NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 26th November 2020, commencing at 9:00am

via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**20/21/173**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**20/21/174**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/175**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 22nd October 2020.**	**D**	Read minutes
4.	**20/21/176**	**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.	**20/21/177**	**9:25 (40 mins)**	• **Access and Restoration of Services Update.**	A Bateman	To provide an update on the progress made with the Access & Restoration initiative undertaken.	**A**	Read report
			• **Staff/Patient Safety:** - **IPC COVID Assurance Framework.**	B. Larru	To provide the Board with an update.	**A**	Read report
			- **Flu vaccine status.**	N. Murdock	To provide an update on the flu vaccine status.	**A**	Presentation
			- **Staff safety metrics.**	M. Swindell	To provide an update on staff absences and testing.	**A**	Presentation
			• **Financial Framework Update.**	R. Lea	To provide an overview of the position for Month 7 and the latest financial guidance.	**A**	Presentation

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			• **COVID Risk Register.**	R. Lea	To discuss the current 5 Key Risks.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**20/21/178**	**10:05 (10 mins)**	**Proposed Approach to Patient Safety.**	N Murdock/ N Askew	To provide the Board with initial outputs from the Trust's Safety Day.		Verbal
7.	**20/21/179**	**10:15 (10 mins)**	**CQC Action Plan.**	E Saunders	To provide assurance of progress against the recommendations arising from the CQC inspection report.		Presentation
8.	**20/21/180**	**10:25 (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
9.	**20/21/181**	**10:35 (25 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
10.	**20/21/182**	**11:00 (10 mins)**	**Digital Futures.**	K. Warriner	To provide the Board with an update.	**A**	Read report
The Best People Doing Their Best Work							
11.	**20/21/183**	**11:10 (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 9)*

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12.	**20/21/184**	**11:15 (25 mins)**	**Alder Hey People Plan Update:** • **Progress against 5 themes within the People Plan.** • **SALS Update.** • **EDI update.**	M. Swindell J. Potier/ J. Chamberlain C. Dove/ M. Swindell	To provide an update on progress against five of the themes within the People Plan. To provide an update on the SALS service. To provide an update on the EDI Task Force Group Action Plan.	**A** **A** **A**	Read report Presentation Verbal
Sustainability through Partnerships							
13.	**20/21/185**	**11:40 (10 mins)**	**Children's Network in Cheshire and Merseyside.**	D. Jones/ A. Hughes	To receive an update on partnership working across Cheshire and Merseyside.	**N**	Presentation
Strategic Update							
14.	**20/21/186**	**11:50 (15 mins)**	**Alder Hey in the Park Campus Development update:** • **Time Lapse Project Update.**	D. Powell M. Flannagan	To receive an update on key outstanding issues/risks and plans for mitigation. To provide an update.	**A** **A**	To follow Verbal
Lunch (12:05pm-12:30pm)							
Strong Foundations (Board Assurance)							
15.	**20/21/187**	**12:30 (10 mins)**	**EU Exit Update.**	L. Stark	To provide the Board with an update.	**A**	Presentation
16.	**20/21/188**	**12:40 (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
17.	**20/21/189**	**12:50 (15 mins)**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's highlight report**	K. Byrne	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
			from the meeting held on the 19.11.20. - **Approved minutes from the 17.9.20** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 23.11.20.** • **Safety & Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 18.11.20.** - **Approved minutes from the 21.10.20.**	I Quinlan F. Beveridge			
Items for information							
18.	**20/21/190**	**13:05 (2 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
19.	**20/21/191**	**13:07 (3 mins)**	**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, 17th December, 9:00am-2:00pm, via Microsoft Teams.							

Alder Hey Children's
NHS Foundation Trust

REGISTER OF TRUST SEAL
The Trust Seal was used in November 2020: - Contract for Phase 3 of the Alder Hey Site Demolition - Mersey Design Group Limited

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M7	**R. Lea**

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

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

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse (designate)	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. P. Brown	Acting Chief Nurse	(PB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Director of Finance/ Deputy Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	Ms. L. Cooper	Director of Community Services	(LC)
	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)
Observing:	Ms. S. De	Staff Governor	(SD)
	Ms. M. Mornington	Public Cheshire, Governor	(MM)
	Dr. N. Thorbinson	Public Parent and Carer Governor	(NT)
	Mr K. Ross	Public Merseyside, Governor	(KR)
	Ms. L. Richards	Account Manager, NHS Professionals	(LR)
	Mr. C. Murphy	Account Manager, NHS Professions	(CM)
Patient Story	Ms. E. Burgess	Patient	(EB)
	Ms. T. Cardwell	Parent of Patient	(TC)
	Ms. A. Simmons	Clinical Psychologist	(AS)
	Ms. V. Gray	Consultant Clinical Psychologist	(VG)
	Ms. E. Twigg	Consultant Clinical Psychologist	(ET)
	Ms. V. Furfie	Clinical Information Officer, Community Division	(VF)
Item 20/21/158	Mr. J. Taylor	General Manager, Research	(JT)
Item 20/21/159	Ms. M. Campbell	Public Health Consultant/Children and Young People Lead, Liverpool City Council	(MC)
Item 20/21/160	Ms. A. Appleton	Development Team	(AA)
	Mr. M. Braund	BDP	(MB)
	Mr. J. Chapman	Development Team	(JC)
	Mr. H. Davies	Development Team	(HD)
	Mr. R. Gates	Development Team	(RG)
	Mr. R. Harkness	Development Team	(RH)
	Mr. D. Houghton	Development Team	(DH)

	Mr. T. Johnson	Development Team	(TJ)
	Ms. J. Kirkham	Capacity Lab	(JK)
	Ms. E. Lord	Capacity Lab	(EL)
	Mr. K. O'Toole	Development Team	(KO)
Apologies:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. K. Warriner	Chief Information Officer	(KW)

Patient Story

The Chair welcomed Emma and her mum, Tanya, who were invited to October's Trust Board to share their story. The Chair also welcomed Anna Simmons, Emma's Clinical Psychologist, and Victoria Furfie, Clinical Information Officer for the Community and Mental Health Division, who was supporting Tanya and Emma from an IT perspective during the meeting.

Tanya informed the Board that Emma was referred to the Clinical Health Psychology Department earlier in the year due to having high levels of anxiety, low mood, anger and low self-esteem as a result of suffering from severe eczema. It was reported that Emma has met with Anna Simmons, Clinical Psychologist, on a number of occasions to complete a thorough assessment and commence intervention.

Anna Simmons provided an overview of the support that was provided to Emma to try and allay her anxieties and increase her self-esteem. Emma advised that she was able to share her anxieties and fears with her psychologist which has helped her to get over the problems that she has been experiencing. Emma has also been able to spend more time with her family and play with her sister since receiving support.

Tanya reported that during stressful situations, Emma experiences severe attacks of eczema that require treatment in a hospital environment which in turn creates additional stress for Emma.
Since Emma's last stay in hospital she has built up a phobia of attending hospital but thanks to Anna she has been able to manage her anger and stress and is feeling much better.

The Chair asked Emma if there was anything that could have been done differently during her time with Alder Hey. Emma informed the Board that she would have loved to have seen Anna on a face to face basis.

The Chair felt that the treatment Emma received at Alder Hey has provided a positive outcome for Emma and her family. Tanya informed the Board that the support that Emma has received has given her confidence to be able to speak to certain members of staff at school which has helped immensely; the school have also noticed a great difference in Emma too.

The Chair pointed out to Emma that you need a lot of confidence to speak up at the likes of today's Board meeting, and advised her of the nice messages that had been sent to Emma in the Teams chat. Tanya thanked Anna Simmons for the support that she has given to Emma as it has changed her life.

On behalf of the Trust Board, the Chair thanked Tanya and Emma for sharing their story.

20/21/147 Welcome and Apologies

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

20/21/148 Declarations of Interest

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

20/21/149 Minutes of the previous meetings held on Thursday 24th September 2020
Resolved:
The minutes from the meeting held on the 24th September were agreed as an accurate record of the meeting.

20/21/150 Matters Arising and Action Log

Action 20/21/93.1: *Serious Incident Report (comparison of the last two to three years could be carried out to look at whether the Trust has more or fewer serious incidents)* – This will feature in November's Serious Incident Report. **ACTION CLOSED**

Staff Story: *Look at the possibility of conducting a Pulse Survey to obtain staff views in respect to the support the organisation has provided during the pandemic* – A number of questions in relation to this action have been included in the staff survey of which the outcome will be shared with the Board in due course. **ACTION CLOSED**

Action 20/21/114.2: Plan for Phase 3 (*Operational Plan (Expansion of Services) - Submit a report on the financial element of the workforce requirements in respect to the developments that the Trust would like to progress)* - This action has been addressed at Divisional level following the agreement of a package with the Divisions. **ACTION CLOSED**

Action 20/21/114.3: Plan for Phase 3 *(Financial Risks - Look at alternative solutions to mitigate the financial risk in the event that the Trust is not recompensed or does not receive the expected funding via the new model that commences on the 1.10.20*. – This item has been included on the agenda. **ACTION CLOSED**

Action 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)* – 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**

Action 20/21/125.1: Serious Incident Report *(The information in the Serious Incident report is taken directly from Ulysses which has a very risk based approach that may not be conducive when reporting publically. It was agreed to review the SI report*) - It has been agreed that a more succinct report will be submitted to the Trust Board going forward. **ACTION CLOSED**

Action 20/21/136.1: Board Assurance Framework *(Provide an update regarding a formal risk appetite that is to be included in the BAF)* – Work is taking place to address this action. An update will be provided during November's Trust Board. **ACTION TO REMAIN OPEN**

20/21/151 Covid-19 Assurance Plan – Progress Update and Incident Response

Louise Shepherd informed the Board that the Trust formally moved into Major Incident mode during October and re-instated Gold Command to address the Covid-

19 second wave incident. The Board was advised that during the meeting there will be a focus on the key areas of the restoration phase and the actions that are taking place to address the risks that the Trust is facing.

Overview – Top Level Indicator

The Board was provided with an overview of the Trust's response to the incident/forthcoming winter and furnished with a number of slides that highlighted the following information:

- The shifting context in which the Trust is operating; bed capacity, Tier 3 status in Liverpool.
- Gold Command:
  - Daily meetings with key leads.
  - Resources in place.
  - Clear lines of accountability.
  - Data driven – forward looking.
  - Business Continuity in place for all departments.
  - Internal Escalation Plans signed off.
  - Developed Cheshire and Merseyside offer.
  - Increased communications.
- Covid-19 Dashboard:
  - Alder Hey's overall status is green at the present time.
  - ED attendances are lower and achieving 95%.
  - Critical Care is green but occupancy is increasing.
  - Staff absence is at 8.5% but Covid-19+ numbers are increasing.
  - PPE Levels are green.
- Partnership work in Cheshire and Merseyside:
  - The Trust is sustaining and enhancing its leadership role in Cheshire and Merseyside.
  - Work is continuing to build upon relationships with District General Hospitals (DGH) and all paediatric links across the patch. The principles are to maintain children's services, be fully supportive of mutual aid and have resilient staffing and service arrangements to provide care to paediatrics but not adults. It was reported that the support of adults would be decided at national level and not system wide.
  - A buddy system has been developed across the patch to support the provision of mutual aid, of which, Alder Hey are linked in with Southport and Ormskirk District General Hospital and St. Helens and Knowsley Hospital NHS Trust.
  - Alder Hey has offered support to the system based on its own escalation level. Support will reduce as the Trust's pressures increase but complex case reviews and Multi-Disciplinary Team (MDT) support will continue regardless as paediatric/DGH partners found this really helpful during the first wave. The Trust also wants to establish virtual HDU support for partners.
- Key risks:
  - Covid-19 second spike impacting delivery.
  - Risk of patient harm due to delays in treatment and patients potentially not presenting for treatment.
  - Uncertain system environment.
  - Increased risk to staff welfare.
  - Risk of infection to children and young people, families and staff.
  - Cyber security threat.

