individuals identified to undertake apprenticeship programmes. We have also been successful in utilising the increased opportunities available through new Apprenticeship Standards and the procurement of new HEIs and Colleges to support departments with workforce planning. The increase in opportunities available is enabling us to continue working towards the achievement of our Public Target Duty.

Since the introduction of the apprenticeship levy in 2017, to date we have successfully identified 152 individuals in total to undertake apprenticeship programmes enabling us to

support the development of our workforce with 45 individuals successfully completing their programmes

6. Governance and Ongoing Business

6.1 Case Management

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

In December there are 23 cases currently ongoing as detailed below.

Table 2- Employee relations activity per division as of 8th Decemebr 2020

Division	MHPS	Disciplinary	Grievance	B&H	ET	Total
Surgery	2	4	2	1	0	**9**
Medicine	1	0	1	0	0	**2**
Community	0	3	0	0	0	**3**
Corporate	0	3	0	0	0	**3**
Grand Total	**3**	**10**	**3**	**1**	**0**	**17**

6.2 Training

At the end of November 2020, Mandatory Training was at 85.5% overall which is below our target of 90%. This is primarily caused by the reduction in compliance across topics that have annual refreshers. In October 2015 a Trust wide project that was undertaken in line with staff transitioning across to the Alder Hey in the Park site to ensure all staff had the relevant mandatory training and therefore there is an increase in the requirements for staff to undertake mandatory training during November and December. In addition a number of topics require some or all of the training to be delivered face to face such as Practical Moving and Handling and Resuscitation Training which has been made much more challenging given social distancing requirements.

The L&D team continue to work with the subject matter experts and management structures to ensure that current compliance is visible and transparent as well as supporting them to improve compliance where required.

Despite this drop in compliance the majority of our mandatory training continues to meet our 90% target which is very positive given the current challenges of the pandemic and winter pressures. This is also positive in comparison with other Trusts around the region where we are aware of other Trusts within Cheshire & Merseyside who have been exploring reducing their mandatory training targets to take into account the current challenges.

Table 3- Mandatory Training compliance November 2020

Trust	Overall Mandatory Training
Trust	**85.80%**
Division	Overall Mandatory Training
411 Alder Hey in the Park	**85.19%**
411 Community	**89.22%**
411 Corporate Other Department	**80.96%**
411 Facilities	**57.56%**
411 Finance	**86.81%**
411 Human Resources	**80.69%**
411 IM&T	**92.39%**
411 Innovation	**98.18%**
411 Medicine	**88.86%**
411 Nursing & Quality	**88.98%**
411 Research & Development	**92.41%**
411 Surgery	**84.75%**

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Board of Directors

Thursday 17th December 2020

Report of	Development Director
Paper prepared by	Associate Development Director- (07/12/2020) Sue Brown
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Trust Directors Report

17th December 2020

Campus Development report on the Programme for Delivery

1. Introduction

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

As of Month 1 in Quarter 3 of 2020/21 the programme Delivery Timetable rag rates projects against planned commencement date.

2. Programme Delivery Timetable

A new row has been added to the programme plan for monitoring of relocations from retained estate.

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

Table 1.	19/20	20/21				21/22				22/23
Scheme	**Qtr. 4**	**Qtr.1**	**Qtr.2**	**Qtr.3**	**Qtr.4**	**Qtr.1**	**Qtr.2**	**Qtr.3**	**Qtr.4**	**Year**
Initial Park Reinstatement (Phase 1)										
Alder Centre occupation **COMPLETE**										
Acquired buildings occupation Future use under review										
Police station (LF) occupation										
Commence relocations from retained estate. 2020 relocations **COMPLETE**									Final phase	
Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks)										Final phase
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										

3. 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. The current financial status of projects is as follows:

Table 2.

Table 2.

Estates Savings Target	Budget	Revised Budget	Best Case	Most Likely	Worst Case	Nov Comments
The Park	1,750	1,750	3,234	3,454	3,634	Based on estimates following quotes for Phase 1
Attenuation	600	600	600	750	800	
Alder Centre	2,184	2,184	2,416	2,426	2,426	The charity have now underwritten the funding shortfall @ £204k. £242k overspend includes external works in relation to paths.
C Cluster Hub & Dewi	19,822	19,822	19,822	20,017	20,017	As agreed by Trust Board - £195k overspend
Infrastructure - Utilities	1,200	1,428	1,428	1,548	1,668	Budget increase £228k via Critical Infrastructure Risk PDC funding
Landscaping	481	481	481	529	577	Slight risk as the plan has not been developed. However there is potential to combine this with the Neonates
Infrastructure - Roads (inc s278)	858	950	950	1,036	1,122	Budget increase £92k via Critical Infrastructure Risk PDC funding
Demolition and decomm	2,356	2,593	2,796	2,796	3,000	Asbestos removal costs will exceed budget as higher than the cost estimated prior to CHP development – pressure is C. £300k. Budget increased by £237k via Critical Infrastructure Risk PDC funding for Boilerhouse demolition acceleration. Includes estimated £400k to remove Asbestos Dump from site
Relocations	1,227	1,227	1,100	1,187	1,227	Mersey design working on police ground floor £6.5k
Neonatal	11,869	16,800	17,000	17,100	17,300	The Trust has agreed up to £16.8m. The current estimates are £17.1m
Development team	1,100	1,100	1,135	1,135	1,135	Slightly over budget
Institute re-works	360	360	120	300	360	
Office Requirement	3,000	3,000	2,570	2,570	3,050	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.
Staff removals	250	250	250	250	250	
Car Park	100	100	100	140	140	Inc £40k for Temp car park barriers
ED Enhancements (UEC)	1,441	741	741	741	1,441	PDC funded scheme - part costs reflected in Neonatal line
Isolation Pods (Covid)	1,800	1,800	1,400	1,500	1,800	PDC funded scheme
	50,955	**55,186**	**56,143**	**57,479**	**59,947**	
Revised Budget	50,916	55,186	55,186	55,186	55,186	
Under/(Over) Budget	**-39**	**0**	**-957**	**-2,293**	**-4,761**	

*** There are plans to sell Alder Park in 2022. The sale is expected to be between £0.5m - £1.5m

*** There is an option to buy back land circa 1.5 acres. The cost of this would be between £1m-£2m

Capital programme to the 7th of December 2020

The format of this table shows a range of values from 'best case', 'most realistic' and 'worst case'. The principal over spending projects remain as:

- Neonatal potential overspend against the revised budget of £16.5m, this has reduced over the last month by a further £0.2m and is currently £0.3m over the target budget set by RABD at £16.8m Value engineering changes and work continues to reduce it furthe
- Work is ongoing with both of these schemes in an attempt to bring them within budget.

4. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Horticon have been completing works on phase one parks, due to inclement weather and more specifically rain the site is water logged and the conditions are therefore not conducive to sowing the grass seed, this will now be delayed for 3 months and competed in March ongoing concerns and objections by some local residents to the location of the Multi-Use Games Area (MUGA) which as shown on the consented drawings, is by the Alder Road boundary. We are currently out to further consultation which will conclude on the 13/12/2020 as to wether the MUGA is sited directly next to Alder Road near to where a planned car park is, or to the south more embedded into the park away from Alder Road residents.	Delivery of phase one of the park will not Complete in December 2020 due to concerns raised by the public on the proposed siting of the Multi-Use Games Area (MUGA) and inclement weather. Public perception that the park phase one is not being delivered	Continued meetings with planners and LCC parks officers to resolve the location. Further consultation with relevant parties in the immediate surrounding area is taking place virtually. This is currently in process and will complete mid-December. This was a requirement of the Liverpool City Council planners. Capacity lab continues to engage with groundworks on a regular basis and involve stakeholders.

Alder Centre

Current status	Risks & Issues	Actions/next steps
Development complete		Build and project complete

Acquired Buildings Occupation (neighbouring sites)

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

Police Station (lower floor) occupation

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

Relocations

Current status	Risks/issues	Actions
All planned moves for September to November have been completed, these were only possible due to many staff working from home, a longer term plan is now required for 2021.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	The Director of HR and OD along with the development director will be taking some time to work through a long term estates strategy, this will include a plan for desk/office supporting accommodation for both clinical and non-clinical staff.

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

Current status	Risks/issues	Actions
Works are now progressing on temporary services and diversions to enable demolition, although more planning is required to co-ordinate these activities. Oncology, genetics and management blocks have all now been vacated and are being decommissioned prior to handover to the Beech Ltd for demolition.	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 services/departments.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Capacity Lab are discussing the setting up of a community driven organisation, with the local community to gain consensus to the preferred approach/option this is likely to be a Community Benefits Society. The detailed information is currently in progress and roles being defined. 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. Currently the group of interested parties are considering roles and a questionnaire has been sent to them to help understand their level experience and interest.	Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 16) Budget for Phases 2 & 3 is inadequate	Monthly review of the programme and progress with Capacity Lab, with weekly presence on site. Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress. Working with landscape designer to reduce costs within the parameters of the Land Exchange Agreement.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
Masterplan of Infrastructure works is currently being prepared. Roads and landscaping – the Trust is currently working with Turkington Martin landscape designers to shape the East/Eaton Road end of the new campus. This is likely to be taken forward in a number of phases as the new builds develop. It will also include the Blue Light access to the Children's Health Park Planning for the new infrastructure is progressing in line with the overall delivery programme for the campus developments.	Early indication is that to complete all of the work, further capital may be required if a truly world class frontage to the site is to be achieved.	Ensure timely process /programme is adhered to.

Clinical Hub and Dewi Jones Construction

Current status	Risks/issues	Actions
Contract with Galliford Try in the summer commenced early August and remains on programme with good visible progress.	Ongoing design development potentially could raise issues of quality leading to increases on cost.	Continue with weekly meetings with Galliford Try and challenge design where necessary.

Demolition Phase 4 (Final)

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

Neonatal Development

Current status	Risks/issues	Actions
RABD approval for £16.5M , this required some value engineering to bring the estimated costs down before going to the market for construction. The costs have been reduced following some value engineering and reduction of the GIFA from £17.8m to £16.8 with a target to get back to the revised budget of £16.5m. This introduced a 4 weeks delay to the overall programme. Further delay for a period of 8-12 week has been agreed whilst further design work on emergency care facilities are planned with the Emergency department teams for the capacity on the ground floor of the planned build (shell and core area). On the Neonatal element of the project the design is currently at stage 3 and will ready to tender at conclusion of the stage, continued work will then progress to stage 4. Following expressions of interest for construction, 10 organisations expressed an interest, however only two parties registered interest (Interserve and Galliford Try) following further dialogue with one of the parties Morgan Sindell may also be interested. .	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 Lack of interested from the construction market competitors. Impact of Covid-19 on construction costs. Planning permission fails to be achieved within the timescale of the overall programme delivery.	Work with the design team and team to further reduce costs through the Stage 3 design. Continue working with Project Co to mitigate impact. Work with LCC planners to minimise impact Consideration may be given to an OJEU tender. Monitor the market for construction cost inflation and robustness of supply chain. Maintain open communication with the LCC planning departments.

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
No change since last month. **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 the trust. Several work streams are taking place to review potential service enhancements. These include Rehabilitation, Patient/Family Hotel, independent living accommodation for complex needs CYP and outpatient rehabilitation. Business cases for each of the work streams will be brought forward over the next 4 to 6 months.	Local community resistance to Trust non-development aspects and planning submission. Cost of providing the developments do not match income from commissioners	Maximise our offering/ support /negotiation on development content and opportunities. Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability. Produce robust business cases to highlight any issues/risks.

Communications

Current status	Risks / issues	Actions/next steps
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.	Loss of reputation, locally and regionally. Lack of engagement internally and externally	Maintain links with community and support their development work.

Car Parking

Current status	Risks/Issues	Actions/next steps
The Trust have agreed and signed aa lease for space at the Thomas Lane playing fields.	Staff resistance to change.	Review car parking requirements in view of the home working currently

The car park will provide 134 spaces and will be open from 6am-6pm Monday to Friday from mid-January and will support the closure of spaces on the Alder Hey site to allow for demolition and then phase 2 of the park to progress The criteria for allocating spaces has been agreed the communication on this is currently being rolled out, an appeals process has also been developed and staff will submit a form for review should they believe they fit the criteria.	Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	in play due to COVID 19 and what the future requirements might look like. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan.

5. Additional elements to be added to the next status report.

The development team will add in a further programme next month in relation to progressing with future office accommodation for Corporate staff , this may also incorporate a separate piece of work on redesigning the CHP layout of level two offices in line with the Workspace (WKS) report and recommendation completed earlier this year.

6. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 7th December 2020.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 17th December 2020

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

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

Board Assurance Framework 2020/21

1. Purpose

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

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

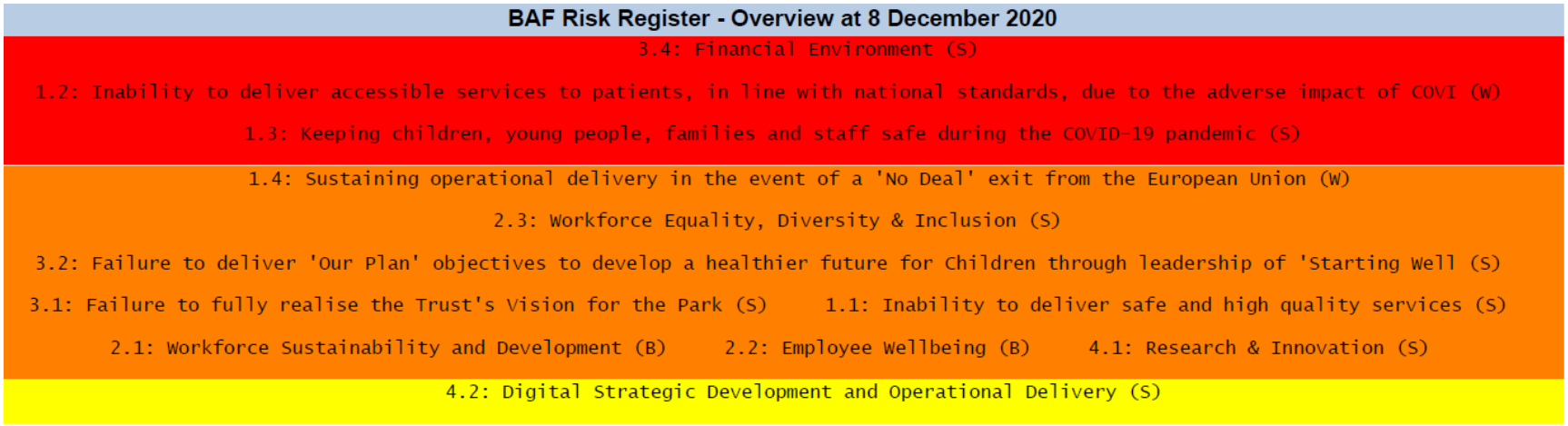
2. Review of the BAF

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

BAF Risk		Reviewed By
1.1	Inability to deliver safe and high quality services	Safety & Quality Assurance Committee
1.2	Inability to deliver accessible services to patients, in line with national standards, due to rising demand	Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
4.2	Digital Strategic Development and Operational Delivery	Resources and Business Development Committee
4.1	Research & Innovation	Innovation Committee
1.3	Keeping children, young people, families and staff safe during COVID-19	Trust Board
1.4	Sustainable operational delivery in the event of a 'No Deal' exit from EU	Trust Board

Overview at 8th December 2020

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



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

Report generated by Ulysses

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

3. Summary of BAF - at 8th December 2020

The diagram below shows that two risks improved their score in-month. The risk relating to Sustainable operational delivery in the event of a 'No Deal' exit from EU increased in score to reflect the upcoming changes from 31 Dec 2020. Inability to deliver accessible services to patients, in line with national standards, due to rising demand also saw an increase in score.

Ref, Owner	Risk Title	Board Cttee		Risk Rating: I x L		Monthly Trend	
				Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care							
1.1 NA	**Inability to deliver safe and high quality services**	SQAC		3x3	2x2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to rising demand**	SQAC		**4x5**	3x2	STATIC	**INCREASED**
1.3 JG	**Keeping children, young people, families and staff safe during COVID-19**	Trust Board		**5x3**	3x3	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	Trust Board		4x3	3x2	STATIC	**INCREASED**
STRATEGIC PILLAR: The Best People Doing Their Best Work							
2.1 MS	**Workforce Sustainability and Development**	PAWC		3x3	3x2	STATIC	IMPROVED
2.2 MS	**Employee Wellbeing**	PAWC		3x3	3x2	STATIC	IMPROVED
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC		4x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships							
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	ARC		3x3	3x2	STATIC	STATIC
3.2 DJ	**Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships**	RABD		4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**	RABD		**4x5**	4x3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation							
4.1 CL	**Research & Innovation**	Innov.		3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**	RABD		4x1	4x1	STATIC	STATIC

8. Summary of November updates:

External risks

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

  Risk reviewed; no change to score in month. Covid impact remains significant but progress in system working, for example HCP C&YP developments. Recommend risk review & update in Q1 2021 in line with Trust Board post-covid strategy update.

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

  Risk reviewed in month. All actions updated.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***

  A series of checklists have been received from NHSE. We are currently in the process of benchmarking AH against these.

  Our roadmap plans and risk assessments are progressing well and due to be finalised for 7th Dec.

  Our intranet page and FAQ's have been updated and Trust wide comms are to be launched to update staff on progress.

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to rising demand (AB)***

  Current risk score increased to 20 to account for two key factors.

  Firstly, to reflect the impact of COVID-19 has had on elective waiting times with approximately 140 children waiting over 52 weeks for surgical treatment, which remains an ongoing challenge.

  Secondly, issues with data quality affecting the accurate reporting and tracking patients on the waiting list. This score does not relate to patient harm as we have no confirmed cases of harm.

  In response to the issues with data quality we have strengthened our Safe Waiting List Management programme with an Executive oversight group. We are focused on validation, review of waiting list report constructs and clinical review of patients. The number of long waiting patients in November is 148 (subject to final validation). 147 of the patients are awaiting surgical care, with one patient waiting in community paediatrics. Against the progress targets we set in October we note significant progress in the community division, with significant challenges remaining in access to surgical care (particularly inpatients). To mitigate this we have the safe waiting list management; operational management of long wait patients; transformational projects commenced in outpatients and theatres; and our restoration programme which is increasing capacity. We are keeping patients safe on the waiting list through clinical review and clinical harm review where required. Our progress with restoration is as follows: 1) Daycase and inpatient operations & procedures: we achieved 92% restoration (an increase of 5 percentage points from October) 2) outpatient consultations: reached 94% of pre-COVID-19 levels (an increase of 10 percentage points from October) 3) Radiology- achieved 89% restoration against the 90% target.

- ***Keeping children, young people, families and staff safe during COVID-19 (JG)***
  Covid response and restoration has been well managed and the Trust is in a relatively strong position at this point both in terms of restoration and managing risk of infection. Key next phases include vaccination roll out, maintaining capacity through winter and remaining vigilant for a third phase.

- ***Inability to deliver safe and high quality services (NA)***
  Risk reviewed and current controls appropriate. There is a need to review the risk and articulate this in the context of the changes in the health and social care economy. There is a plan to fully review this strategic risk during Q4 and to work with the board and appropriate subcommittee to review and approve.

- ***Financial Environment (JG)***
  The 2020/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction. The framework beyond this year remains uncertain, expected guidance is due to be released mid-December. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Risk reviewed for November - no change to score in month. All actions remain on track

- ***Digital Strategic Development and Operational Delivery (KW)***
  BAF reviewed, risk score at target, future actions on track against plan.

- ***Workforce Sustainability and Development (MS)***
  Risk reviewed in month, current score decreased and actions reviewed.

- ***Employee Wellbeing (MS)***
  Risk reviewed in month. Score reduced and additional actions identified.

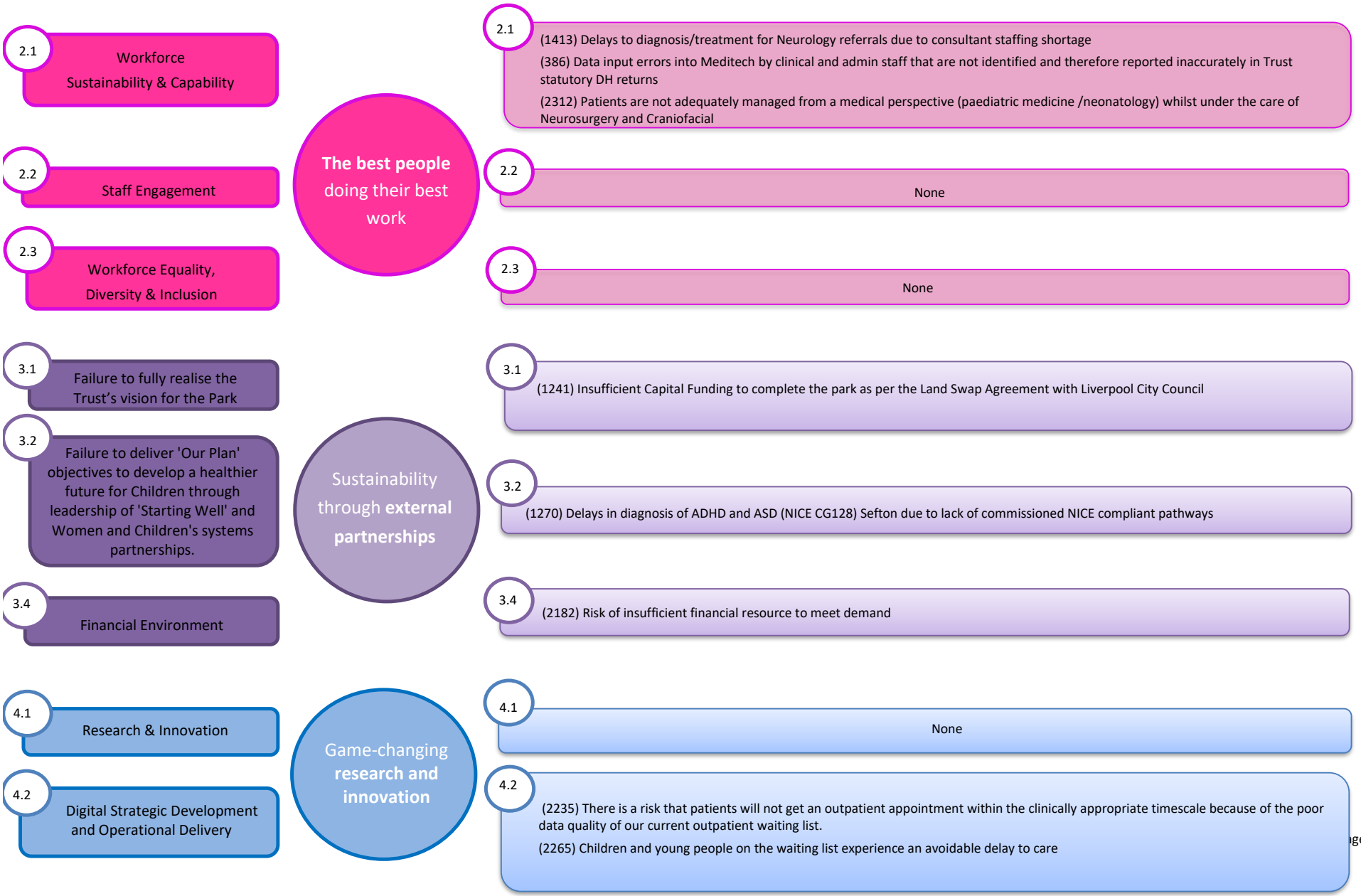
- ***Research & Innovation (CL)***
  Risk reviewed with no change to score in-month. Full update to risk to be actioned from January 2021.