Winter and Covid-19 Plan Progress

The Board received the Trust's winter and Covid-19 Emergency Response Plan. The following key points were highlighted for information purposes:

- The plan is designed to deliver six key priorities:
  - Effective testing and tracing service for staff and patients.
  - Adequate forward supply of PPE.
  - Increase capacity, staffing levels and support to emergency and critical care services.
  - Wellbeing and psychological support to staff.
  - Flu vaccination programme.
  - Reduce transmission through hands, face, space and strong infection and prevention.
- The escalation scenario and response framework has been finalised and has a focus on maintaining urgent and critical care services.
- Each department has been asked to prepare a development plan for winter.
- Action cards are in place for each level of escalation.
- Alder Hey has a baseline inpatient capacity of 240 beds, with an additional 7 escalation beds to open in winter taking the total to 247.
- The staffing model sets out winter optimal levels for wards and departments, along with the minimum staffing level that the Trust may have to move to.
- *Critical Care Surge* - In extreme pressure additional surge beds in reserve would be opened, supported by a medical staffing plan.
- The Trust has established an Alder Hey track and trace service.

The Chair felt that the winter and Covid-19 Response Plan was very clear and thanked all those concerned for the amount of work that has taken place to produce the final version of the plan.

Fiona Marston queried as to whether the Trust needs to further develop the support provided to staff in the event of an escalation, especially for staff groups who are more vulnerable due to social or ethnic background, and asked as to where that escalation of support for staff is addressed.

The Board was advised that staff welfare is being addressed via the development of the Trust's Staff Advice Liaison Service (SALS). Resources within the team are increasing with the recent appointment of a SALS manager.

There are a range of measures that are available to staff; 24 hour Employee Assistance Programme, 9-5 accessibility to the SALS Team, the Alder Centre is open each day and work is taking place with teams who are struggling due to the challenging times being experienced at the present moment. Dr. Jo Potier is ensuring that Organisational Development colleagues are supporting these teams.

There are a series of listening sessions that are due to take place shortly. The Chair of the EDI Task Force Group, Claire Dove, has agreed to have a personal conversation with staff members who don't wish to attend an open forum. The SALS Team are working closely with the Chief Operating Officer, Adam Bateman, and the Exec Team to make sure that the organisation has got the appropriate interventions in place at all levels.

Access and Restoration

An update was provided on the progress that has been made with the Access and Restoration initiative undertaken at Alder Hey. The Trust's performance for restoration of services w/c 12.10.20 is as follows:

Outpatients:
- NHSE's Plan for October = 100%
- Alder Hey's performance = 86.6%

Elective:
- NHSE's Plan for October = 90%
- Alder Hey's performance = 91%

Radiology:
- NHSE's Plan for October = 100%
- Alder Hey's performance = 95%

It was reported that Outpatient Services have the largest gap in restoration. The Trust's high impact interventions to improve outpatient restoration is to introduce a new outpatient schedule with more capacity and to increase the adoption of digital clinics. The Board was advised that staff members are working additional hours during the weekend period to see patients, 8 digital consultation rooms will be available from the 26.10.20 and the Trust is in the process of trying to arrange temporary staff cover to support weekend theatre lists.

On behalf of the Board, the Chair expressed thanks to staff members who are going above and beyond to achieve restoration targets.

Access to Out of Hospital Care and Mental Health Services

The Trust has maintained its mental health services throughout the pandemic and has mobilised its 24 hour Crisis Care service in full. The Board was advised that the organisation has set itself some challenging targets internally around waiting time standards that predate Covid-19. These have been reviewed in light of the pandemic and are being closely monitored due to the predicted increase in children and young people presenting to locality based services since schools have reopened. There has been an increase in contacts via the Crisis Care service particularly from the teenage group who aren't known to CAMHS. Work is also taking place to support the health and wellbeing of staff.

Mental Health Act (1983) Report

The Board was provided with an overview of the contents of the report and an update on activity in relation to the Mental Health Act (1983) for the reporting period 1st of September 2019 to the 31st of August 2020. The following points were highlighted:

- The Trust has had 13 children sectioned under the Mental Health Act in the reporting period.
- There have been no children detained in police cells this reporting period which it was felt is an improvement in comparison to the previous year.
- There have been 11 children and young people deprived of their liberty in the acute main hospital, this is as a result of patients presenting with complex conditions. There have also been three applications to the court for Deprivation of Liberty Safeguards (DOLS) for children and young people, this includes one adult inpatient.

- It was reported that Mersey Care will continue to provide an administrative role for the Mental Health Act, via an SLA, for the Trust.
- The Board was advised that the Trust will be compliant with its Mental Health Act training by the end of October 2020. It was reported that the organisation commenced training in January 2020 for all staff and in particular senior managers and staff members who cover the on call rota, in order to provide relevant information/contact details in the event of an emergency.

  It was queried as to whether there is a work plan/timescale for rolling out Mental Health Act training. It was pointed out that the recommendation made by CQC relates to mental health staff being compliant in Mental Health Act training. It was reported that the Trust has delivered training to large groups of staff virtually during the year and is on track to achieve full compliance by the end of October 2020.

  Mental Health Act training for directors and 1st/2nd on call will recommence virtually in January 2020.

The Chair thanked Lisa Cooper and her team for the work that is taking place to maintain Mental Health Services for children and young people.

Resolved:
The Board noted and approved the Mental Health Act (1983) Report for the period of the 1.9.19 to the 31.8.20.

Staff /Patient Safety

IPC Covid-19 Assurance Framework

An update was provided on the recruitment of the new Director of Infection, Prevention and Control (DIPC) and the staffing levels in the IPC Team.

It was reported that the Trust is compliant with the IPC Covid-19 Assurance Framework, and it was agreed to circulate the framework to members of the Board for assurance purposes.

20/21/151.1 Action: NM

The Chair congratulated Dr Beatriz Larru on her new role as the Trust's DIPC.

Flu Vaccination Status

The Board received a number of slides which provided information on the highlights of the Flu Campaign, progress and the Trust's self-assessment of the NHSE/I best practice management checklist.

It was reported that Alder Hey is donating vaccines to UNICEF. For every three members of staff who have a flu vaccine, one child will receive a vaccine via UNICEF. To date, the Trust has donated 6,567 via UNICEF.

The Board was advised that there have been pockets of resistance from staff across the Trust. Awareness sessions have taken place and the organisation is hoping to achieve a 100% compliance by the end of November. The Chair advised that the Board is fully supportive of the Alder Hey Flu Campaign and is looking to achieve the 100% target in respect to the workforce being vaccinated.

Staff Absence.

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

- Non Covid-19 related sickness – 5.27%
- Covid-19 related sickness – 0.68%
- Absence related to Covid-19, not including sickness – 1.71%
- Absence related to Covid-19, including sickness – 2.39%
- Overall absence – 5.32%

The Board was advised that Alder Hey is sharing clear messages with staff members about adhering to social distancing, socialising and the consequences of breaching PPE. It was also reported that the Workforce Availability Group meet on a bi-weekly basis and feed into Gold Command.

Financial Update: 2020/21 Financial Plan and Phase 3 Framework

In Month 6, the Trust is reporting a breakeven position. The new financial regime for 2020/21 consists of block contract payments set by NHSI with a retrospective top up made for any additional costs or differences that have not been included to achieve an overall breakeven position. It was reported that the Trust has received guidance on the new financial regime and framework for the rest of 2020/21.

The Board was advised that the Trust has received payment for Month 5 and does not anticipate any issues in respect to payment for Month 6. It was reported that Deloitte will be conducting an audit on Covid-19 expenditure (*spending and recording*) for each Trust/organisation over the next couple of months. It was pointed out that MIAA have already conducted an audit of the Trust's Covid-19 expenditure and it was confirmed that the Trust has been appropriate in claiming everything that it could.

The current regime of block payments and retrospective top ups ceased as of month 6. The Trust will receive a block payment and the remaining funding envelopes for top up and Covid will be managed and distributed via the Cheshire and Merseyside system. Plans are the in the process of being developed with Cheshire and Merseyside and are due for submission to NHSI on the 22nd October.

The Trust's main focus going forward is to understand the new financial framework for the next six months. From a national perspective, despite the allocation of funds, there is still a gap in the NHS funding for the winter period. Reviews with regulators are taking place at the present time to agree the validity of projections made by organisations. There is also a £200m gap across Cheshire and Merseyside, whilst it is recognised that the gap won't be zero it is felt that a £200m gap is far too big therefore discussions are taking place to deem what is a reasonable figure.

The Trust has been allocated £6m from NHSI for the remainder of the year as it was recognised that the organisation required a top up above last year's run rate. Cheshire and Merseyside have been allotted a funding envelope of £180m, via the system, which will be apportioned to Trusts on a fair share version model linked to turnover and Covid expenditure during the first six months of the year, of which, Alder Hey is to receive £5.2m. It was reported that an incentive scheme is to be activated in October of which there is a marginal rate for application if trusts over/under perform. Cheshire and Merseyside have raised concerns about the incentive scheme as District General Hospitals and University Hospitals are having to cancel elective

operations due to the pandemic, therefore it is felt that a penalty model feels inappropriate considering the situation in the North West.

It was reported that the Trust has received written confirmation that Sefton Clinical Commissioning Group have agreed to fund the ADHD/ASD Mental Health investment, along with verbal confirmation of the funding for the Crisis Care investment.

The Board was provided with an overview of the financial impact to Alder Hey. It was pointed out that the underlying deficit amounts to £4.5m, this incorporates £1.6m of Covid and restoration costs higher than funding, £320k Crisis Care investment yet to be formally confirmed, £1.7m reduced non-clinical income and £950k capital charge increases not recognised in the Top Up.

There has been some acknowledgement by the Centre of the unrealistic assumption that the Trust will recover non-clinical income pre Covid run rates. This issue is being escalated to the Centre for further discussion. There are also actions in place to try to reduce the gap and work is ongoing to manage this issue either through cost reduction or improvements. It was pointed out that the deficit is still a concern but it is felt that the Trust will achieve a breakeven positon by the end of the financial year. The Trust will continue to work with the system and respond to any challenges.

The Chair summarised the financial discussion drawing attention to the risk in relation to cash and capital from a breakeven perspective. The Board was advised that a lot of work has taken place on capital and cash and fed into the Resources and Business Development Committee (RABD). Work will continue on the 5 year Capital Plan and the team will regroup to address a breakeven model for Alder Hey. It was agreed to provide an update on the breakeven model and strategic approach during January's Trust Board meeting.

20/21/151.2 Action: JG

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.

Attention was drawn to one particular high risk relating to nurse availability and transmission risk.

The Chair felt that it is important to set time aside at Board meetings to discuss the progress that is taking place in response to the incident and restoring access to services. Following LLuthe update, it was felt that the Trust is in a good position as it heads towards the winter period. Attention was also drawn to the importance of continuing with the positive work to sustain staff health and wellbeing. The Chair offered her thanks to all those concerned for providing an update.