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 1st December 2020

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	1.1 (1413) Delays to diagnosis/treatment for Neurology referrals due to consultant staffing shortage. Current RTT performance is 33% with 454 patients waiting over 18 weeks for a first outpatient appointment and 1,997 overdue follow up patients. (1159) There is a risk that we are not able to make infectious waste safe prior to disposal, this would result in the stockpiling of CL3 waste which has to be stored on site until the device is repaired. The inability to make safe CL3 waste in a timely fashion contravenes HSE guidance. (2192) Delay in treatment due to the ASU having to use one isolator for both CIVAS and cytotoxic products (2229) Unable to fully coordinate care for traumatically injured patients. (2233) Failure to meet QST Major Trauma peer review standards. (2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list. (2242) Risk of self-harm due to inappropriate clinical placement (2265) Children and young people on the waiting list experience an avoidable delay to care (2138) There is a risk that front line nurse availability to work will be significantly compromised during winter 2020 / the second covid peak and that compliance with national nursing standards for safe staffing levels on wards and departments will not be met (RCN / PICS / BAPM / QNIC / NQB) and / or the ability to have beds / services will be significantly affected (386) Data input errors into Meditech by clinical and admin staff that are not identified and therefore reported inaccurately in Trust statutory DH returns (2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
1.2 Inability to deliver accessible services to patients, in line with national standards, due to rising demand		1.2 (1524) Young people over 16 years age are unable to access adult specific ADHD services which includes prescribing and review of medication. (2233) Failure to meet QST Major Trauma peer review standards. (2270) Repeated failure to submit data to Trauma & Audit Research Network (TARN) accurately and within the required timeframe.
1.3 Keeping children, young people, families and staff safe during COVID-19		1.3 (2180) Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained
1.4 Sustainable operational delivery in the event of a 'No Deal' exit from EU		1.4 None


2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.
3.4
Financial Environment
Sustainability through external partnerships
4.1
Research & Innovation
4.2
Digital Strategic Development and Operational Delivery
Game-changing research and innovation
2.1
(1413) Delays to diagnosis/treatment for Neurology referrals due to consultant staffing shortage
(386) Data input errors into Meditech by clinical and admin staff that are not identified and therefore reported inaccurately in Trust statutory DH returns
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
2.2
None
2.3
None
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
(1270) Delays in diagnosis of ADHD and ASD (NICE CG128) Sefton due to lack of commissioned NICE compliant pathways
3.4
(2182) Risk of insufficient financial resource to meet demand
4.1
None
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 1413, 2235, 2242, 1159, 2192, 2265, 2233, 386, 2312		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. International recruitment in line with UK Guidance International nurses commenced in post Feb 20	31/12/2020	Nurses who joined the Trust from India in February 2020 have all successfully passed their OSCE test and are fully registered with the NMC and in practice on the wards

		Second cohort of 15 nurses from India have arrived in UK end of October 2020, currently 2 weeks quarantine. Induction programme, OSCE training and date for OSCE assessment (December 2020) all arranged
Alignment of workforce plans across the system	31/12/2020	Winter and Covid staffing plan devised in collaboration with Ward Managers, Matrons, Heads of Nursing, ACNs defining clear escalation and "red line" staffing levels in times of extreme pressure. Registered nurse to patient ratios to be presented at Execs; signed off by incoming Chief Nurse. Regional C&M work to agree staffing ratios underway; Alder Hey model to be shared with ACCN to benchmark Continued recruitment particularly to specialist areas. Low vacancies however large number of staff unavailable to work linked with sickness, shielding and self isolation. 20 nurses have started in September with further 38 in October and 15 international nurses who undertake OSCE 22nd December Review of NHSP rates underway

Executive Leads Assessment

December 2020 - Nathan Askew
Risk reviewed and current controls appropriate. There is a need to review the risk and articulate this in the context of the changes in the health and social care economy. There is a plan to fully review this strategic risk during Q4 and to work with the board and appropriate sub committee to review and approve.

November 2020 - Pauline Brown
Winter and Covid staffing plan approved by Executive team following wide collaboration with Ward Managers, Matrons, Heads of Nursing and ACNs. Associated QIA / EA devised. ,

Agreement to incentivise winter NHSP shifts for front line nurses; to be reviewed in December 2020

Further 38 nurses joined the Trust in October; 15 nurses from India arrived end of October, currently in quarantine for 2 weeks prior to induction, OSCE training and assessment on 22nd December

Safety day planned for November to be held by MD and new Chief Nurse

October 2020 - Pauline Brown
Winter and Covid staffing plan devised in collaboration with Ward Managers, Matrons, Heads of Nursing, ACNs defining clear escalation and "red line" staffing levels in times of extreme pressure. Registered nurse to patient ratios to be presented at Execs; signed off by incoming Chief Nurse. Regional C&M work to agree staffing ratios underway; Alder Hey model to be shared with ACCN to benchmark

Continued recruitment particularly to specialist areas. Low vacancies however large number of staff unavailable to work linked with sickness, shielding and self isolation. 20 nurses have started in September with further 38 in October and 15 international nurses who undertake OSCE 22nd December
Review of NHSP rates underway

Pressure Ulcer Quality Summit held September 29th with 55 staff in attendance and CCG attendance. Outputs and next steps for wide dissemination

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2270, 2233, 1524		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x2	Trend: INCREASED

Assurance Committee: Safety & Quality Assurance Commitee

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
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Assessing incentivised models to support an increase in restoration activity levels	31/12/2020	remains ongoing
Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training.	18/06/2021	
Outpatient transformation project supports surgical specialties to increase restoration to > 100%	01/03/2021	
12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce	07/12/2020	
Theatres transformation project supports surgical specialties to increase restoration to > 110%	07/12/2020	

Executive Leads Assessment

December 2020 - Adam Bateman
I have updated the current risk score to 20 to account for two key factors. Firstly, to reflect the impact of COVID-19 has had on elective waiting times with approximately 140 children waiting over 52 weeks for surgical treatment, which remains an ongoing challenge. Secondly, issues with data quality affecting the accurate reporting and tracking patients on the waiting list. This score does not relate to patient harm as we have no confirmed cases of harm.

In response to the issues with data quality we have strengthened our Safe Waiting List Management programme with an Executive oversight group. We are focused on validation, review of waiting list report constructs and clinical review of patients.

The number of long waiting patients in November is 148 (subject to final validation). 147 of the patients are awaiting surgical care, with one patient waiting in community paediatrics.

Against the progress targets we set in October we note significant progress in the community division, with significant challenges remaining in access to surgical care (particularly inpatients). To mitigate this we have the safe waiting list management; operational management of long wait patients; transformational projects commenced in outpatients and theatres; and our restoration programme which is increasing capacity. We are keeping patients safe on the waiting list through clinical review and clinical harm review where required.

Our progress with restoration is as follows: 1) Daycase and inpatient operations & procedures: we achieved 92% restoration (an increase of 5 percentage points from October)
2) outpatient consultations: reached 94% of pre-COVID-19 levels (an increase of 10 percentage points from October)
3) Radiology- achieved 89% restoration against the 90% target

November 2020 - Adam Bateman
In October our restoration programme status is as follows:

a) Daycase and elective - is at 87% against a target of 90%. Whilst this is below the target it represents a real step-forward in restoration increasing from the 80% achieved in September.

b) Outpatients restoration (for the NHSE definition) is at 84% against a target of 100%. This is lower than the 90% achieved in September and has been affected by transition to the new outpatient schedule and higher COVID-19 community prevalence. The latter manifested in an increase of 254 patient cancellations, or 12%.
c) Radiology- achieved 88% restoration against the 90% target. This is the same level of restoration as was achieved in September.

On access to care our In performance status is as follows:
In October there are 145 patients waiting over 52 weeks for treatment; this is the same as September and thus the number of long waiting patients is static.

In order to redress this and reduce the number of long wait patients some additional goals have been agreed between the clinical Divisions and the Executive Team:
1. No surgical inpatient waiting >52 weeks by 31 December 2021 with the exceptions of ENT; Paed Surgery; Ortho & Spinal
2. No surgical outpatient waiting > 52 weeks by 30 November 2020, with the exception of the Pain service which will still have 12 patients waiting > 52 weeks. In Pain the goal is to have no long waiters by end of March (ie reduce by 2-3 per month).
3. No community paediatrics patients waiting over 52 weeks by the 30 November 2020.

A restoration plan for elective and outpatient services was presented to the Executive Team in November.

October 2020 - Adam Bateman
The number of patients waiting over 52 weeks is 145. We are not . Of which there are 10 patients in community paediatric. In community there is a plan to increase capacity to bring the maximum wait down to 46 weeks. The majority of long-wait patients are awaiting surgical care. There is focus on increasing surgical and outpatient capacity, see actions below, to reduce long waiting times but the issue of staff availability is affecting our ability to do this. At the end of September our level of restored services is as follows: 90.3% outpatient restoration, 80% inpatients/daycase restoration and 87.8% Radiology. Actions taken to reduce the gap between current restoration and target: 1. new outpatient schedule is on-track to go-live on Monday 26 October and it will increase F2F outpatient capacity and support delivery of the 100% restoration target. 2. Additional Attend Anywhere training w/c 12/10 to increase use of digital consultations 3. Additional weekend activity in outpatients (weekend spinal and cardiology lists) and in theatres (Saturday 17/10) 4. extended day for ultrasound and MRI scanning Challenges to staff availability are increasing with three staff outbreaks in September, one of which was potentially hospital-acquired (Radiology). In theatres the reduction in anaesthesia availability affected theatre restoration; 12% of theatre sessions On Safe Waiting List Management, a detailed report was delivered to RABD on the response to this. As of the 13 October 2020 100 of the 102 inpatients who were waiting over 52 weeks as at July 2020 have now received treatment. The remaining 2 patients have been contacted to access treatment but there are some challenges in arranging this with the families. No harm has been reported on Ulysses relating to the delay in treatment. Nonetheless, on the 12 October 2020 it was agreed with the COO and the Divisional Director for Surgery that a more formal post-treatment harm review will take place.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Keeping children, young people, families and staff safe during the COVID-19 pandemic		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring		Link to Corporate risk/s: 2170, 2180		
Exec Lead: John Grinnell	Type: External,	Current IxL: 5x3	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Trust Board

Risk Description

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

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

Gaps in Controls / Assurance

Staff availability to meet capacity plans through the winter

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increase awareness and vigilance around keeping staff safe from Covid-19 by maintaining social distancing.	31/12/2020	The PPE audits are underway as part of Perfect Ward audit. Poster signage is on view in the wards & communications of PPE via (CAG, weekly briefings etc). If outbreaks - targeted education to that area.
Ensure actions that have been identified through COVID-secure risk assessments take place	31/12/2020	Work continues regarding the installation of protective screening
Oversight Group initiated focussing on redeployment,	31/03/2021	

temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment		
Vaccine roll-out	31/03/2021	On 2nd December 2020 the Department of Health and Social Care announced that the Government had accepted the recommendation from the independent Medicines and Healthcare products Regulatory Agency (MHRA) to approve Pfizer/BioNTech's Covid-19 vaccine for use.

Executive Leads Assessment

December 2020 - John Grinnell
Covid response and restoration has been well managed and the Trust is in a relatively strong position at this point both in terms of restoration and managing risk of infection. Key next phases include vaccination roll out, maintaining capacity through winter and remaining vigilant for a third phase.

November 2020 - John Grinnell
Overall Covid response remains controlled given the environmental risks were operating in. Staff availability remains a key risk which could be further impacted by the roll out of A-symptomatic staff testing. Our ongoing focus in improving access to services for C&YP.

October 2020 - John Grinnell
Winter Plan and Covid phase 3 approved by Board with implementation underway. Gold Command initiated given the scale of the response required. Key areas of focus are on staff availability and our role in maintaining access to C&YP across Cheshire & Mersey.

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: 4x3	Target IxL: 3x2	Trend: INCREASED

Assurance Committee: Trust Board

Risk Description

In the event of a 'no deal' exit from the EU there maybe disruption to Alder Hey supply chain. Significant National, Regional and Local action is underway to safeguard the organisation's ability to deliver services safely and maintain business continuity. The 11 month transition period underway within which plans have been developed and finalised in readiness for full exit on the 31st Dec 2020. The NHS Strategic Commander (Keith Willett) hosted a webinar on the 9th Nov which confirmed requirement to prepare for a No Deal exit on the 31st Dec. We have a well developed infrastructure and Subject Matter Expert team in place to support Alder Transition.

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alder Hey Brexit group formally recommenced and will now review Road Map and Operational Plans. Meeting bi-weekly.	31/12/2020	Supplier list received from NHSE which will confirm central/local supplier review Walkabouts to be recommenced SME review and feedback or risk assessments
each lead aware of the above requirement To feedback formally to the group To develop plans where required	11/12/2020	SME teams have been reviewing local/national guidance and updating their respective risk assessments and business continuity plans Procurement team have completed their local reviews and are now liaising with departments to support stock management. SME's are finalising Roadmap detailed up to and beyond EU exit. All documents are located on the K Drive / EU Exit
Procurement Team have completed their initial assessment of suppliers (excluding those being reviewed Nationally). Feedback provided to the EUX group.	07/12/2020	
provide a week by week breakdown of action required up to and beyond the 31st Dec. This will provide a "roadmap" for us to follow.	07/12/2020	

Executive Leads Assessment

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

November 2020 - Lachlan Stark
NHSE seminar on 9th October confirmed preparation required for No Deal on the 31st Dec.
Feedback from the seminar was that plans are now well developed with learning from the 1st wave of the pandemic shaping our NHS response.
There will be reduced traffic through the short straits regardless of whether a deal is in place or not however plans are developed to offset this.

October 2020 - Lachlan Stark
New Series of Monthly meetings to commence w/c 7th Sep. Each lead has been tasked with liaising with their professional bodies to scope out current guidance and feedback on any risks/issues for the group to consider. No new National Guidance has been issued. Await 15th October deadline

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: 1413, 386, 2312		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: IMPROVED

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	28/02/2021	There has been a drop in mandatory training compliance , as a result of the covid pandemic. All e-learning training has continued throughout. L&D are focusing on a recovery plan to bring the compliance position back to 90%.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	31/12/2020	to be reviewed in line with divisional workforce planning process
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	31/03/2021	The inaugural meeting of the Recruitment and Apprenticeship task and finish group met in Nov 2020, with a clear and Robust action plan to address diversity and inclusion in Recruitment, Selection and Retention.
2. HR/Managers/SALS and Wellbeing officers are working together to wrap around and effectively support all	31/01/2021	HR/Managers/SALS and Wellbeing officers are working together to wrap around and effectively support all absences. Deputy HR

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

Executive Leads Assessment
December 2020 - Melissa Swindell Risk reviewed in month, current score decreased and actions reviewed.
November 2020 - Melissa Swindell actions updated and progress monitored through the PAW Committee
October 2020 - Sharon Owen Actions from both the NHS people plan and the Trust people plan are being progressed in respect of workforce planning.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
SALS Offer: ensure psychology post is permanent and full time given increase in demand for SALS over the past few months.	10/01/2021	Clinical Psychologist now appointed into SALS (6 month fixed term). SALS manager now in post (permanent). Business Case being developed to be agreed in Jan 2021
Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to determine future service development and delivery that meets demand and is integrated with internal and external counselling provision.	31/03/2021	
Liaise with Regional Resilience Hub as it develops and ensure Alder Hey staff can access the screening tools and support can be offered	01/04/2021	

Executive Leads Assessment

December 2020 - Melissa Swindell
Risk reviewed in month. Score reduced and additional actions identified.

November 2020 - Melissa Swindell
Risk and associated actions reviewed. good progress in development of SALS and wider MH support

October 2020 - Sharon Owen
Risk and associated actions reviewed. Wellbeing coaches are being developed throughout the month of November, to support the wellbeing conversations identified though the NHS people plan.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

Executive Leads Assessment
December 2020 - Melissa Swindell Risk reviewed in month. All actions updated
November 2020 - Melissa Swindell Actions reviewed and updated. Good progress being made in the BAME Taskforce
October 2020 - Sharon Owen A EDI taskforce group has been set up and led by Non Executive Director, Clare Dove. The inaugural meeting has set clear objectives to increase representation across the Trust at all level.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Establish Executive Design Group	31/12/2020	
Executive Leads Assessment		
December 2020 - David Powell Prior to Dec Board		
November 2020 - David Powell Incorporation of Eaton Road Masterplan		
October 2020 - David Powell Review prior to October Trust Board		

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.2	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led		Link to Corporate risk/s: 1270		
Exec Lead: Dani Jones	Type: External, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	31/03/2021	Paused due to Covid. Consideration to take place following Phase 3.
1. Strengthening the paediatric workforce	31/03/2021	Ongoing mutual aid and paediatric network connection and escalation arrangements with partner DGHs C&M wide.

Executive Leads Assessment

December 2020 - Dani Jones
Risk reviewed; no change to score in month. Covid impact remains significant but progress in system working, for example HCP C&YP developments. Recommend risk review & update in Q1 2021 in line with Trust Board post-covid strategy update.

Board Assurance Framework 2020-21

October 2020 - Dani Jones Risk reviewed; no change to score in month. Second wave of Covid underway - significant system planning. Progress made in Liverpool and Sefton on alignment of plans and programme resource for C&YP.
September 2020 - Dani Jones Risk reviewed - no change to score in month. Additional control added re: Alder Hey's leadership of C&M Paediatric recovery.
July 2020 - Dani Jones Risk reviewed; action plans updated. Impact of Covid continues though work ongoing to shape the strategic direction for paediatrics across the region. No change to score in month. Pending review of BAF at September trust board.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2182		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x5	Target IxL: 4x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. RABD to oversee productivity and waste reduction programme	31/03/2021	
5. Childrens Complexity tariff changes	31/12/2020	Tariff paper agreed with NHSI pricing team and further work continuing to influence the 21/22 tariff to be concluded by Dec 20.
1. Revised financial plan pending updated guidance from NHSI	31/12/2020	Further plan submitted to NHSi early December due to overall gap across region. Gap still remains for Alder Hey and awaiting outcome of this submission for next steps.
4. Long Term Financial Plan	31/12/2020	A new 5 year financial plan is required based on new architecture that is expected to remain in place. This will be presented to RABD and Trust Board and will outline the underlying position and risks.
2. Five Year capital plan	31/12/2020	Latest 5 year capital plan presented at RABD and an updated estates capital plan approved at RABD in October. Review of the capital plan over next 5 years will form part of 5 year strategy.

Executive Leads Assessment

December 2020 - Rachel Lea
The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction.

The framework beyond this year remains uncertain, expected guidance is due to be released mid December. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.

Board Assurance Framework 2020-21

November 2020 - Rachel Lea Financial regime in NHS remains uncertain due to the ongoing pandemic. The position for 20/21 is more known and mitigations are in place to ensure financial balance is achieved; however the longer term next 5 years is still a significant risk.
September 2020 - Rachel Lea Extension of current framework and arrangements for COVID reimbursement and top up has been confirmed to end of September. Awaiting guidance from NHSI on Phase 3 expected September.
July 2020 - Claire Liddy COVID Financial arrangements including COVID reimbursement and top-up. Regime now extended until September 2020

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation		Risk Title: Research & Innovation		
Related CQC Themes: Responsive, Well Led			Link to Corporate risk/s: No Risks Linked		
Exec Lead: Claire Liddy	Type: Internal, Known		Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

Failure to grow research & innovation due to potential weaknesses in R&I Strategies

Existing Control Measures	Assurance Evidence (attach on system)
RABD review of commercial contracts per SFI. Trust Board oversight of shareholding and equity investments.	Reports to RABD / Trust Board and associated minutes
Establishment of Research Management Board	Research Management Board papers.
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	
Plans for joint research & innovation clinical leadership being explored	
Research - recovery plan operational.	Trust Board papers
Research - monthly focus on research at Care Delivery Board to support strategy deliver.	Care Delivery Board papers
Research - appointment of associate divisional research directors to provide leadership and support to the research community	Research activity is captured by speciality and division. Latest extract of participation attached.

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Development and deployment of the 2030 Innovation Strategy	31/03/2021	
Approval of the research commercial case (core)	21/12/2020	
Research recovery plan operational	31/03/2021	Participating in 7 Urgent Public Health (UPH) Studies. Reactivated 38.9% of Suspended CRN studies. 19 New Studies opened - 13 Academic & 6 Commercial.

Executive Leads Assessment

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

November 2020 - Claire Liddy
Risk reviewed - no change to score in month. All actions remain on track

October 2020 - Claire Liddy
Risk reviewed - no change to score. Actions reviewed - all on track.

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: 2235, 2143, 2265		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x1	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of cyber actions including managed service and cyber essentials accreditation	31/03/2021	Plans progressing with regards to cyber essentials accreditation

Executive Leads Assessment

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

November 2020 - Kate Warriner
BAF reviewed, good progress against plans.

October 2020 - Kate Warriner
Risk rating reduced due to actions completed in relation to completion of phase 2 infrastructure resilience

Resources and Business Development Committee

Confirmed Minutes of the meeting held on Monday 19th October 2020 at 4:00pm, via Teams

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Alison Chew	Associate Director Operational Finance	(AC)
	Robin Clout	Interim Deputy Chief Digital Information Officer	(RC)
	Mark Flanagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Adrian Hughes	Interim Deputy Medical Director	(AH)
	Dani Jones	Director of Strategy	(DJ)
	Ken Jones	Associate Finance Director Financial Control & Assurance	(KJ)
	Claire Liddy	Director of Innovation	(CL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies:	Rachel Lea	Acting Deputy Director of Finance	(RL)
	Sue Brown	Associate Development Director	(SB)
	Claire Dove	Non-Executive Director	(CD)
	Nicki Murdock	Medical Director	(NM)
Agenda item: 97	Hannah Rogers	Service Manager	
98	Lisa Cooper	ACOO Community and CAMHS	
98	Kerry Lythgoe	Business Accountant	

20/21/89 **Minutes from the meeting held on 23rd September 2020.**
Resolved:
The minutes of the last meeting were approved as an accurate record.

20/21/90 **Matters Arising and Action log**
A number of items on the action log had been deferred mainly due to the large number of items being presented today. As there had been no resolution in relation to Handrails this had been deferred until the November meeting. The action log would be updated.

20/21/91 **Declarations of Interest**
There were no declarations of interest.

20/21/92 **Finance Report**
Month 6
AC reported a breakeven position, to achieve this a top up payment is required under the new financial regime of £3.4m including £0.9m COVID reimbursements.

Spend on revenue directly relating to COVID 19 year to date is £7.4m, a breakdown was provided within the report.

Main risks going forward are in relation to cash and the potential impact any in year, and future operating deficits may have on the capital plan, further updates are to be received under the heading: Assurance on RABD key risk (Improving the Alder Hey £).

Due to the new financial framework being implemented from M7 onwards a resetting of budgets for M7 – M12 is taking place.

Resolved:
RABD received and noted the M6 Finance report.

20/21/93 **2021 Framework - Phase 3 Planning submission**

Following the update from last month KJ went through the headlines of the new phase 3 framework that will be in effect from from 1st October 2020 – 31st March 2021:

- The C&M (Cheshire and Merseyside) overall deficit "gap" against the financial envelope has come down slightly, however the target for the system as a whole remains as breakeven.
- There is a "Break Glass" clause within the framework in relation to the developing second Covid spike, the detail of which is not yet clear.
- A slide was presented on income, what this means for Alder Hey, the current estimated deficit gap and potential opportunities to close this gap and the likely risks should this gap continues to increase.
- Verbal confirmation has been received that Trusts will not be financially penalised if unable to meet set targets under the activity incentice scheme, but this is yet to be formally approved.
- Next Steps included completing Phase 3 NHSI Finance submission on 22nd October 2020.

CL asked if the Children's Tariff (CT) was in a closer position to be resolved. JG said the (CT) consultation document is due to be distributed in December 2020.

RABD noted the ongoing changes and how it was unclear to see Alder Hey's underlying position. Whilst RABD acknowledged the difficulties presented by operating in changing financial regimes it was agreed that an update would be provided on this at the November RABD.
Action: KJ

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

20/21/94 **Debt Write Off**

For RABD's approval a total of £15,435.33 was presented. KJ noted a lot of the debt is dated back to 2016. CCI (Debt Collecting Agency) are unable to locate the debtors despite numerous attempts, hence the request to write off these amounts.

As the debts are in relation to salary overpayment the Chair queried how it happened. AC reminded RABD that in 2016 Alder Hey were outsourcing payroll to a company called CAPITA. There were many issues that came to light after termination of the contract had been agreed before Alder Hey and other Trust's came out of the contract. MS noted the E-Rostering contract to be approved that was an item on today's agenda and how this would support Alder Hey in reducing these errors going forward.

Resolved:

RABD APPROVED the debt write off for £15,435.33.

20/21/95 **Assurance on RABD Key Risk**

Cash

KJ highlighted the risks in relation to cash actions completed and key areas to be kept under review.

A slide showing cash commitment was presented for now and future years. The Chair noted the forecasted position for 2024/25 adding that focus to improve this position is required to commence.

SA highlighted from the slides that there is no deficit included for 2021/22. KJ agreed there is likely to be a deficit (subject to delivery of the mitigation outlined in the finance report) however at this current time it is difficult to predict what that will be.

A further update will be presented next month.

Capital

AC highlighted the capital plan for M6 as well as the slippage expected for future months and what this potential slippage relates to. Key actions going forward included keeping NHSI updated on any forecast slippage, regular calls with NHSI have already been arranged.

A discussion was held around Capital spend and mitigating any further slippage.

Campus Development Update

RG presented the financial risks in relation to the campus and progress to date.

Park Phase One works approval to Commence

Following an action from the previous meeting estimated cost of phases 2 & 3 of the Park reinstatement project have been reviewed to see if there are any areas that might provide a reduction against the high-level costs. Upon review it is unlikely that there is room for costs to be reduced however this will continue to be monitored.

A query was raised in relation to whether previous agreements could be renegotiated given the number of years that have past since the contracts were agreed. RG agreed to take this going forward and provide an update at the December RABD.

Action: RG

Capital Plan Process

In order to provide stronger governance and control to Alder Hey's development projects, a procedure has been drafted for use on all live and future projects. It was noted the process isn't new and has just been reviewed.

RG highlighted in general issues stem from the description of the original brief, the new changes implemented are to provider further structure around each project. RG noted a number of projects already have project teams supporting them and this will continue going forward.

The Chair noted previous agreement to include an external assessor of costs on each project and asked if this had been included. It was noted at this stage the design would not yet be approved. RG explained the different levels of approval advising that previously there may not have been enough engagement with all the stakeholders hence the costs rising through the process. RG agreed to amend the sentence for absolute transparency.
Action: RG – NB this action has been completed.

Resolved:
RABD received and noted updates against the key risks as well as approval of the revised Capital Plan Process subject to queries raised from both the Chair and SA.