20/21/152 Mortality Report, Q1

The Board received the Mortality Report for quarter 1, 2020/21. The following points were highlighted:

- The HMRG performance of primary reviews within four months is 100%. It was felt that this is due to the COVID pandemic resulting initially with decreased elective activity, resulting in the HMRG reviewers having more opportunity to undertake reviews. The use of Microsoft Teams for the meetings has consistently

increased the ability of people to attend within the Trust and outside, enabling more thorough discussions of the cases.

- The Board was advised of the reporting issue that was raised by Liverpool CCG (LCCG) in respect to the numbers relating to the deaths of children with learning disabilities. It was felt that the Trust wasn't submitting the same data to LCCG that was identified in the Mortality Report. LCCG have since confirmed that this was a process error on their behalf which has been rectified.
- It was reported that 85%-90% of the Trust's deaths occur in PICU as in other children's trusts. The funnel chart in the report indicates that the standard mortality ratios (SMRs) for Alder Hey is within the control limits of the funnel plot, suggesting that mortality is under control.
- *Paediatric Mortality Index* – During the period from July 2019 - June 2020, it was reported that Alder Hey had a performance of 63 deaths against 52.1 expected deaths, which is in line with Manchester's and Birmingham's mortality levels.
- The Bereavement Team are working more closely with the Mortality Review Group with two new Palliative Care Consultants attending meetings. Attention was drawn to the visiting restriction issues on the Bereavement Suite. Nicki Murdock agreed to look into this matter as it was felt that more can be done to assist the families of deceased patients access the suite.

20/21/152.1 Action: NM

- Louise Shepherd highlighted the unusually lower than expected figures for Great Ormond Street Hospital in the Standardised Paediatric Mortality Index and 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 speak to Julie Grice regarding this matter.

20/21/152.2 Action: NM

Resolved:
The Board received and noted the Mortality Report for Q1.

20/21/153 Weekly Corporate Report – Top Line Indicators

The Board received the top line quality, safety, effectiveness and responsive indicators highlighted in the weekly Corporate Report. The following points were highlighted:

Safety

- There were five moderate incidents reported between the 21.9.20 and the 12.10.20, of which, four have been downgraded following 72 hour incident reviews, and the fifth is being investigated.
- *Sepsis* – There has been a real improvement in figures, especially in inpatients. ED figures relate mainly to intravenous access. A suggestion has been made to use an amber RAG rating within this metric as a lot of the time the sixty minute target is missed due to not being able to gain intravenous access. It was confirmed that forthcoming reports will reflect the amber metric for ED.

Effectiveness and Responsive

- The Emergency Department has treated 95.71% of patients within four hours.
- There were seven operations cancelled on the day as a result of accommodating urgent patients.
- The Trust has increased its swabbing capacity for emergencies.
- Reporting within 6 weeks is improving.

- It was reported that there are no patients waiting over 52 weeks for an appointment with the Division of Medicine. Attention was drawn to the challenges the Division of Surgery are having in respect to reducing their 52 week waiting list. Figures should start to decrease as work progresses on the restoration of services.

It was pointed out that the Board is not currently receiving Divisional performance highlights as part of the top line indicators report and it was felt that this is an important part of Board assurance. It was agreed to ensure that this information is covered on the main agenda going forward.

20/21/153.1 Action: KMC

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

20/21/154 Serious Incident Report

The Serious Incident report was presented to the Board to provide an overview of the current position for incidents reported externally to the Strategic Executive Information System (StEIS), including new incidents reported between 1.9.20-30.9.20. The following points were highlighted:

- There were zero serious safeguarding incidents, zero 'Never Events' and zero 'moderate harm' incidents reported during this period.
- There is one new incident that has been uploaded onto StEIS which relates to the front teeth of a patient being re-planted into the incorrect sockets following a traumatic incident. It was confirmed that this is a low harm incident and an investigation is underway.
- There are 8 RCAs open at the present time and none have been closed in September.

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

20/21/156 Weekly Corporate Report – Top Line Indicators

People

This item was discussed during agenda item 20/21/151

20/21/157 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:

- Mandatory training figures are slightly below the Trust's target of 90%, at 89.27%. The Trust will continue to focus on this area of work during the winter.
- PDRs recommenced in June 2020 and figures are currently at 36.25%.
- The national Social Partnership Forum (SPF) issued an updated statement on the management of industrial relations during the pandemic in September 2020. The guidance confirms that disciplinary and other employment

procedures are able to commence and outlines the need for partnership working with staff side colleagues to proactively and effectively support staff. Cases continue to be managed on a case-by-case basis with appropriate measures and risk assessments put in place to ensure staff health and wellbeing continue to be prioritised. It was reported that there are a total of 18 employee relations cases to date.

- Staff survey response is currently 26% to date.

EDI Task Force Action Plan

It was reported that the inaugural meeting of the EDI Task Force has taken place. Meetings will continue on a monthly basis until the end of the year and from thereon will take place every six weeks. The task force is going to look at internal/external strategies along with processes and procedures. There will be a focus on recruitment/how the Trust can recruit in an alternative way, and listening sessions have commenced for BAME staff.

It was reported that some BAME staff didn't feel as though they could be open at meetings in case they offended their colleagues with their view points. Claire Dove informed the Board that she has agreed to meet separately with these members of staff. Seminars are to be scheduled to enable the Trust to listen, engage and make changes. The Task Force Group is also looking to liaise with universities who provide Alder Hey with students and work will commence with local schools.

Claire Dove drew attention to the success of 'Black History Month' at Alder Hey and provided an overview of the activities that are taking place/forthcoming locally and regionally to support the 'Black Lives Matter' campaign and raise awareness.

Anita Marsland informed the Board that the inaugural EDI Task Force Group meeting was excellent and commended Claire Dove on her leadership and support in establishing the group. It was felt that a sustainable strategy is required to ensure that this area of work remains an integral part of the Trust going forward.

Resolved:
The Board received and noted the contents of the Alder Hey People Plan update and the EDI Task Force progress update.

20/21/158 Research Recovery Plan

The Board received a presentation which provided an update on the Research Recovery Plan. The following information was shared:

- Work Streams: Delivery, Partnerships and Enablers.
- Research Delivery: Outbreak response, delivery objectives, progress, LAVA Study.
- The aim of the Starting Well Programme/partnership collaboration development with Mersey Care.
- Innovation and partnerships: CLIK audiology testing, Apple and University of Liverpool.
- Partnership/Commercial: Commercial Research Unit to be established.
- Enablers/visibility: Internal staff engagement/external industrial and academic engagement.
- Enablers/future talent: Future Researchers' Programme.
- Enablers/Reach: Commercial and non-commercial.
- Liverpool Health Partnership: Urgent Public Health portfolios.

It was felt that the current work that is taking place between the Research Team and the Divisions has improved research visibility immensely. Attention was drawn to the importance of progressing the commercial element of work, along with the LAVA Study and Starting Well Programme. Louise Shepherd thanked all those involved for the excellent job they are doing in driving this area of work forward.

Fiona Marston asked as to whether the ten year Research Plan links in with innovation. It was reported that there has been an increasing amount of work taking place between the Research Team and the Innovation Team to look at how these two areas of work will come together. The Trust is also recruiting to a joint Director of Research and Innovation post and discussions are taking place to agree a robust approach to underpin research and innovation.

The Chair thanked Jason Taylor for the presentation and felt that it is clear that studies are re-commencing and the Team is being proactive.

Resolved:
The Board noted the update on the Research Recovery Plan.

20/21/159 Starting Well, Prevention and Alder Hey's Partnership with Liverpool City Council Public Health

The Chair welcomed Liverpool City Council's (LCC) Consultant in Public Health for children and young people (CYP), Melissa Campbell.

The Board was provided with an overview of the direction of travel in respect to Starting Well, prevention and health inequalities and received a high level presentation on the proposed work that will help to strengthen previous partnership work between Alder Hey and LCC. The following points were highlighted:

- It was pointed out that generally Liverpool has the worst population health outcomes at every life stage. This is driven by social inequalities due to a high proportion of people living in deprivation which tends to impact on children. By implementing measures to protect children and enhance their early years it was felt that this could influence early adulthood too.
- *Covid-19 impact on CYP:*
  - Inequalities gap will increase.
  - There will be a short and long-term impact on CYP.
  - Direct/Indirect impact.
- *What's the strategy*? - Work has been taking place to align the City Plan, the health segment of the One Liverpool Plan and Alder Hey's Strategic Plan. It was reported that there is a direct line through all three of the system strategies with a key focus on starting well.
- *Our Vision for Liverpool City* – 'Starting Well, Living Well and Ageing Well'. It was reported that Alder Hey has agreed to take leadership for the system proposal to collectively progress the Starting Well agenda.
- *Our Plan*
  - Starting Well.
  - Public Health and prevention at Alder Hey.
  - Alder Hey action on health inequalities.
- *Starting Well Partnership*
  - Delivery of the City Plan Starting Well priorities.
  - Drive a better future for CYP and families through working together to reduce; infant death by a third, improve school readiness, reduce childhood obesity, reduce health inequalities and improve mental wellbeing.

- *One Liverpool Strategy/City Plan* – An overview was provided of the membership of the Starting Well Board along with the strategic alignment of accountability groups and delivery groups.
- *Joint AH/Public Health Role*:
  - The ambition of this role is to support enhanced partnership working between Alder Hey and LCC.
  - Help align priorities for tackling and embedding interventions and measures for wider determinants of health.
  - Create a shared understanding of need.
  - Work internally with Alder Hey, support the Starting Well Board and feed into the Integrated Partnership Group.
- *Recommendations*:–
  - The Board is asked to endorse the establishment of the Alder Hey partnership with LCC on public health.
  - Support the establishment of public health governance in Alder Hey.
  - Support the recruitment of the joint public health resource.
  - Endorse Alder Hey's role in the commencement and delivery of the Starting Well Programme Board.

It was queried as to whether there is going to be a similar plan implemented in Sefton for CYP to ensure an alignment of services. Melissa Campbell advised that this project has a Liverpool focus but pointed out there will be an opportunity to discuss this matter at the Starting Well Board.

Claire Dove highlighted the importance of having a joined up approach to address the poor educational attainment of a large number of children in Liverpool, and queried as to whether a discussion has taken place between LCC and Jonathan Jones in respect to the work that he is conducting in relation to this issue. Melissa Campbell advised that LCC works closely with Jonathan Jones and School Improvement Liverpool and confirmed that Jonathan will be sitting on the Starting Well Board. It was confirmed that the membership of the Board will cover education.

Anita Marsland felt that one of the key components for successfully addressing health inequalities in Liverpool is the resource, and acknowledged that there is much more clarity now as well as a stronger partnership across the city and beyond, which feels encouraging.

Fiona Beveridge queried as to whether there is anything that can be done in the interim period whilst the longer-term piece of work gets underway, and highlighted the urgency of linking the Covid-19 impact emergency pieces to the education outcomes of young people. Attention was drawn to the worrying state in which some children will leave school given the amount of absence this year and the fragility of the qualifications agenda. The Government has been quite intransigent about the procedure for GCSEs and A Levels therefore many more children may leave school without the qualifications that will enable them to progress.

It was reported that there are a number of things that can done that aren't being done presently. The recruitment to the shared role will support this area of work operationally and link in with clinical teams and services. In addition to this Professor Taylor Robinson who is based at Alder Hey has been driving this agenda for many years and will be a core member of the Starting Well Board.

Louise Shepherd thanked Melissa Campbell and the Public Health Team for driving this area of work forward. The Board was advised that Melissa Campbell's leadership and Matt Ashton's recruitment has helped to change the focus of public

health in Liverpool in a positive way. The Chair recognised the importance of the work taking place in terms of the greater Merseyside area and offered Alder Hey's full support.