20/21/97 **Neonatal Business Case update**

AB went through the recommendation set within the paper and presentation for the capital development set out in option 1. A request for approval was also made to increase the budget to £16.8m whilst redirecting funding from the ED scheme and set a parameter to reduce the scheme cost from £17.3m to £16.5m. AB provided background on the analysis that had been carried out that have led to these recommendations.

A slide on the Neonatal vision to create a 22 cot NICU facilitating a family integrated care model was received. An update was also received in relation to the design and development to have the 22 cots together, one of the reasons for this is reduce staffing levels as individual rooms require an increase in staffing levels. 19 cots will have family integrated rooms with 3 spare rooms for families. This allows for families to stay in the same room for their whole stay and would be the first of it's kind.

RG presented the design plans including the benefits of the proposed plans and the square meter of new build for both the Neonatal Unit and Emergency Department.

JG went through the financial analysis noting the request for a 2 storey build to provide opportunities for growth going forward. Whilst a number of areas are being explored there has been no agreement of what services will be expanded. A discussion was held on further funding opportunities and for these to be explored.

Resolved:
RABD approved:
- The request to increase the Neonatal scheme envelope to £16.8m noting the ongoing works to continue to reduce costs.
- Request for a 2 storey build noting the opportunities for further growth this would provide in the future.
-

20/21/98 **Dewi Jones Unit**

LC and KL presented the revised business case in relation to the clinical case for change for approval.

LC provided background on the current Tier 4 site based in Sefton with 7 beds. Funding has been secured for 9 beds and for all beds to be based on the Alder Hey site. It is planned for there to a total of 12 beds on site, 10 to have secured

funding and the further 2 are planned to be funded through private patients (or other Trusts).

KL highlighted the request today was to seek approval for further funding from NHSI/E to support the expansion from 9 to 12 beds. KL noted the service had previously ran at a loss and how NHSE have now increased the costs paid into this service.

KL also went through the changes to be implemented to staffing to provide care for patients in the 12 beds. A benchmarking exercise has been carried out in relation to the cost of delivering each bed and how this compares to other Trust's, the cost at Alder Hey is lower.

Resolved:
RABD ratified the request to seek for further funding from NHSI/E to support the expansion from 9 to 12 beds. This will be presented at the November Trust Board.

20/21/99 **Digital Update**
KW gave an introduction to the three papers being presented:

Digital
KW reported the BAF risk in relation to resilience has now been reduced has the later phases of work have now been completed.

The department were successful in winning a national award in relation to the Tele Medicine project. Two projects have also been shortlisted for national awards, the event will be held this Thursday.

RC highlighted the reduced waiting times across the Trust for responses in relation to IT issues. The scanning project is on track to complete the set deadline by the end of the financial year.

IT Capital Program Update
The purpose of the update today is to inform RABD of the expenditure agreed alongside the five-year plan and how savings are being used to fund the first 2 years of the funding pressure from the closed GDE programme and the escalation of the scanning project.

Benefits Financial and non-financial of GDE, HIMSS
RC highlighted the following savings: £50k Health Records, £150k-300k savings through transcription and £150k through a new printer deal. Further savings are planned going forward however this may change due to the block contract agreement.

Resolved:
RABD received and noted:
- Digital Report
- IT Capital Program
- Benefits Financial and non-financial of GDE, HIMSS

20/21/100 **Month 6 Corporate Report**
Resolved:
RABD received M6 Corporate report.

20/21/101 **Safe Waiting List Management**

Following an action from last month AB provided a further update noting from the 149 patients waiting over 52 weeks in July all patients except for 6 have now received treatment. An update was received in relation to the 6 remaining patients and when they would receive their treatment no later than November.

A breakdown of services and the number of patients waiting over 52 weeks was also received. AB advised the majority of patients waiting over 52 weeks is for surgery and the action plan for each of the services.

Medicine have been able to meet the goal of no patient waiting over 52 weeks. Medicine have also been able to reduce the number of patients waiting for treatment up to 18 weeks.

Community/Mental Health Division have 10 patients wating over 52 weeks, these 10 patients are due to receive their treatment over the next 4 weeks. AB agreed to present more of a deep dive into this pathway at the November RABD.
Action: AB & LC

Resolved:
RABD noted progress made since the last update received at the September RABD.

20/21/102 **PFI Report**

Resolved:
RABD received and noted the PFI report. No queries were requested for a response from Graeme Dixon.

20/21/103 **E Rostering**

MS provided background noting RABD had previously approved a supplier for E Rostering called Softworks and the reasons behind this. It was noted that Softworks have not yet been able to go live with Trust's under their contract and it may be a further 12 months before they are able to. NHSI's request is for all Trusts' to be signed up to an E Roster system by March 2021.

Due to this a number of Directors have re-looked at the E Rostering market and propose to move forward with a company called Allocate. Benefits of moving forward with Allocate have been outlined in the paper as well as the financial costs. MS highlighted NHSI/E will cover implementation costs in year one and two, year three's costs have not yet been approved however Alder Hey are waiting on the outcome of a bid.

Following operational approval at Operational Board a request was made to RABD to APPROVE moving forward with Allocate as set out within the paper.

The Chair asked if any Operational feedback had been received from other Trusts' working with Allocate. It was noted the E Rostering Manager and Kate Warriner have both worked with Allocate previously. Liverpool Heart and Chest NHS FT are contracted with Allocate, KW noted the positive staff feedback.

A conversation was held on the benefits realisation and for this to be monitored going forward.

Resolved:
RABD APPROVED moving forward with Allocate as the E Rostering service provider.

20/21/104 **Trust Wide Agile Strategy**
MS presented the now named Flexible Working Projects, phase 1 – Flexible working for staff working from home and across the organisation. Phase 2 – Review of the Estate. Phase 1 will run to April 2021.

Resolved:
RABD noted the 2 phases and the actions to be taken forward within phase 1.

20/21/105 **Car Parking Policy**
Resolved:
RABD RATIFED the Car Park Policy following approval at Operational Board.

20/21/106 **Communications update**
Resolved:
Due to time restrictions RABD received the communications update. MF agreed to provide a more detailed update at the November RABD.
Action: MF

20/21/107 **Board Assurance Framework**
Resolved:
RABD received the BAF noting the updates received in relation to the Campus.

20/21/108 **Terms of Reference**
Resolved:
RABD noted the requested changes from last month and APPROVED the RABD terms of reference for 12 months.

20/21/109 **Any Other Business**
Proveca and Alder Hey collaboration
CL provided background on a Research agreement around a data sharing arrangement between Alder Hey and a trusted commercial Industry partner, to support development of better medicines for children.

Going forward an external assessor will be asked to look review and approve any future work. CL agreed to include ES in future discussions in relation to data sharing.

A discussion was held on where future updates would be received going forward agreeing that future updates would be presented to RABD.

20/21/110 **Review of Meeting**
Whilst the meeting had overran members agreed there had been positive discussions.

Date and Time of Next Meeting: Monday 23rd November 2020, 10:00, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

17th December 2020

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	17th November 2020 – Summary 14th September 2020 - Approved Minutes
Report of:	Claire Dove, Committee Chair
Paper Prepared by:	Jackie Friday, PAW Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 14th September 2020 along with the approved minutes from the 2nd March 2020 meeting.
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** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3 BAF 2.2 - Staff Engagement – current risk IxL: 3x3 BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4

1. **Introduction**
   The People & Wellbeing 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 strategic direction and board assurance in relation to all workforce matters including monitoring progress against workforce indicators and supporting the organisation in delivering a positive patient centred culture.

2. **Agenda items received, discussed / approved at the meeting)**
   - To agree top 5 Risks
   - People Plan Update
   - People Plan – Action Plan
   - Non AfC Pay Update
   - Internal Communications Update
   - SALS Update
   - Annual Non-clinical Claims Report
   - BAME Task Force – Action Plan
   - Corporate Metrics – October 2020
   - Board Assurance Framework – October 2020
   - CQC Action Plan
   - HEE Self-Assessment Review 2019-20
   - Policies reviewed and ratified
     - Special Leave
     - Supervision of Medical Staff in Training Policy
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – 10.08.20
     - JCNC – 24.08.20, 29.09.20
     - Health & Safety Committee – 31.01.20, 22.04.20
     - BAME Task Force – 1.10.20

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - Staff absence and ongoing ability to ensure safe staffing levels to respond to the pandemic and continue to provide clinical services, especially linked to winter planning

4. **Positive highlights of note**
   - Significant progress made on SALS
   - Significant support for leaders during and post-covid
   - Annual EDI report
   - Mandatory training compliance maintained at 90%
   - Significant number of people policies ratified

5. **Issues for other committees**
   - RABD – sickness levels

6. Recommendations

The Board is asked to note the committee's regular report

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on Monday 14th Septemebr 2020
Via Microsoft Teams

Present:	Mrs C Dove	Non-Executive Dorector (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mr Ian Quinlan	Non-Executive Director (Part attendance)	(IQ)
	Mr A Bateman	Chief Operating Officer	(AB)
	Mrs P Brown	Acting Chief Nurse	(PB)
	Mrs R Greer	Associate COO – Community	(RG)
	Mr A Hughes	Deputy Medical Director	(AH)
	Ms E Saunders	Director of Corporate	
Affairs	(ES)		
	(ES)		

In attendance:	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Ms E White	Care Pathways, Policies & Guidance (Part)	(EW)
	Mrs J Potier	Associate Director of Organisational Development	(JP)
	Mr T Johnson	Staff Side Chair	(TJ)
	Mr D Shaw	Head of Learning & Development	(DS)
	Ms C Wardell	Associate Chief Nurse – Medicine	(CW)

Apologies:	Ms L Cooper	Dir. of Community & Mental Health Services	(LC)
	Ms R Chhokar	Associate COO - Medicine	(RC)
	Dr N Murdock	Medical Director	(NM)
	Mr A McColl	Associate COO – Surgery	(AMcC)
	Ms J Pointon	Associate Chief Nurse – Community	(JP)
	Ms F Beveridge	Non-Executive Director	(FB)

Declarations of Interest
PAWC noted that there were no items to declare.

20/21 **Minutes of the previous meeting held on 2nd March 2020**
Resolved: The minutes of the last meeting were approved as an accurate record.

20/22 **Matters Arising and Action Log**
Action Log
None discussed.

Trust People Plan 2019-2024

20/23 **Staff Survey 2020 – Update on Plans/Timelines**

The Committee received a report presented by the Head of Learning & Development, the report outlines key deadlines, delivery method, changes to the questionnaire and targets for 2020 survey. Highlights are:

- Launch w/c 14th September 2020 through to 27th November 2020. Access to survey data w/c 25th January 2021.
- Following review, haver remained with current provider, Quality Health. The reporting facility meets Trust needs better than other providers.
- The majority of questions have remained the same to allow national benchmarking of results throughout the pandemic, pre and post pandemic. there is the addition of a Covid-19 section. The other change of note is the removal of the questions related to personal development.
- The national survey co-ordination centre have advised that there is no expectation for Trusts to surpass previous completion rates. We are striving to match the previous year's completion rate of 62% (our highest ever completion rate).
- HR&OD team worked hard to produce divisional and departmental survey result packs to facilitate 'Big Conversations' using the 'Listening into Action' methodology. There were also plans for training to be delivered to departmental leaders to facilitate these conversations. Unfortunately, due to the pandemic conversations and training were halted. This information was shared with divisional and departmental leads to utilise how they saw fit given the pressures on the Trust.

Resolved:
PAWC received and noted the content of Staff Survey Report

20/24 **People Plan Update**

Following discussion at Trust Board about the national people plan, the Committee received a brief outline of the Alder Hey People Plan presented by the Director of HR & OD. MKS outlined national focus and advised that she will be working with the Deputy HRD and Associate Director of OD to be clear about Alder Hey priorities and incorporate into our People Network. Future updates will be shared with the Committee prior to presenting to Trust Board. The Chair acknowledged the importance of flexible working. No questions were raised by the Committee.

Resolved:
PAWC received an noted the content of the People Plan Update.

20/25 **CQC Action Plan – July 2020**

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. The report outlines the action required and the progress made for two recommendations. The recommendations are:

The Trust is required to ensure that staff improve **mandatory training compliance** and **appraisal compliance** to meet the trust target for clinical support and administrative and clerical staff. Both are on target for completion 30th September.

ES gave her perspective; there were only 2 recommendations that came out as the regulators homed in on ED. ES reminded the Committee of due diligence and compliance requirements particularly as Mandatory Training and Appraisal are key metrics. ES congratulated everybody on huge progress made re assurance to regulators and recognised that this is lowest number for HR to come out of an inspection. MKS paid thanks and advised the Committee that there were no Corporate specific workforce issues that came out of the inspection and that is testament to all the work done.