Resolved:
The Board approved the recommendations highlighted in the presentation.

20/21/160 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:

- *Park Reinstatement* – The Board was advised of the legacy overspend in respect to the reinstatement of the park. It was reported that work is taking place to address the funding issue.
- *Alder Centre* – This project is in its final stage of completion.
- *Clinical Hub and Dewi Jones Unit* – It was reported that the construction of these two buildings are progressing at a pace.
- *Neonatal Development* – This development is being progressed.

The Chair thanked David Powell for the update and drew attention to the key challenge for the Trust in respect to the resources required to reinstate the park. The Board noted the resource issue but agreed that the Trust has a responsibility to honour its commitment to reinstate the park.

The Board was advised that a reset of resources has taken place which has enabled a readjustment of the existing envelope. A check and challenge process will take place in the next two weeks to ensure that the Trust is meeting its obligations in a best value way. It was also reported that the Resources and Business Development Committee (RABD) are allocating a lot of time on the Committee's agenda to address this matter.

3D Model Campus Presentation

Louise Shepherd gave an overview of the purpose for providing the Board with an update and virtual tour of the campus. It was felt that the vision for the campus all those years ago is starting to come into fruition and is going to be an amazing platform for children's health going forward. The Board was advised of the fabulous job that David Powell and his team have done, they've been passionate about the project and have held the organisation to account over the quality of the construction. It was pointed out that this is a staging post in a very long journey with a team who have held the vision.

David Powell advised that the Trust's vision was to create a beautiful setting for its patients, families and staff and to put a lovely well maintained park asset back into the local community. The work that has taken place so far has allowed the Trust to develop schemes, for example, the new hospital, the Institute, etc. within this context and create a green masterplan that will be an Alder Hey USP.

There are three elements to the vision; Alder Hey schemes, designing and restoring the park and park sustainability. It was reported that there have been a number of ideas put forward around the opportunities for the park once the campus is complete; socially prescribed activity, ideas for health and wellbeing for staff, cycling, running, etc.

The Board was provided with a video that gave an aerial view of the vision for the

campus upon completion. The Chair thanked the team for the presentation and pointed out that the plans for the site will support the Trust's ideas for improving the health of patients, families and staff and will provide lots of opportunities.

Jim Chapman drew attention to the importance of maintaining the quality of the project right through to completion. The financial challenge to do this was acknowledged, but it was felt that the Trust has made such a huge investment in creating a very special place that has produced a quality of health and wellbeing that hasn't been done elsewhere to date, and with this in mind it is imperative to retain that quality.

Engagement Plan

The Board received an activity update on the Springfield Engagement Plan and noted the progress to date.

Attention was drawn to two risks that were highlighted in March 2020:
1. Sustaining the park; it was reported that Capacity Lab has conducted a large piece of work to address the sustaining of the park and will provide an update during their presentation.
2. Lack of engagement and vocal opposition on the ground; work has taken place with the wider community groups, MPs, Councillors and it was reported that LCC has officially acknowledged ownership and responsibility of the park.

The Board was advised of the potential for an infrastructure of the new cycling hub for disability with 'Wheels for All'. Discussions are on-going at the present time as a result of Capacity Labs involvement.

The Chair extended a warm welcome to Jenni Kirkham and Emma Lord from Capacity Lab.

Capacity Lab shared a number of slides with the Board to provide information on the following areas:

- Scope of the work being conducted by Capacity Lab:
  - Community and Stakeholder engagement alongside park activities.
  - Fundraising £2.5m for enhancements above and beyond the core park.
  - Mobilise a legal vehicle to lead the park beyond the Trust's work.
- Progress on connecting, activities and building a sustainable legacy.
- Core park features and enhancements for the world's best park. Attention was drawn to the issue relating to lighting in the park. It was pointed out that lighting is not part of the basic core requirement therefore discussions are ongoing regarding this matter of which Capacity Lab are managing.
- Where Next?
  - Fundraising to lock in park enhancements.
  - Continued activity to drive footfall and profile of the park.
  - Mitigate outstanding risks.

Claire Dove suggested having a greater variety of activities in the park to make it more appealing to the community, and involving local entrepreneurs. Jenni Kirkham advised that there is an extensive list of exciting activities that have been proposed by various people and it was confirmed that the aim is to have locally grown social enterprises involved with the park.

Shalni Arora highlighted the importance of ensuring lighting/security are part of the basic core requirement.

David Powell summarised the next steps for the campus referring to the PR Plan/increasing the Trust's profile, and offered the Board an opportunity of a guided tour of the site.

The Chair expressed her thanks to everyone who provided an update and felt that it had provided a good opportunity for the Board to gain an understanding of the practicalities required to progress the ongoing campus development work.

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

20/21/161 Reducing the Burden: Board Assurance Committee Re-set Proposal

The Board received a number of slides that provided information on Phase 2 of the Divisional Governance Review. The following points were highlighted:

- Principles:
  - Better alignment with information flows/data driven.
  - Operational Excellence Programme – brilliant basics.
  - CQC Well Led.
  - Reflects and supports the Trust's post Covid-19 plans.
  - Enabling but safe reduced burden.
  - Measure what matters – high level KPIs.
- Current position of Phase 1 and Phase 2.
- Review of the Operational Delivery Board and revised arrangements for the Care Delivery Board.
- Divisional governance key themes.
- Divisional governance – What works well.
- Divisional governance – Points for discussion: System improvements, required corporate support and changes in working practices, with particular actions proposed around a 'back end' cleanse of Ulysses and the benefits of creating a centralised RCA support function.

It was felt that the outcome of Phase 1 and 2 of the review reflects a strong position in respect to the governance arrangements that are in place across the organisation. Attention was drawn to the importance of progressing the cultural change work with the Divisions leading on it.

The Chair highlighted her delight that this piece of work has come into fruition.

Resolved:
The Board received the Phase 2 Divisional Governance Review update and endorsed the approach/suggested changes.

20/21/162 Board Assurance Framework

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

- A meeting has taken place with the Chairs of the Assurance Committees to discuss the alignment of risks in the BAF with respective Committees in order to offer assurance to the Board on risks.

- It was confirmed that deep dives into the risks incorporated in the BAF will take place at specific times.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report as at the 13.10.20.

20/21/163 Board Assurance Committees

RABD **–** During the meeting on the 19.10.20 the Committee discussed the Trust's long-term cash position for the next 5 years. It was reported that there will be a reduction in cash towards the end of year 5 but it was confirmed that mitigations will be in place prior to this. The Committee also discussed the implementation of a process to ensure overruns don't occur on capital projects.

SQAC – The Committee did not discuss the top 5 key risks during the meeting on the 21.10.20 due to receiving a large number of apologies from key people. It was felt that it was important for key staff members to be in attendance when discussing these risks. This gave the members of the Committee additional time in which to have an off-line discussion about the embedding of the Committee's new approach. It was reported that the Committee received the Quality Accounts for 2019/20 and approved the content. The Committee was observed by one of the Trust's new governors, Nicki Thorbinson.

Innovation Committee – The Innovation Committee spent a large period of time discussing the Innovation Strategy, during October's meeting. It was reported that this piece of work will be completed in the near future and submitted to the Trust Board for approval.

Liaison Committee – The minutes from the meeting that took place on the 9.9.20 were submitted for information purposes.

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

20/21/164 Any Other Business

There was none to discuss.

20/21/165 Review of the Meeting

The Chair felt that there has been a great deal of input from respective staff members in order to provide relevant information and assurance to the Board of the Trust's position to date. Attention was also drawn to the progress that has been made in managing Board meetings virtually since March.

Date and Time of Next Meeting: Thursday the 26th of November 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 26th of November 2020							
07.07.20	20/21/91.3	Year-End Quality Assurance	*The Work of Alder Hey Youth Forum during Covid-19* - Provide an update in October on the work that has taken place between the Youth Forum and the NSPCC.	Lisa Cooper	26.11.20	Closed	**20.11.20** - The Alder Hey Youth Forum will be providing an update on the 26.11.20 at 5:00pm via Teams in respect to the work that has taken place between the Youth Forum and the NSPCC. **ACTION CLOSED**
24.9.20	20/21/122.3	Phase 3 Covid-19 Response	*2020/21 Financial Plan and Phase 3 Framework* - Submit a regular update to the Board in order to outline the cash balance in terms of cash commitment.	John Grinnell	26.11.20	Closed	**20.11.20** - This item has been included on November's Board agenda. **ACTION CLOSED**
24.9.20	20/21/136.1	Board Assurance Framework	Provide an update regarding a formal risk appetite that is to be included in the BAF.	Erica Saunders	26.11.20	Closed	**22.10.20** - Work is taking place to address this action. An update will be provided during November's Trust Board. **20.11.20** - This item has been included on November's Board agenda. **ACTION CLOSED**
22.10.20	20/21/151.1	Covid-19 Assurance Plan – Progress Update and Incident Response	*IPC Covid-19 Assurance Framework - circulate the IPC Covid-19 Framework to members of the Board for assurance purposes.*	Nicki Murdock	26.11.20	On Track	
22.10.20	20/21/152.1	Mortality Report, Q1, 2020/21	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.	Nicki Murdock	26.11.20	On Track	
22.10.20	20/21/152.2	Mortality Report, Q1, 2020/21	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.	Nicki Murdock	26.11.20	On Track	
22.10.20	20/21/153.1	Weekly Corporate Report – Top Line Indicators	Arrange for Divisional performance highlights to be covered on the main Board agenda going forward.	Karen McKeown	26.11.20	Closed	20.11.20 - This item has been included on November's Board agenda and will continue to feature on forthcoming Board agendas.
Actions for the 17th December 2020							

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
03.03.20	19/20/346	Key Issues/Reflections and items for information	Invite the new Nurse cohort from India to the Trust Board lunch and write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff.	Pauline Brown	17.12.20	On Track	This item has been deferred until further notice due to the Covid-19 crisis.
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**
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	17.12.20	On Track	
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	26.11.20		**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**
Actions for the 28th of January 2020							
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		
Status							
Overdue							

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
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD

Thursday 26th November 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 has been dealing with the COVID-19 pandemic since mid-February which has had a significant and adverse effect on capacity, productivity and waiting times. Despite high COVID-19 community prevalence, preparations for EU Exit and winter pressures we remain focused on reducing waiting times by restoring service capacity. 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 October expressed is as follows:

Service	NHSE Plan	Aug-20	Sep-20	Oct-20
Outpatients	100%	86%	87%	84%
DC/IP	90%	84%	76%	87%
Diagnostics	90%	73%	86%	86%

Service	Provisional	
Forward Look	w/c 2nd Nov	w/c 9th Nov
Outpatients	89.7%	89.2%
DC/IP	90.6%	91%

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

The detail behind the trend and reasons for performance are set out in section 3. In **outpatients** the proportion of restored activity reduced relative to September. Nonetheless, the total number of children receiving a consultation increased. The new OPD schedule did

go-live, as planned, on the 26 October and we expect this to increase restoration levels in November.

In **elective care**, there was a 11 percentage point increase in restoration driven by additional weekend working and an increase in Day Case activity levels.

The **diagnostic** standard performance has plateaued. In **radiology** overall levels of restoration are good but they did fall in month driven by a reduction in referrals from OPD, ED and GP's and it remains difficult to fully restore productivity levels given COVID-19 guidelines.