The Chair questioned AH about developments in Medicine. AH advised that having a workforce plan and business case for staffing in place will have a significant impact. Recruitment over the next few months will reap dividends. The Committee were advised that Mandatory Training will be discussed further as is an agenda item.

Resolved:
PAWC **received and noted** the content of the CQC Action Plan.

20/26 **Internal Communications Update**

The Committee was advised by the Marketing & Communications Director that with the introduction of Phase 3, working with the Division and join work with KPMG a paper will be presented at the next meeting outlining the Marketing & Communication formal plan.

Resolved:
PAWC noted this item has been **deferred** to November 2020 Committee

Leadership Development and Talent Management

20/27 **Leadership Update**

The Committee received a report presented by the Associate Director of Organisational Development. Highlights are:

- Prior to Covid pandemic, leadership was provided in the form of Strong Foundations programme; the Mary Seacole leadership programme and bespoke leadership support and coaching from the OD team on request.
- Leaders and managers support hub: in development in February, was prioritised as a response to Covid-19 was made. Via the hub, leaders and managers can access advice and guidance regarding managing self and others along with opportunities to request support for self or team. i.e. coach/mentor or counselling, support for team interventions, stress and wellbeing health check/self-assessment with further signposting to support the outcome, resilience self-assessment/signposting, managing conflict within the team etc. Whatever the need maybe, the hub exists to provide a listening, consulting advisory, signposting and support service for leaders across the Trust.
- In response to Covid-19 – training for line managers was put in place based on the principles of Psychological First Aid – called Keeping Going Together. Over 250 people attended the live event in August and a further 117 have accessed the recorded version.
- The Strong Foundations leadership programme has been redeveloped for delivery via virtual platform with enhanced content and is being relaunched on 28th September.
- Mary Seacole – 6-month leadership programme – implemented delivery during 2019 suitable for new and existing leaders, supervisory to middle

management levels. Now delivering its 3rd cohort. The aim is to delivery 2 cohorts a year (40 places).

- The national and C&M Leadership academy offer a full range of Leadership development programmes that support healthcare workers to be able to progress from foundational team leader level right through to Director level. The OD team communicates, supports and advises on the availability of these programmes.
- Apprenticeships – generic leadership development programme opportunities are available from Team Leader right up to Masters, with additional specialist subjects available. The OD and apprenticeship team are currently working to map and align the competencies from the Strong Foundations programme into the apprenticeship programmes. On-line delivery has been developed and currently in operation.
- Following the growing need for access to the coaching offer, this is being further developed and the OD Team are currently finalising the framework to provide additional support.
- Team interventions/building – the OD team have supported several of these team interventions across the Trust in the shape of team building/objective setting/team cohesion etc. Plan to introduce a method of data/activity collection and reporting in the near future.
- Leadership 360 Feedback – of which all leaders have access to. The OD team have 2 fully qualified feedback practitioners who support this process.
- Resilience self-assessment – all staff can access this and receive a fully comprehensible analysis report which identifies areas of strength and areas of development.
- HR workshops – deliver bi-monthly workshops to support transactional management of Sickness, grievance and disciplinary, performance management, PDR, recruitment and selection.
- Leadership Support Circles – the OD team have been working on a plan to introduce the Alder Hey LSCs – this is a group of leaders from all levels and disciplines who have come to the end of the Strong Foundations Programme. The premise is designed to provide safe time and reflective space for those with responsibility for managing others and offer each member an opportunity to share experiences and support one another especially during times of challenge.

JP advised on 'next steps' and recognised the increased burden on leaders and managers in this phase of Covid. including managing their own stress and supporting their teams who themselves may be in distress or struggling and who may now be experiencing increased tensions and conflict due to the impacts of Covid on ways of working.
Further development of the leadership support as described in the report will be crucial in the overall staff support offer. The OD team are also reaching out to be involved in regional and national project linking leadership and health and wellbeing (national project lead by NHSE developing the tools and training for HWB conversations and NWLA developing a 'Healthy Leadership' Framework – competency Framework of Leadership Behaviours that enable and encourage employee wellbeing at work).

AB added that the 'principles of Psychological First Aid – called Keeping Going Together' training was immensely valued at the Trust. AB advised he would want to be assured that services reach those that require it. The Chair referred to the programmes in place and suggested we need to look at how staff join programmes and if they are given time out by managers to take part. JP advised that they look

quite regularly for any gaps in process. The next step is building in via PDR and talent management for aspiring staff. JP advised that SALS service is being well used by the Trust. The Chair requested that this be on the agenda for the next PAWC to see what it is being utilised for.

Action: SALS update, review of usage.

The Chair thanked JP for the overview.

Resolved:
PAWC **received and noted the content** of the Leadership Update.

Health and Wellbeing

20/28 **Sickness Absence/Shielding/Agile Working**

The Committee received a report prepared by the Deputy HRD. The report is noted as read. SO emphasised that it is imperative that a detailed and central overview of staff sickness absence (including ongoing shielding), redeployment and working from home is maintained to support operational delivery and the phase 3 recovery plan. There are potential future risks that need to be considered in relation to and readiness for winter planning which are: the potential for staff to have to shield again based on local or regional lockdowns and the impact of the Track & Trace on the workforce. SO provided an overview of data on the following: Sickness Absence, Shielding, Risk Assessments (both individual and environmental) and Staff Working from Home.

- Sickness absence – reviewed daily
- Shielding –as of 8th September 2020, 36 staff remain absent from work due to shielding. From those staff shielding there are a total number of 27 pregnant staff Nurses/HCA's across the wards in Medicine, Surgery and Community.
- Risk Assessments (both individual and environmental) – Throughout the pandemic emerging evidence suggested that there were groups of people who were disproportionately affected by Covid-19, which included those with certain health related physical conditions, black, Asian and minority ethnic (BAME), pregnant staff, men and those in higher age brackets. A demographic risk assessment was developed to holistically assess those individual staff most at risk. In addition to the above demographic risk assessments there is the requirement to assess all staff. The Trust self-assessment risk assessment was also developed to ensure the risk for all is captured so appropriate measures can be put in place to mitigate the risk.
- Staff working from home – In order to keep everyone at Alder Hey as safe as possible, the way we work has been reorganised. A total of 833 staff continue to work from home, this is anticipated to remain static over the coming months. SO went onto share a breakdown of staff groups and divisions.

SO outlined next steps – HR Business Partners and HR Advisors have been working extremely closely with the managers and divisional leads, to provide support and guidance on all absences, shielding and staff return to work. Expert advice has been sought from Occupational Health, Health & Safety, Infection Prevention and Control and Staff advice and liaison Services to ensure a joined-up approach to supporting managers and staff accordingly. This integrated approach will continue to ensure we are effectively supporting our staff members physical and psychological wellbeing. The workforce absence data will continue to be closely monitored and shared with

appropriate committees and stakeholders to enable effective planning of staffing levels to support the phase 3 recovery plan.

MKS advised that there is a national drive to ensure every single staff member has a risk assessment. A process for self-assessment is in place, this will enable staff to decide if they require a full risk assessment and HR will be chatting to the divisions to decide how we will fulfil the national requirements.

The Chair asked, with the strong possibility of Covid spiking again and the pressures on staffing, (attention was brought to pregnant staff and theatres), is there a winter plan in place? SO advised this will form part of Phase 3 planning, staff will be repurposed and finance colleagues looking to cost up. AB confirmed that the winter plan will be finalised in October and they are looking to support theatre and offset absences.

The Chair acknowledged that home working is going to be feature for Alder Hey staff going forward and as mentioned earlier, advised that we need to ensure that staff do not feel isolated/lonely and the whole plan on health and wellbeing with good communications is in place.

The Chair requested the winter plan be brought back to the next Committee in November, to ensure workforce is monitored.

Actions: Update on working from home review
Update on Winter Plan

Resolved:
PAWC **received and noted** the content of **Sickness Absence/Shielding/Agile Working**

Equality, Diversity & Inclusion

20//29 **EDS2 & Workforce EDI Annual Report**

The Committee received a presentation prepared by the Deputy HRD. The purpose of the report is to summarise the annual EDI, EDS2 & Workforce reports. In compliance with UK equality legislation, Alder Hey is required to compile and publish an annual report. This report details the progress against our Equality, Diversity and inclusion objectives (2018-21). SO acknowledged the Trust has seen a lot of change with the effects of Covid, particularly on BAME staff and it is hoped that sharper focus will be made toward this going forward. The reports are noted as read.

SO shared that the report references and uses the data from the following: The Workforce Race Equality Standard (WRES), The Workforce Disability Equality Standard (WDES), Gender Pay Gap Report, EDS2 Goals 3 & 4, Workforce Demographic Profiles, Recruitment & Selection Data & Training and Development. As shared in the presentation, SO went on to outline the workforce EDI Objectives 2018-2021 and the summary of findings, including Learning & Development/NHS jobs data outcomes for age, gender, disability, ethnicity and sexual orientation.

SO advised that there is a requirement to publish EDI by end October and sought sign-off by the Committee. SO recognised further progress is required to the actions going forward, to also include the really important areas that have come out of this year and ensure they are captured in WRES & WDES action plans. Several

questions were raised. SO confirmed that the Trust is compliant with the national living wage and this will be added to the report.

The Chair advised on other areas that central government are keen to see improvements on. i.e. ethnic pay gap/modern slavery. Particular attention was brought to the questions asked by Procurement when sourcing suppliers/services to ensure the Trust values are in place as part of Procurement processes. ES recollected that a statement was put together about 12 months ago, in terms of Procurement assurance, although it was understood that it wasn't a regulatory requirement this year (as the Trust didn't meet the private income monetary threshold/parameters set). The Chair acknowledged that a planned meeting she had with Procurement was postponed, this will be reinstated and advised she will share government Procurement guidelines with the Trust. EA welcomed external input and suggested that ES and MKS pick this up again to get a sense of what further action we need to take as an organisation.

The Chair referred to the Nursing profession and asked is the aging workforce an issue? PB advised that several nurse specialists' and band 7 frontline nurses are in that age group. Regional and national feedback is that staff due to retire could possibly go down that route following the difficulties with Covid, although locally nurses are not sharing these intentions with the Trust currently. There is a strategy in place re recruitment and succession planning to support this challenge.

Several observations/challenges were raised by the Committee to see improved reporting processes - such as comparisons to other similar Trusts. IQ asked if the target for BAME recruitment needs adjusting to reflect the population in the Liverpool region. SO confirmed that the Trust is working towards this. The Liverpool demographic is 11% BAME population, the Trust is currently 7% and the target is 1% year on year to ensure we increase BAME applicants. The Committee agreed that the following be referenced in the report; national living wage, ethnic pay gap and the ageing workforce. The Chair requested that highlights of this report be shared with BAME Task Force to inform of challenges ahead for the BAME agenda.

Actions: Share strategic government guidelines Procurement when sourcing suppliers/services with ES/MKS.
Revisit Procurement statement to get a sense of what further action is required.
Share highlights to the of report to BAME Task Force agenda to inform of challenges ahead

Resolved:
PAWC **received and approved** the content of **EDS2 & Workforce EDI Annual Report** and noted the content of WRES/WDES & Actions

Governance

20/30 **Review and agree PAWC Terms of Reference & Workplan 2020-21**
The Committee received and discussed the Terms of Reference and Work Plan. MKS acknowledged that EA has progressed a significant piece of work with all Committee Terms of Reference to assure governance processes. MKS advised a specific duty had been added to focus more on Health & Safety (previously the minutes were received by the Committee). Additional focus has been applied to H&S during the pandemic to ensure we monitor compliance against strategic H&S

requirements and to make sure we are reaching our statutory requirements and this Committee are sighted on this going forward to ensure Board assurance.

ES advised that the TOR were similar to previous TOR, but the emphasis has changed. ES informed the Committee that the it was agreed at Board that the assurance Committees would focus on key risks; measuring what matters and what the metrics are (a significant piece of work is taking place around risk just now). ES suggested, with the Chair's permissions, what we may see going forward is a pared back agenda alongside the work plan where the points of emphasis are.

The Chair asked where we are in relation to the Networks identified in the TOR and questioned the effectiveness. MKS acknowledged they were set up as a formal mechanism, but accepted a review is needed this year. It was agreed to leave them in the TOR, but a position will be required going forward on statutory requirements. ES confirmed the TOR will go to Board for ratification.

Action: Streamline agenda and workplan

Resolved:
The Committee approved the Terms of Reference and noted ongoing work to Work Plan.

20/31 **Corporate Report Metrics – July 2020 & Workforce KPI's**

The Committee received the above two documents. MKS referred to the regular report concerning the key KPI's relating to workforce monitoring and prepared by HR. Headlines are:

- Sickness 5.4%, was 5% in June, long term sickness still an issue. There is a new Wellbeing Team in place to support sickness and ensure no delays in processes.
- PDR's – they were paused and have started up again with new refreshed paperwork. Feedback from staff is that they like the new paperwork. Only recording 13% and not sure of accuracy. Target is end of October for closure, so need to take stock.
- Medical appraisals on track 90%.