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

3. Restoration by service area

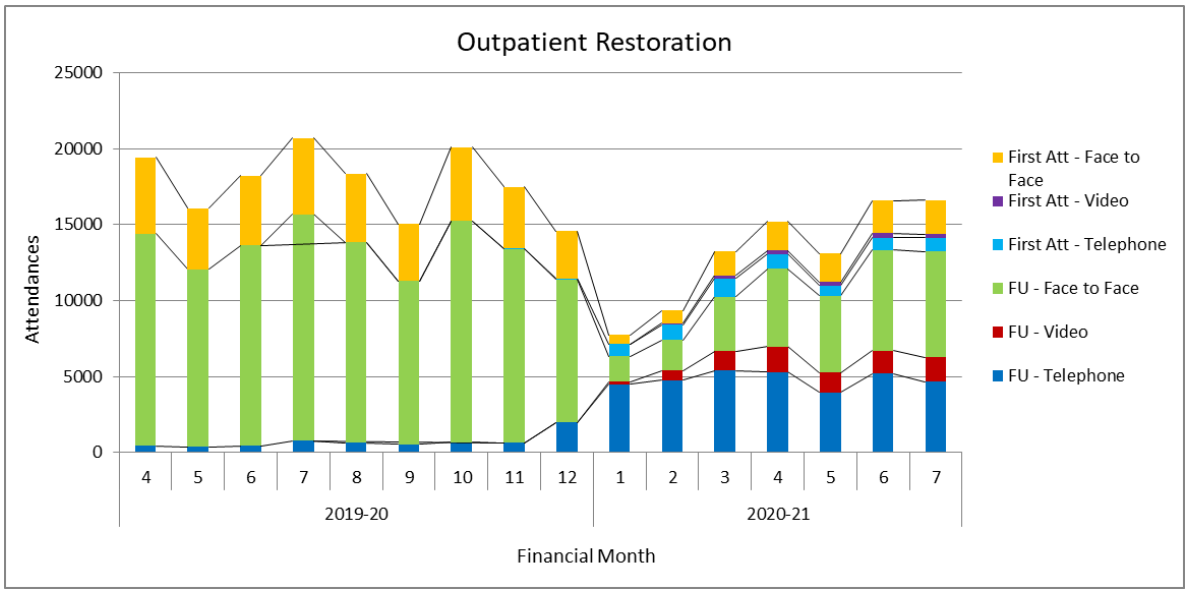
3.1 Outpatients

Our high-impact interventions continue to improve outpatient restoration. The aggregate levels of OPD activity are continuing to increase; however, when compared to M7 activity in 19/20 we have not bridged the gap. We have seen an increase in OPD activity for Medicine which has been offset by a slight reduction in surgical OPD activity (n.111 / -1.18%).

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
- Review of specialty use of attend anywhere for scope to expand virtual clinics
- Increased Nurse Lead & Registrar clinics
- Locum Consultant Recruitment
- 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

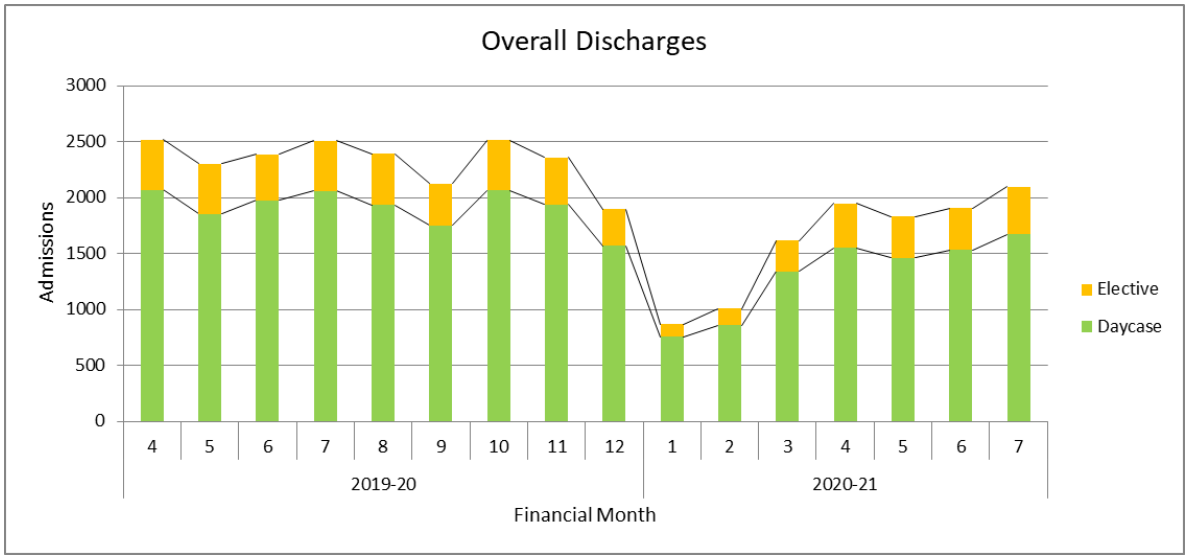
The aggregate activity profile in the table shows a slight increase in aggregate activity in M7 relative to M6.



3.2 Elective & Day Case Activity

Elective activity restoration has continued to increase, reaching 87% in October, up from 76% in September, but is just short of the target for M7 which increased to a target of 90%. In elective care the following actions continue to further improve restoration:

- Focus on day case surgery improvement programme
- Additional Saturday theatre list commenced from October.
- Continuing to develop extra weekend theatre sessions
- Day Case utilisation improvement programme
- Pooling of lists
- Review cases per list to maximise utilisation



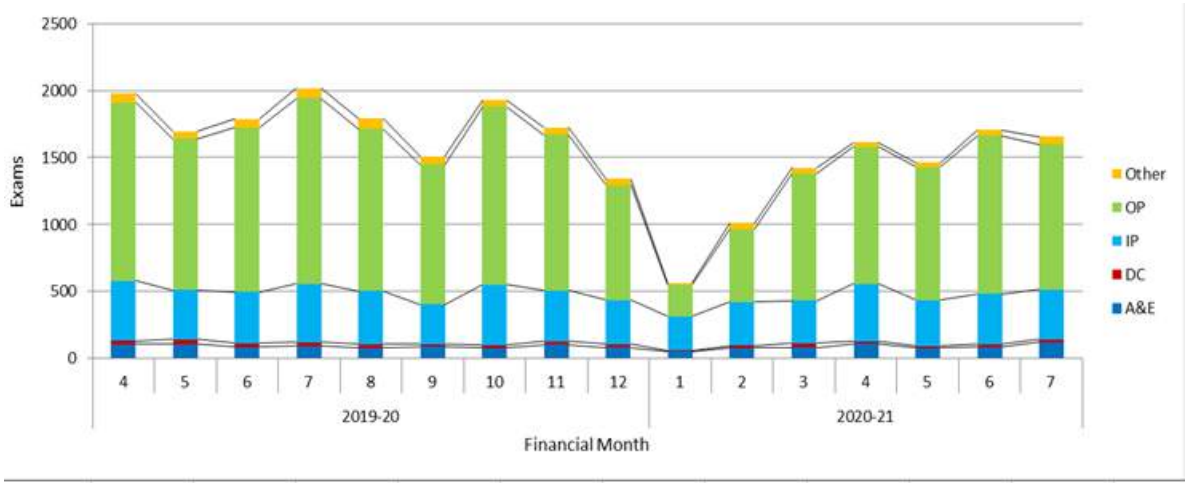
3.3 Diagnostics

In diagnostics progress continues with restoring services which has reduced the number of children waiting less than 6 weeks for a scan and improved performance against the DM01 99% standard. Despite the progress the Radiology performance has reduced against 19/20 levels. This is due to a reduction in the volume of referrals received from OPD, ED and GP Direct Access reduced across M7. The high levels of restoration have been achieved by the Department undertaking a range of initiatives to maintain increased levels of protection against the virus which has supported staff to return to running full lists. Restoration continues to be developed within the Restoration Endoscopy procedures (colonoscopy, flexi-sigmoidoscopy & gastroscopy) which are undertaken within the Day Case theatre environment. The teams have continued to improve access by developing a range 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 increased resilience in Ultrasound and MRI upstairs to enable us to do more elective work.
- Plans being developed to reinstate the second on call for MRI and CT which will support IPC recommendations for donning / doffing over the winter as prevalence is high in attenders for trauma when COVID status is not known.
- Staff welfare/engagement continues with departmental de-brief via teams following on from the Trust briefing by Louise and team.
- 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

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

Diagnostics (Restoration)

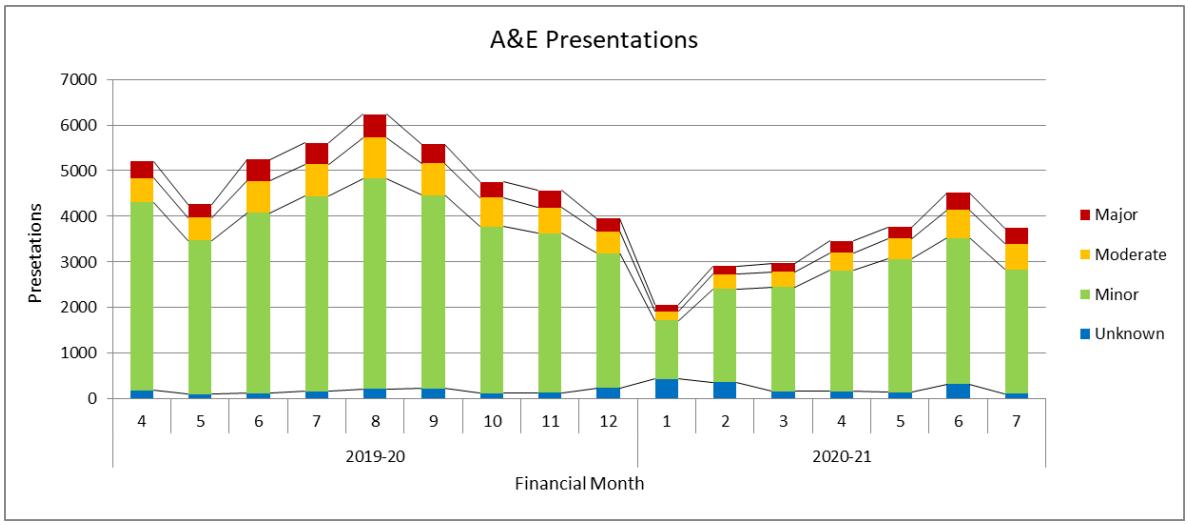


Diagnostics (DM01) Performance against 99% standard

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Diagnostics: % Completed Within 6 Weeks	99.8%	100.0%	99.7%	100.0%	100.0%	99.1%	42.8%	67.0%	81.9%	82.9%	78.9%	87.6%	96.4%

3.4 ED attendances

ED performance for the year continues above the 95% standard despite the challenges of social distancing. Attendance has been steadily increasing from M1 however has reduced in month 7:



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	98.54%	98.54%

3.5 Cancer Performance

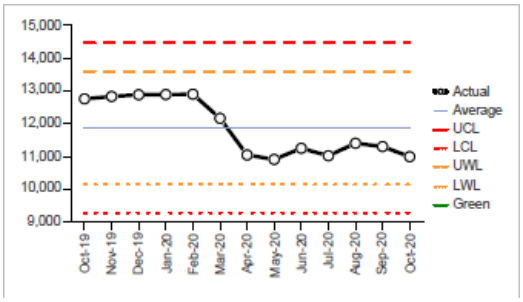
Throughout the pandemic we have maintained delivery of robust cancer performance at Alder Hey as reflected in the tables below.