No questions raised.

Resolved:
The Committee received and noted the content of the Corporate Report Metrics & Workforce KPI's.

20/32 **Board Assurance Framework – August 2020**

The Committee received a full report, the report is noted as read.

ES signposted the Committee as to where we are with risks at this stage with phase 3 plan. ES advised in the next phase there is a requirement to update a lot of actions to tie together some of the issues i.e. issues raised today and the last 2-3 weeks; the impact on staff with schools returning. With the people agenda coming more into the fore due to Covid, careful consideration will be required in relation to the Trust's tolerance of risks and the BAF document will continue to be the driver for that and how its set out. The re-establishment of the PAWC Committee in its new

format/TOR, what will be driving the Committees agenda in how we respond to the strategic as well as operational risks. MKS found the overview helpful and recognised it was time for a review, particularly as we move into Phase 3 and picking up PB's points re developments in nursing community and future recruitment.

PB shared the latest developments to support the nursing workforce plans. Nationally there is directive to increase nursing numbers by 50,000. Following a joint bid AH has been successful in receiving an award to see increased placement capacity for student nurses. Further money to be bid for, will see an increase in international recruitment, along regional nursing apprenticeships.

The Chair shared her reflections on: student nurses - ensure that protocols re Trust values are in place at Universities; apprenticeships – look to build a campaign to get local BAME people interested in apprenticeships; overseas recruitment – we are going to see massive unemployment coming up, what are we going to do in this country to support local communities back into work. Congratulated PB on the successful bid for nursing but would like to see some of the plan to carefully to implement the above.

The Chair thanks ES for her contribution and acknowledged this Committee has a key role to play to face the challenges ahead of us.

Resolved:
PAWC received and noted the latest position of the Board Assurance Framework

20/33 **Mandatory Training & PDR's**

The Committee received a report prepared by the Head of Learning & Development. DS advised that the overall Mandatory Training compliance has been above target of 90% for the last 14 months. Through the period of the pandemic mandatory training compliance has reduced significantly and has seen a drop in all topics accept Infection Control Level 2. Heavier impact has been seen with training that requires updating more often. One of the key things that took place during this time was to ensure staff have easy access to training and reports. As we move into Phase 3 L&D are looking to see increased activity and re-engaging with all areas to achieve that. DS referred to the overview that is presented to this Committee but acknowledged CQC reviewed individual departments/individual compliance topics, so going forward we may need to focus on certain staff groups (e.g. ED) for potential problem areas. The Committee recognised it was a good time to aim for increased compliance prior to the expected 2nd wave.

MF initiated a discussion about Teams usage at the Trust and the requirement of a layer of support for staff to be put in place for training/appropriate usage. MF pointed out that it is a core working tool, some staff may struggle to use Teams effectively so may be disadvantaged at meetings. The Committee acknowledged the great work completed by the IT team in rolling Teams out but recognised a long-term plan was required on usage/data protection to fully educate staff. EA thanked MF for raising.

ES referred to an ancillary risk issue around data protection, with staff not being fully educated on the implications of having discussions on Teams (to be discussed at the Information Governance Committee the following day). ES advised that a SOP was produced when Teams was introduced and rolled out to the Divisions, but that is reliant on staff reading it. The data breach impacts are huge. DS added L&D can address part of this issue to educate our staff with the local advice available. Also feedback our concerns that the current IG national package is built for an

environment that no longer exists due to Microsoft Teams. Although this support will only be annually refreshed each year, so will not be a quick change.

The Chair pointed out there were different facets to this issue and who owns what for progression (i.e. training/digital inclusion/data protection). The Committee noted that progression to resolve issues will be taken outside of this meeting.

Resolved:
PAWC received and noted the latest position of Mandatory Training & PDR's

20/34 **HEE NW Annual Assessment Visit 2015-2019 - Update for Information**

The Committee received a report prepared by the Medical Education Manager. The purpose of the paper was to update the Committee following the Trust's Annual Assessment visit in 2019 and further developments and plans put in place to provide assurance on the progress made.

MKS reminded the Committee that following the Trust's assessment visit from Health Education England and summary findings from GMC survey in 2014 the Trust has been in special measures. Concerns have focussed on the handover process of junior doctors. Action plans have been put in place and improvements have been seen year on year. Since the Director of Medical Education came on board a lot of work has taken place with Education Supervisors, the feedback received from the Quality Team from HEE was that they were impressed with the development and practical solutions that have been implemented.

MKS concluded that it has been agreed to run a virtual assessment in November this year with an updated action plan submitted following this review. The Quality Team from HEE will aim to report their findings and recommendations February/March 2021. AH advised that following positive feedback received at the last meeting with HEE, he understood that we need to demonstrate improvements on two occasions in a row, so felt hopeful about coming out of special measures following the outcomes of the next assessment.

ES referred to CQC monitoring reports whereby they look at risks attached to organisations (currently quarterly meetings take place with the Trust). ES suggested a report is put forward to CQC for assurance purposes as this has regulatory ramifications and is interconnected with some other things that we are monitored on. ES & MKS will touch base with Director of Medical Education to formulate a report for CQC (incl. of self- assessment and feedback received from Quality Team from HEE).

The Chair referred to the scoring of future self assessments/action plans and suggested they be brought to future Committee's to ensure robust scoring processes, MKS to review how this is managed going forward. The Chair thanked the Medical Education Team for all their hard work.

Action: HEE NW Annual Assessment Prepare assurance report for CQC

Resolved:
The Committee received and noted the content of the HEE NW Annual Assessment Visit 2015-2019 – Update.

20/35 **Policies**

The Committee received the following policies and Equality Assessments for formal ratification/approval. The Deputy Director of HR outlined high level changes and advised all policies had previously been approved at either the Policy Review Group or LNC with the support of Staff Side colleagues.

- **Capability & Performance**
  Some steps removed to formal procedures. More information had been added in terms of staff support, via sign posting.
- **Recruitment & Selection**
  Pre employment checks - factual references added, legislation updates added.
- **Maternity**
  Minor amendments made, section on shared parental leave added and appropriate legislative changes added.
- **Grievance**
  Minor changes made, updated section on informal grievance, mediation and facilitated conversation (agreed with Staff Side to reinstate information in relation to this section)
- **Respect at Work**
  This policy required a complete rewrite. A Task & Finish Group was organised to agree, several meetings took place ahead of approval at PRG. Sign posting – additional clarification added. More positive working culture, links into EDI objectives.
- **Equality & Analysis**
  Clarity on when it is required. Improved format of template.
- **Consultant & SAS Doctor Job Planning**
  Previously approved by LNC, slight amendment by adding the list of external representatives on panel.
- **Domestic Abuse**
  The Policies & Guidance Manager – shared the changes made to reflect latest guidance and advice for staff; terminology and descriptors updated; update in law/impacts on witnesses of DA; also highlights the spectrum of age range seen. EW advised this policy has been approved by CQSG in relation to safeguarding of children and requires approval of this Committee in relation to workforce.

Resolved:
The Committee ratified the policies and the equality analysis for the above were approved.

Sub Committee/ Working Groups reporting to Committee

20/36 The Committee received the minutes for the following for information.

- LNC – 29.01.2020 & 07.05.2020
- JCNC – 24.02.2020
- Education Governance 24.07.2020

Resolved:
The Committee **noted** the content of LNC, JCNC & Education Governance minutes.

20/37 **Any other business**

None

20/38 **Date and Time of Next meeting**
17th November 2020 at at 9.30 via teams

Minute Reference	Action	Who	When	Status
Leadership Development & Talent Management				
20/27	• SALS update – review of usage	JP	November 2020	
Health & Wellbeing				
20/28	Sickness Absence/Shielding/Agile Working • Working from home – update on review • Winter plan update – workforce monitoring	 MKS MKS	 November 2020 November 2020	
Equality, Diversity & Inclusion				
20/29	EDS2 & Workforce EDI Annual Report • Share Procurement strategic government guidelines for sourcing suppliers/services with ES/MKS • Revisit Procurement statement to get a sense of what further action is required. • Share highlights of EDS2 & Workforce EDI Annual Report to BAME Task Force	 CD ES/MKS SO	 November 2020 November 2020 November 2020	
Governance				
20/30	Terms of Reference / Workplan • Streamline agenda and workplan	 ES/MKS	 November 2020	
20/34	HEE NW Annual Assessment Visit 2015-19 • Prepare assurance report for CQC	 ES/MKS	 November 2020	
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Noted on 19/09/2019 that DMO support is in place for this ongoing action.	ND MKS		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed.	MKS/CD	Ongoing	Ongoing
	Engagement			
15/08 16/02	• Develop Values in Procurement, values-based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Ongoing	Ongoing

Equality & Diversity				
20/20 17/13 19/68	• Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	MKS/CD HA HA/SM HA	TBS 1/4ly Update 6 monthly Review	 Ongoing Ongoing
Education Governance Update				
18/38	• To be a regular item on the Committee Agenda.	HB	Agreed May 2019	Ongoing
19/91	• Update on HEE action plan	HB	April 2020	Ongoing
Nurse Associate Recruitment				
19/69	Develop a wider plan – to be reviewed	Vikki Hughes	April 2020	
Mandatory Training & CQC				
19/73	To be standard agenda items going forward	MKS/JF	October 2019	Ongoing

Alder Hey Children's NHS
NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 12th October 2020,**
Innovation Hub

Present:	Mrs S Arora	Non-Executive Director (Chair)	(SA)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs. C Liddy	Director of Innovation	(CL)
	Dr. F Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E Saunders	Director of Corporate Affairs	(ES)
	Mrs. L Shepherd	Chief Executive	(LS)
	Mrs. K Warriner	Chief Information Officer	(KW)
In Attendance:	Ms. J. Blair (JB)	Acting Director of Research	(JB)
	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. R. Guerrero	Clinical Director of Innovation and Consultant Congenital Cardiac Surgeon	(RG)
	Mr. J. Hague	External Advisor.	(JH)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mrs. E. Hughes	Assoc. Chief Innovation Officer	(EH)
	Ms. R. Lea	Acting Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr. D. Powell	Development Director	(DP)
Item 20/21/37	Mr. J. Wrench	Innovation Consultant	(JW)
Apologies:	Prof. I Buchan	Appointed Governor (External Advisor)	(IB)

20/21/28 Apologies

The Chair noted the apologies that were received.

20/21/29 Declarations of Interest

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

20/21/30 Minutes of the previous meeting held on 6th July 2020
Resolved:
The minutes from the meeting held on the 6th July were agreed as an accurate record of the meeting.

20/21/31 Matters Arising and Action log

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Action 20/21/21.1: *Acorn General Update (timeline to be shared with the Committee to enable members to have an overview of the timeframe that is in place for winding up respective companies (as detailed in the report); include any barriers that are being experienced from Nova Group)* - An update will be provided during December's Committee meeting **–** ACTION TO REMAIN OPEN Open

Action 20/21/21.2: *Acorn General Update* - (*Hand Hygiene Solutions/Audiology Metrics Ltd - Liaise with the investors to request observer status on the Board of*

each company, and request a copy of the business plans and management accounts) – An update on this action will be provided in December.
ACTION TO REMAIN OPEN.

Action 20/21/21.3: *Acorn General Update (Audiology Metrics Ltd - Discuss the Trust's investment for the clinical trial relating to Audiology Metrics)* – A discussion will take place regarding investment for the click audiology assessment tool following feedback from the Research Team who are trialling and evaluating the tool presently. **ACTION TO REMAIN OPEN**

Action 20/21/26.1: *Board Assurance Framework (Circulate the outline of new operational risks; commercial and clinical along with new mitigations that relate to risks incorporated in the BAF, in preparation for the next Committee meeting)* – The Board Assurance Framework is to be reviewed prior to December's Committee meeting and will incorporate the new commercial and clinical risks.
ACTION TO REMAIN OPEN

Action 20/21/26.2: *Board Assurance Framework (Policies for managing innovation risks - Share the policies with the Committee for managing innovation risks, as agreed on the 6.7.20)* – Jonathan Hague agreed to circulate the policies after the Committee meeting. Have we received anything from John Hague?

20/21/32 Innovations Limited and Acorn Update

Attention was drawn to the hand washing sensor that has progressed to trial at Alder Hey. It was confirmed that an update on the success of the trial would be provided during December's Committee meeting.

20/21/32.1 Action: EH

It was reported that the click audiology assessment tool is being advanced via thee Research Team who are trialling and evaluating the tool. An update on the outcome will be shared with the Committee on the 7.1.2.20.