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	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%	100.0%	0.0%	100.0%	100.0%

4. Waiting times analysis

4.1 Overall waiting list size

With levels of referrals lower than pre-COVID-19 and the general increase in aggregate capacity the overall size of the consultant-led waiting list has reduced. As phase 3 restoration plans continue to roll out the positive impact on waiting list size can be seen within the SPC chart and data below.



Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
12,754	12,827	12,879	12,885	12,895	12,162	11,046	10,909	11,248	11,022	11,402	11,033	10,994

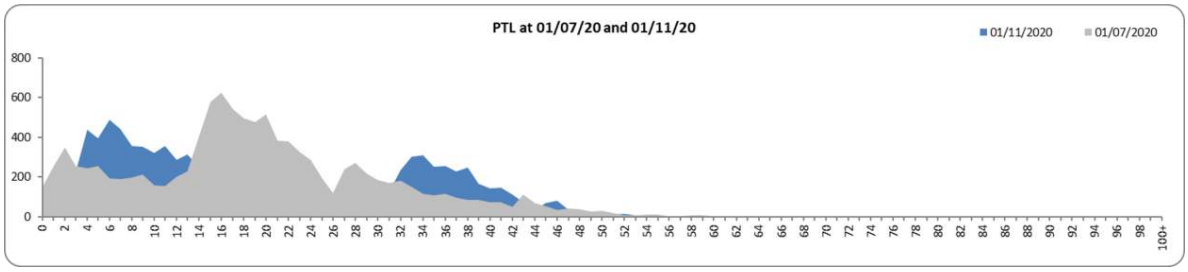
4.2 New outpatient care: waiting list size and waiting times

Between July and November the number of patients on the outpatient waiting list (new patient) has reduced from 11,086 to 9,832. The number of children waiting over 52 weeks for a new appointment is reducing marginally:

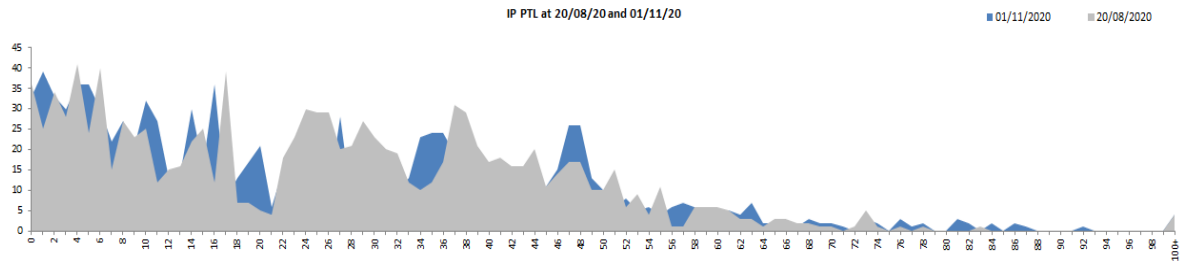
Size of OP WL		0 - 39	40 - 51	52+
01/07/2020	11086	10405	610	47
01/08/2020	10509	9913	558	37
01/09/2020	10385	9608	734	29
01/10/2020	10015	9142	835	30
01/11/2020	9832	9010	469	24

The movement in the **distribution of the outpatient waiting list,** from July to November, is shown graphically. It demonstrates:

- A positive trend of more patients in the less than 14 weeks wait category
- A challenge to provide capacity for patients waiting 32-42 weeks so they do not wait greater than 52 weeks



4.3 Inpatient care: waiting list size and waiting times



Size of IP WL		0 - 39	40 -51	52+
20/08/2020	1,144	873	181	90
01/09/2020	1,116	819	181	116
01/10/2020	1,126	841	170	115
01/11/2020	1,059	791	162	106

- Total size of IP waiting list has reduced
- Slight reduction in patients waiting 40-51 weeks.
- Number of IP waiting >52 weeks stable month on month (slight reduction since 1st Sept)

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 are seeking to book treatment dates for all patients waiting over 46

weeks and ensure the majority are within the 52 week timescale. The goal is to reduce the number of surgical inpatients waiting >52 weeks to 80 by 31 December 2021.

5. Conclusion

The collective challenges with managing Covid19, winter, flu and now asymptomatic testing and vaccine preparations are not insignificant and yet despite this Alder Hey continues to improve access to care for our Children and Young People. We will continue to focus on improved restoration in outpatients and day case surgery over the next 3 months and develop our transformation programmes to support this.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th November 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		

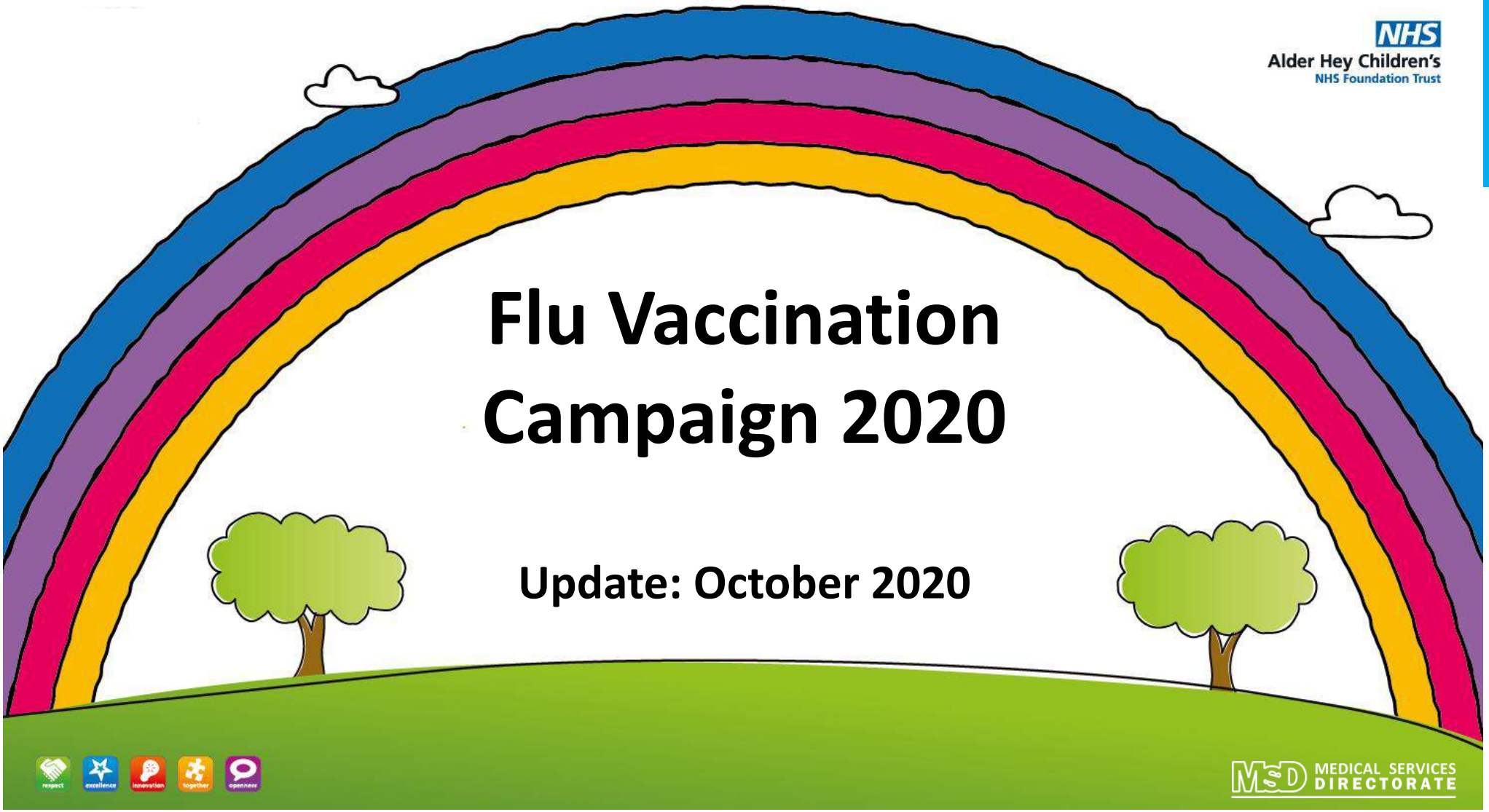
	holder.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified 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			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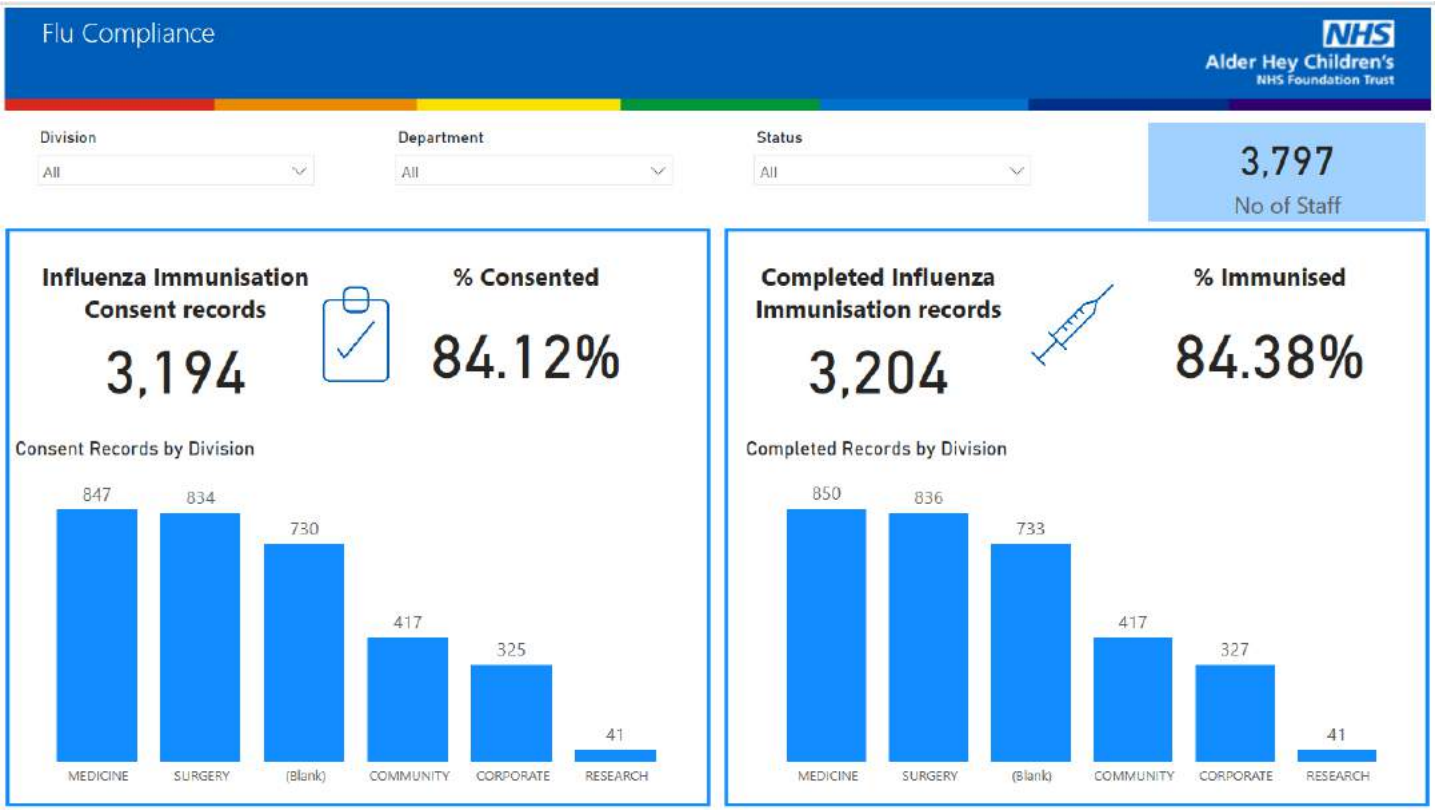
Flu Vaccination Campaign 2020
Update: October 2020
respect
excellence
innovation
together
openness
MSD MEDICAL SERVICES DIRECTORATE