20/21/32.2 Action: EH

The Chair requested further clarity in respect to the status of Alder Hey Innovation Limited. It was agreed to discuss this separately outside of the meeting.

20/21/32.3 Action: CL/RL/SA

Resolved:
The Committee noted the Innovations Limited update.

20/21/33 Impact Report

It was reported that there has been a large amount of engagement taking place with staff around case studies on Impact to Care. The Trust has also been aligning its priority pipelines with the Divisions and the Research Team in order to support projects and develop detailed research protocols. This engagement process in ongoing.

Alder Hey is also liaising with possible strategic partners to see if they are able to support the development of the Trust's two priorities; Alderhey@nywhere and Alderhey@dvancingsafety. Discussions are taking place with Vodafone from an Alderhey@nywhere approach and it was reported that a project has been conducted in respect to virtual visiting which is a spin-out of Philips. This technology could be expanded to support the 'NICU of the Future' concept and a Living Lab at Alder Hey. The Committee was advised that Philips has a Research and Innovation

Lead in the UK and are looking at the possibility of Alder Hey becoming an e-test bed and a strategic partner.

Discussions have taken place with Apple on remote monitoring, and the Trust is working with Health Innovation Liverpool (HIL) and the Knowledge Quarters in order to build and strengthen partnerships locally and regionally. There has been an increase in activity around Alder Hey's media campaigns and the organisation has been liaising with agencies in respect to the relaunch of the Innovation Strategy and its branding. It was felt that further work is required to produce a more detailed briefing. Mark Flannagan agreed to link in with Emma Hughes outside of the meeting to provide support on this area of work.

20/21/133.1 **Action: EH**

A query was raised around the growing of the pipeline of strategic partners in respect to understanding the opportunities and the appropriate time in which to expand these opportunities. The Committee was provided with an overview of the recent discussions that have taken place with prospective strategic partners in respect to the Trust's requirements, along with the expected benefits of partnerships for all concerned. As mentioned above, there are a number of impending meetings with Vodafone and Philips. It was agreed to provide an update on discussions with partners the outcome during December's Committee meeting.

20/21/133.2 **Action: EH**

Fiona Marston pointed out that some of these relationships seem to be historic and asked as to why the Trust has chosen these partners and how strategically selective has Alder Hey been when making choices.

It was reported that Vodafone was recommended via another partner and are interested in supporting the organisation with its 'Living Trust' ambition, the new Campus and connectivity. From a Philips perspective, it is about exploring common areas, collaboration and co-creation.

Fiona Marston drew attention to the importance of ensuring that the Trust establishes relationships with strategic partners who will link in with Alder Hey's Innovation Strategy as well as being the best option for the Trust.

Resolved:
The Committee noted the impact update.

20/21/34 **Rapid Prototyping Report for the Period**

The Committee received a progress update on rapid prototyping. The following points were highlighted:

- The Rapid Prototyping Centre (RPC) was opened in the summer of 2019 as a place where ideas could quickly be designed and made into something physical.
- It was reported that there have been 32 prototypes produced to date; 15 have been parked, 9 are in progress and 8 have been deployed. The Committee was provided with a summary of the RPC outputs and attention was drawn to the list of ideas that are actively being built/worked on that may have a limited deployment to test.
- The Committee was advised of the importance of increasing the functionality of the RPC in order to grow this work. The RPC is partially functional with limited resources. It has an annual budget of £2000 and has no dedicated

staff. The Chair confirmed that rapid prototyping is part of the Innovation Strategy going forward.

Resolved:
The Committee received and noted the Rapid Prototyping Progress Report.

20/21/35 Commercial Agreements Schedule

The Committee received an update on the commercial agreements that are active and the due diligence that is being carried out by the organisation in respect to these agreements. The following points were highlighted:

- It was reported that the Trust has renewed its agreement with 3D Life Prints. This agreement has been in place for a number of years and the partnership focusses on innovation and the development of new technology in addition to the supply of 3D prints to the organisation. The Committee was advised of the percentage of income that the Trust receives as a result of supporting other trusts with 3D printing along with the commercial deals from exploiting jointly owned/jointly developed IP.
- *Brilliant Masks* – The Trust is in the final stage of completing a commercial agreement with Brilliant Masks, which has already been launched. The Committee was advised of the financial arrangements of the agreement and the revenue received to date as a result of the sale of face coverings designed by Alder Hey and developed in partnership with English Fine Cotton. It was reported that Brilliant Masks commenced to sell the face coverings during the last week of September 2020 and within two weeks had sold 500. Alder Hey is confident that the commercial deal will be a lucrative one as Brilliant Masks are looking to sell 1000 face coverings per day.
- There are a number of on-going projects within 'AlderPlay' and the children and young people 'As One' platform.
- It was reported that the majority of the due diligence for digital transformation has been conducted as the Trust is working under the Countess of Chester framework. This will enable the organisation to work with multiple partners on the provision of new technical solutions for 'AlderPlay' and 'One Digital Front Door'.
- *Alder Hey Hospital in Kidszania* – This is a sponsorship agreement with Kidszania with no upfront costs. It was reported that the Trust has provided Kidszania with kit.

Fiona Marston asked as to whether the Trust is able to register the design of the face covering in order to protect it from being copied. Advice has been taken on this matter and it was reported that with the slightest tweak organisations are able to produce equivalent products. From an English Fine Cotton perspective they won't be producing a face mask with the same design that Alder Hey has. In the event this did happen, Alder Hey would receive commission accordingly. Fiona Marston felt that it might be worth looking at how the Trust protects future designs.

Ian Quinlan queried the assurance process for monitoring the royalties received on the sale of each mask. The Committee was advised that as part of the agreement Brilliant Masks are legally bound to share their accounts and sales reports with the Trust on a monthly basis. In addition to this, the Trust arranged for an independent financial advisor to look at due diligence in terms of Brilliant Mask's records. Ian Quinlan asked as to whether the submitted reports are signed off by Brilliant Masks Director of Finance/auditors. Following discussion it was agreed to request a copy of Brilliant Masks audited reports following the 2020/21 year end. The Chair felt that it would be beneficial to submit a trading account to the Committee at future

committee meetings detailing the income that the Trust is receiving from commercial agreements; include an update on a separate sheet of the agreements that aren't generating income.

20/21/35.1 **Action: EH**

Resolved:
The Committee noted the Commercial Agreement Schedule update.

20/21/36 **Health Innovation Liverpool**

It was reported that regular discussions are continuing to take place between the Trust and Liverpool University in respect to Alder Hey being part of the next phase of Health Innovation Liverpool (HIL). It was felt that it would be beneficial to invite Dr. Amanda Lamb, who is tasked with progressing the content of HIL, to forthcoming Innovation Committee meetings.

20/21/36.1 **Action: KMC**

Resolved:
The Committee noted the Health Innovation Liverpool update.

20/21/37 **Health Tech Seed Fund Proposal**

The Committee received a presentation on the proposal for a Health Tech Seed Fund. A number of slides were shared with the Committee which provided information on the following areas:

- Overview of the proposal.
- The aims of the proposal.
- Details of the investment programme.
- The role of the Delivery Team.
- The collaboration process.
- The governance process.
- Risks.
- Next steps.
- The ask.

A discussion took place around the risks of advancing the seed fund, resourcing in terms of the pipeline, the landscape and timing of the proposal along with funding.

The Committee was asked to support the progression of the investment programme. The Chair felt that a more detailed report was required before a decision could be made regarding this matter. It was agreed to submit a report on the 8.2.21.

20/21/37.1 **Action: MDA/JW**

Resolved:
The Committee received and noted the Health Tech Seed Fund proposal

20/21/38 **Innovation Strategy Discussion**

The Committee received a presentation on Alder Hey Children's Hospital Innovation Strategy; 'Daring to Innovate'.

It was pointed out that the strategy depicts that technology is a key component to helping children become healthier adults, but it was queried as to 1. How will the Trust know what it is aiming for? 2. How will the Trust know that it has achieved its

goal/s? Fiona Marston drew attention to the importance of being able to articulate this to underpin the vision.

An example of forthcoming plans to intervene in the treatment of asthma in children and young people (C&YP) was shared with the Committee. It was reported that a programme of work is going to be developed with the Divisions to break through the current methodology to contain asthma in C&YP via the use of technology, which will be in line with the themes of the strategy.

Louise Shepherd concluded the discussion by highlighting the importance of linking in with the Divisions/Clinical Teams to socialise the strategy. Claire Liddy advised the Committee that meetings are taking place with the Divisional Directors as part of the engagement plan and a copy of the strategy has been shared with the Innovation/Research Active Clinicians for comment. Support is also being sought from the Communications Team to help socialise the strategy internally.

Resolved:
The Committee received and noted the presentation on the Innovation Strategy.

20/21/39 Board Assurance Framework

The Committee received and noted the contents of the Board Assurance Framework for August 2020/21.

Attention was drawn to the importance of reframing the Innovation Committee's strategic risks in line with the Trust's new strategy. It was felt that in preparation for the next iteration of the BAF it is necessary to think about the risk appetite for commercialisation and the wider influence of programme work around C&YP, to ensure alignment. Following discussion, it was agreed to review the BAF prior to December's meeting and incorporate the new commercial and clinical risks.

20/21/39.1 Action: EH

Resolved:
The Committee received and noted the Board Assurance Framework for June 2020/21.

20/21/40 Any Other Business

There was none to discuss.

20/21/41 Review of the Meeting

It was felt that the discussions regarding the Innovation Strategy and the Health Tech Seed Fund were very informative and productive.

Date and Time of next meeting: Monday 7th December 2020, at 1300 via Microsoft Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 17th of December 2020

Paper Title:	Board update on the Ockenden Report
Report of:	Nathan Askew, Chief Nurse
Paper Prepared by:	Nathan Askew, Chief Nurse

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ■
Background Papers and/or supporting information:	This paper provides an overview of the Ockenden report into failings in maternity services at The Shrewsbury and Telford Hospital. The full report is available I the appendix via a link and the board are asked to note the assessment in terms of recommendations made regarding neonatal services.
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

Board update on the Ockerden Report into Maternity Services

Introduction

Donna Ockenden was asked to chair an independent review into failings in maternity care at The Shrewsbury and Telford Hospital NHS Trust. The report was published on 10th December and has 7 urgent actions to improve the safety of care for all women and infants in maternity units across the country. This paper summarises the main outcomes of the review for the board at Alder Hey Childrens hospital and any pertinent recommendations.

Why This Report is Important

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones. The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible.

They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past. The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

Urgent actions required of all Maternity Units

The 7 urgent actions in the report are contained in the letter to Trust CEO's (appendix 1). These are relate to maternity services and therefore do not require any action by the AH board.

However section 4.92 of the report relates specifically to a review of neonatal care. The section below details the outcome of that review and the associated recommendations:

Neonatology

4.92 From our review of patient clinical records in 250 cases to date, for most babies the quality of neonatal care at the Trust appears to have been satisfactory or good and at times excellent. The period 2000 - 2019 includes the time when services across England and Wales were moving from a situation where many units delivered intensive care to one where all units became part of networks within which certain units were designated intensive care units and others were not.

4.93 Prior to 2006, the neonatal unit at the Royal Shrewsbury Hospital regularly delivered neonatal intensive care, as was appropriate at that time. From 2009 the unit was designated as a Local Neonatal Unit (LNU). LNUs are not expected to deliver ongoing neonatal intensive care. It appears that there was a period between 2006 and 2011 when the local network was transitioning from one model of neonatal care to another.

4.94 We have found a small number of cases where the neonatal care was substandard. However, these were very much the exception and we have to date found no evidence of systemic poor practice or lack of care in the neonatal service.

4.95 It appears from the majority of the 250 medical records reviewed to date that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents.

4.96 Review of the medical records show that advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. It appears that their practice has been sound and likely to have contributed to the maintenance of good standards of neonatal practice within the Trust.

LOCAL ACTIONS FOR LEARNING: NEONATAL SERVICE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their neonatal services.

- 4.97 Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.

  Fully compliant - All nursing and medical notes at AH are made directly into badger EPR and so are combined and stored in one place.

- 4.98 There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.

  Not applicable – AH NNU is not a local unit it is the tertiary surgical unit, deteriorating patients are currently referred to and managed in association with PICU or the NNU at the Women's

- 4.99 The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.

  Fully complaint – The NNU does not provide ventilation to any infant. Deteriorating patients are transferred to PICU on site if they require ITU level care.

- 4.100 There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

  Fully compliant – this is in the work programme for the LNP and will involve the rotation of staff. Staff already rotate from the Women's to AH to ensure education and most up to date practice.

Conclusion

The board are asked to note the content of this report. The pertinent neonatal actions are noted above. The full report can be accessed from the link in appendix 1.

Appendix 1

Ockenden Letter CEO Chairs final 14.1