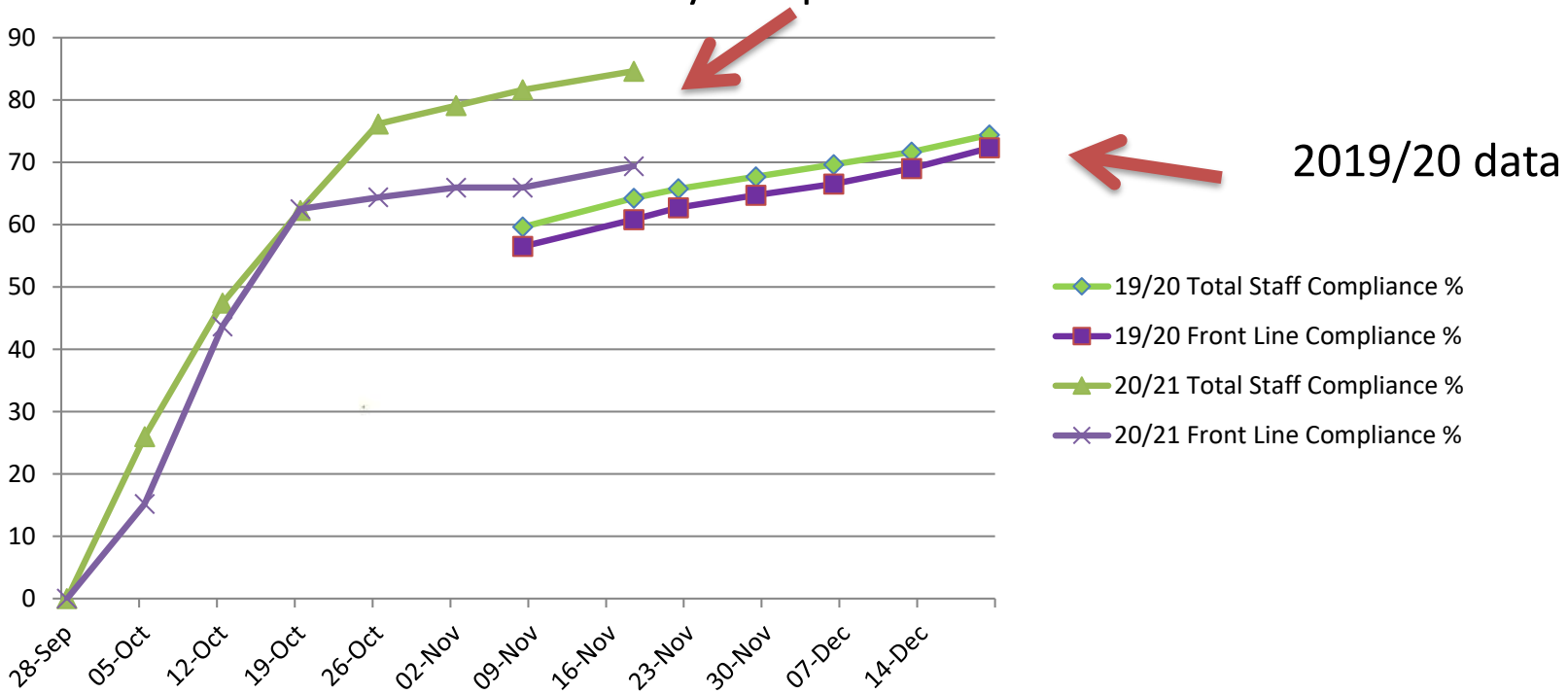
Progress



(*figures from 18/11/2020)

Progress

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



2019/20 data

(*figures from 18/11/2020)

MSD MEDICAL SERVICES DIRECTORATE

Challenges

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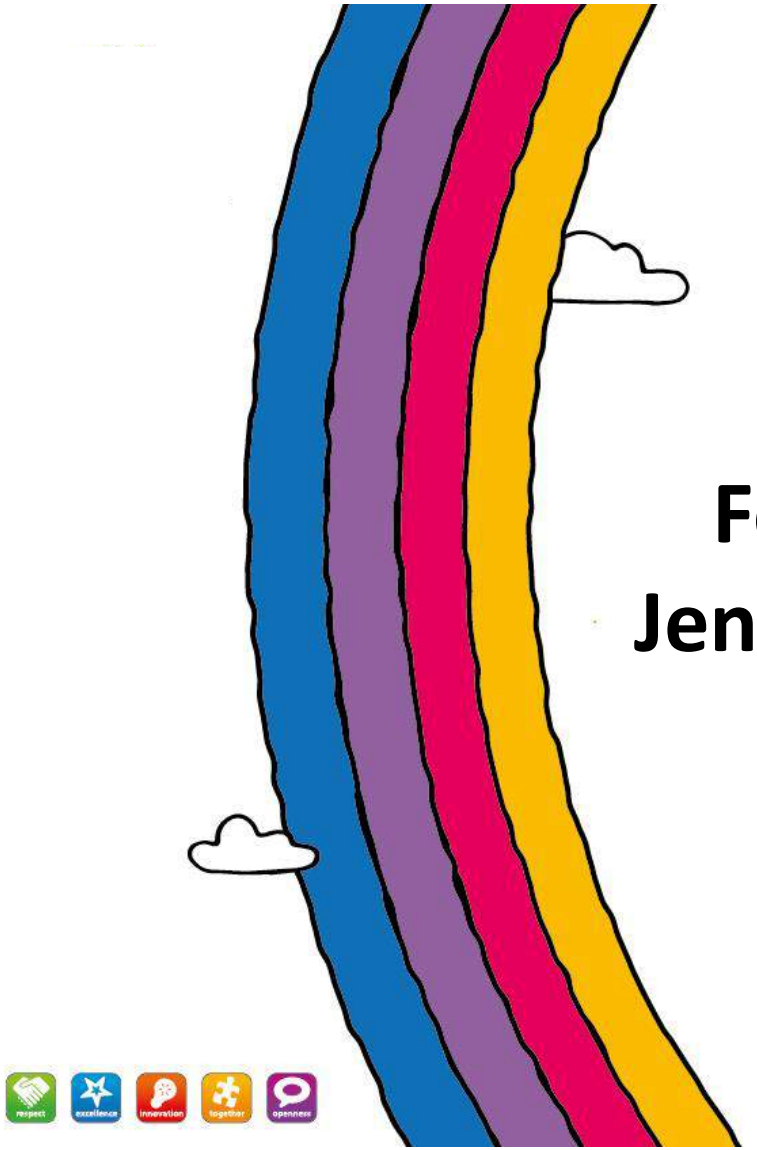
- Have most staff that would have it had it?
- Flu jab in advance of COVID vaccination
- End to campaign but staff still able to obtain it if desired
- Operational resources required to support COVID vaccination service



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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 26th November 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 **32** risks identified on the COVID 19 risk register compared to **36** in the previous reporting period to board. There are **3** high risks on the register (references 2138, 2188, 2182) compared to **4** in previous reporting period, **24** moderate risks 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 = 4 (table 3)

Number of new open risks = 1 (table 5)

Number of risks with an overdue review date = 6 (table 6)

Number of risks with overdue actions = 12 (table 7)

Number of risks with no agreed action plan = 7 (table 8)

Number of open risks with increased risk scores = 2 (table 9)

Number of open risks with reduced risk scores = 2 (table 10)

Number of open risks with no risk rating = 0

Note: Appendixes 1 - shows summary tables

3. Themes

3.1. Access to services

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

Firstly, a risk around delays in accessing services and the potential short- and long-term impact this could have on patient safety. *"Risk of not seeing C&YP who need treatment, 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. The significant reduction in this risk is due to partnership working and the associated internal and external controls being enacted, for example communications directly from Alder Hey to local community that we are open for business, National 'NHS Open for Business Campaign', weekly MDT established with Alder Hey and all C&M paediatric network partners. Also, late presentations, capture of incidents on the Ulysses incident reporting system , which at time of reporting shows minimum evidence of incidents and no evidence of significant harm.

As highlighted in the previous reports the Trust has identified an issue around increased waiting times due to COVID 19. The current risks identified include " *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, but it is currently rated at 4x3=12. The reduction is due to the contingency plan being enacted, however at time of reporting there are 146 patients on the waiting list to be validated. In addition, work has begun to book diagnostics with clinics now that some of the clinic templates are open but approx. 1,500 outstanding without a planned clinic date. Work is ongoing to resolve this in the wider divisions.

"*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 was 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 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'. However, to mitigate the risk requires support from CCG.

"*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 2142, 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. However, quality of the data being received is not reliable. Data manager although appointed has not been released from current job due to staffing pressures. 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

There are a further 5 lower level risks identified within this theme.

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".* As highlighted in previous reports, this risk cuts across many of the 'business as usual' risks identified on the Trust risk register, with the potential to increase the level of many of these risks, although this has not been identified so far on operational risk registers.

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

This is the second highest rated risk on the COVID register i.e. 4x5=20 *"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 was first identified in April 2020 and was subsequently closed in July 2020. However due to the second COVID wave and the anticipated winter pressures it was reopened in October 2020. There are numerous actions identified to help mitigate this risk for example, work ongoing with HR Recruitment Team to further the reach of job advertisements - currently majorly through NHS jobs. To explore social media,

radio advertising, etc, pay enhancements, staffing workstream established reporting to gold command. It is anticipated this risk will be reduced before 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.

This is clearly a central theme across the COVID 19 risk register. The third high risk on the register relates to Personal Protective Equipment (PPE). (risk ref.- 2082), 5x5 =15 "*Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained".* 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 are other ongoing risks identified ranging from 12 to 6 relating to staff contracting COVID, although there are numerous controls in place and ongoing contingency plans to mitigate. The expectation is that these risks will continue to be further mitigated prior to the next reporting period.

Appendix 1

1. Risk Register Profile - 16th November 2020 (Total 32)

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**	**1**	**1**	**3**	**4**	**10**	**4**	**6**	**1**	**0**	**2**	**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 – 16th November 2020

Table 2

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

1. SUMMARY High Risks

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

Table 3

Strategic Objective	CQC Domain	Ulysses Ref.	Risk Description	Current Risk Score CxL	Trend	Target Risk Score CXL	Action plan	Progress update	Risk Owner	Governance
The Best people doing their best work	Well - Led	**2182**	Risk of insufficient financial resource to meet demand	4x5 = 20	↔	3x3 = 9	Action plan in place	The Trust is currently in active dialogue with NHSI to address the identified defects in funding. In addition, a cost review programme has been activated to mitigate the risk.	Deputy CEO/ Director of Finance	RABD
Delivery of Outstanding Care	Safe	**2138**	Risk that front-line nurse availability will be significantly compromised during winter 2020 / second COVID peak Consequently compliance with national nursing standards for safe staffing levels on wards and departments will not be met	4x5 = 20	**new**	4x3 = 12	Action plan in place	Contingency plans progressing , progress reporting to gold command weekly.	Director of Nursing	SQAC
The Best people doing their best work	Safe	**2180**	Risk of not securing suitable and sufficient PPE to meet demand, to	5x3 = 15	↔	2x3 = 6	Action plan in place	The management of PPE stocks continues to be undertaken and, currently, there are no areas of concern in	Chief Operating Officer	SQAC

			ensure safety of patients and staff is maintained					relation to product shortages or stock levels. In addition, the PPE Predictor continues to be submitted weekly to the Care Board and bi-weekly to the PPE Oversight Group.		

Table 4 Closed risks

Risk reference	Risk description	Target
Risk 2149	Unable to guarantee ward staff can adhere to 2m social distancing guidance as set by the government	5
Risk 2201	Staff contracting COVID due to non-compliance with safe social distance	5
Risk 2213	Increased exposure to a cyber-attack / cyber security incident - which could result in data confidentiality, integrity and availability being compromised	8
Risk 2255	Risk of deterioration in physical condition due to lack of face to face physiotherapy	2

Table 5 New risks

Risk reference	Risk description	Current risk rating
Risk 2287	Risk that complex neurodisability patients who require aerosol generating procedures (AGPs) physical condition will deteriorate further over time	12

Table 6 Number of risks with overdue review date = 6

Risk reference	Current Score	Target score
Risk 2142	12	6
Risk 2165	9	6
Risk 2172	4	2
Risk 2178	9	9
Risk 2182	20	9
Risk 2268	8	3

Table 7 Number of risks with overdue actions = 12

Risk reference	Current risk rating	Actions past expected date of completion	Target date set for completion
Risk 2118	8	3	2 x 30/09/20 1 x 31/10/20
Risk 2128	8	1	30/10/20
Risk 2153	6	2	2 x 29/05/20
Risk 2157	9	1	30/09/20
Risk 2162	9	1	01/11/20
Risk 2164	9	2	1 x 01/10/20 1 x 31/10/20
Risk 2165	9	1	07/09/20* (no owner or staff responsible)
Risk 2180	15	1	30/09/20
Risk 2181	12	2	1 x 30/09/20 1 x 31/10/20
Risk 2182	20	1	31/10/20
Risk 2268	8	1	20/09/20
Risk 2287	12	1	11/11/20

Table 8 Number of risks with no agreed actions = 7

Risk reference	Current Score	Target score
Risk 2119	5	5
Risk 2142	12	6
Risk 2160	9	Not allocated
Risk 2161	9	9
Risk 2172	4	2
Risk 2228	9	4
Risk 2285	12	6

Table 9 Number of open risks with increased risk scores = 2

Risk reference	Current Score	Target score
Risk 2138	20 (↑ 12)	12
Risk 2285	12 (↑no risk rating allocated previously)	6

Table 10 Number of risks with reduced risk scores = 2

Risk reference	Current Score	Target score
Risk 2178	9 (↓15)	9
Risk 2143	12 (↓15)	5

END

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BOARD OF DIRECTORS

Thursday 26th November 2020

Paper Title:	Serious Incident Report
Report of:	Nicki Murdock Medical Director 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 (1dt October -31st October 2020). The report includes recommendations and actions for improvements for StEIS investigations completed since the last 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 new incident reported
shows there was 1 incident reported that met the serious incident criteria during this reporting period. Investigation underway.

Section 3 incident Investigations completed- shows summary of 2 incident investigations, which were closed and completed on time.

Section 4 open ongoing investigation - shows there are 7 open incidents (excluding 1 new at section 2), 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					
Open (Total)	4	4	1	4	8	9	8					
Closed	1	0	3	1	0	1	2					
Never Events												
Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
New	0	0	0	0	0	0	0					
Open (Total)	1	1	0	0	0	0	0					
Closed	0	0	1	0	0	0	0					

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

Section 2 New incident

Table 3

StEIS Reference	Incident	Duty of Candour
2020/19349 **Date reported: 7/10/2020**	Potential issues with C-spine clearance	Completed - Compliant
Lead investigators identified. Investigation has commenced and is expected to be completed within the agreed timeframe		
Expected investigation completion date - 07/01/2021		

Section 3 Incident investigations completed

Table 4

StEIS Reference	Incident	Duty of Candour
2020/12954 **Reported 9th July 2020**	Incorrect setting on portacount machine (set at US standard not UK standard), invalidating all Fit testing carried out on staff.	Completed - Compliant

Recommendations

To adopt a non-medical equipment approval process to assess the appropriateness of equipment that is brought into the Trust. Consideration also needs to be given to any software issues relating to the introduction of such equipment.

Communicate with the Porta Count supplier in relation to the training that was carried out and to discuss the importance of making the default global setting the UK standard for those machines purchased in the UK.

Ensure that the FIT Test Project Plan is reviewed and monitored by the Health and Safety Committee and includes reference to:

Standard Operating Procedures.
Competencies,

A. The number of FIT test trainers required within the Trust to ensure FIT testing can be carried out for all required staff.
B. A register/record of FIT test trainers.
C. A register/record of FIT tested staff.
D. Fit2Fit accreditation for an identified number of staff on ESR.
E. Mandated requirement to upload all training records relating to FIT testing to ESR.
F. Management of the risk on the risk register.

To underline the importance of good risk management to managers. Ensure managers are aware of Trust risk management training schedule and that staff attend scheduled training.

Consideration should be given to having a train the trainer approach to FIT testing as part of a Business Continuity Plan. This would ensure that the necessary competencies are already written should this approach to FIT testing be necessary.

Actions for Improvement:

Non-Medical Equipment Committee to be set up or appropriate alternative to be put in place.
Contact Porta Count supplier to highlight issues with training manual; training material; instruction manual in relation to UK settings
Contact HSE to raise awareness of any further issues raised around Porta Count machines and supporting documentation in relation to UK settings that have not already been raised
Review and update the Trust Risk Management Strategy in line with best practice standards
Audit compliance with the Trust Risk Management Strategy Standards
Develop action plan to address recommendations from MIAA audit
Implement action plan from audit
Trust Audit Committee to ensure risks are managed appropriately across the Trust
Audit and risk committee to monitor audit action plan progress
FIT Test Project Plan to be regularly reviewed and updated by owner and regularly monitored by designated Trust body i.e. Health and Safety Committee to include the recommendations from this report.
Fit Test Project Plan is recommended to include FIT Test training records to be added to staff ESR records.
DIPC and IPC team to determine if a train the trainer approach to FIT test training is to be included in a Trust BCP
DIPC and IPC team to determine if a train the trainer approach to FIT test training is to be included in a Trust BCP
Train the Trainer FIT test trainer competencies and associated policies and procedures to be added to Trust BCP if appropriate

Expected investigation completion date - 23/10/2020 (Completed & submitted on agreed date)

Table 5

StEIS Reference	Incident	Duty of Candour in line with regulation 20
2020/14837	**Grade 3 pressure ulcer (moderate harm incident)**	Completed - Compliant

Recommendations

To formally apologies to patient and their family for the failings identified through this investigation.
To provide feedback to pat family and staff involved in the incident.
To review the clinical pathway for patients having planned spinal surgery and to amend so that all spinal patients have an airflow mattress ordered on the day of admission (pre-operatively).
To transfer the current paper clinical care pathway for children having spinal surgery into an electronic pathway accessible in meditech 6.
To carry out a full review of all tissue viability care plans and risk assessments held within meditech 6.
To ensure that the 'Helping to prevent pressure ulcers patient/parent information leaflet is given out to all patients/parents who have an active tissue viability care plan.
To include the recording of the Braden Q score in the electronic clinical care pathway for spinal patients.
For Tissue Viability training to be included in annual mandatory training.
To ensure all nursing staff has the correct information to enable them to order an appropriate pressure relieving mattress, included in this should be information on troubleshooting and reporting/returning a mattress that may appear to have a fault.

Actions for Improvement:

Apologise and feedback finding to patient and family
To provide feedback to the staff involved in the incident.
Care plan to be amended to reflect recommendation. Change in care plan to be cascaded to the spinal team and Ward 4A.
Current clinical care pathway with also be transferred to an electronic care pathway within meditech 6
TV Nurse Specialist and Surgical Matron working with meditech for full review of Tissue Viability care plans, risk assessments and documents with the aim of improving the quality of documentation and risk assessments.
Until the previous action is complete documentation and risk assessments relating to skin integrity and the prevention and management of pressure ulcers will still be audited monthly by the ward teams as part of the monthly safety scan and perfect ward audits.
To monitor compliance by review as part of monthly perfect ward audit.
New starter ward induction to include specific training session on prevention and management of pressure ulcers.
Included case study, break out group work, TV quiz.
Practice Education team to facilitate attendance of Tissue Viability link nurses at monthly meeting

Expected investigation completion date - 30/10/2020 (Completed & submitted on agreed date)

Section 3 : Open ongoing investigations
Table 6

StEIS Reference	Date reported	Incident	Agreed date of completion
2020/13420	07/07 2020	Suspension of treatment for patients with Tics, Tourette Syndrome and Paediatric Acute onset Neuropsychiatric Syndrome (PANS/PANDAS).	13/11/2020
2020/13501 & 2020/15432	05/07/2020 & 12/08/2020	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	09/11/2020 Combined investigation Note: 2020/13501 – CCG stepped down incident from StEIS as did not meet SI criteria.
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

END

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report October 2020

How Did We Do?

Executive Summary **Month: October** **Year: 2020**

Alder Hey Children's NHS

Delivery of Outstanding Care

Safe

- 1 severe harm relating to a trauma patient in AED was reported. This incident has been reviewed and has been StEIS reported with a 72 hour review completed and an investigation is underway. This incident although still showing on the system has been downgraded to a near miss following a detailed review.
- Patients treated for sepsis in AED is at only 74%

Highlight

- High numbers of near misses reported 83
- 94% of inpatients treated for sepsis within an hour
- 0 Hospital acquired MSSA
- 0 never events
- 0 hospital acquired COVID infections
- 0 Grade 3 and above pressure ulcers following last month's summit

Challenges

- AED sepsis score is red in terms of receiving antibiotics within an hour. This partly reflects the acuity of the patients who are presenting later and also relates to attaining IV access for fluid resuscitation. There are also some issues re data capture that the team are working on
- 2 medication errors resulting in harm. One patient with low oxygen saturations and reduced blood pressure was found to have received their fentanyl infusion at a higher rate than intended. Another patient received one dose of oral frusemide and spironolactone which was 10 times more than prescribed, however, only slightly higher than the maximum permitted dose. Both incidents are being investigated to identify learning.

The Best People Doing their Best Work

Caring

- There were 97 PALS referrals in October compared to 120 in October 2019

Highlight

- Friends and Family scores are generally above 94% across the board and generally improved in comparison to 2019

Challenges

- Friends and Family result in mental health is at 90% which is down from September. Again the number of responses has affected the overall score. There have been 0 poor or very poor responses in this area and 3 responses which are neither good nor poor which has accounted for 10.34% of overall percentage. The remaining responses have been either good or very good (89.66%).
- Complaints are up to a year high of 20 mainly reflecting the issue in Neurology

Delivery of Outstanding Care

Effective

The timeliness of care in the Emergency Department remains very good with 96.8 % of patients attending the Emergency Department receiving treatment within 4 hours.

The majority of patients who have had an operation cancelled have had their operation re-booked within 28 days.

The number of cancelled operations is significantly lower than pre-COVID levels, even after accounting for reduced activity levels. This level has been affected by staff availability related to COVID-19 and unavailability of COVID-19 swab results for patients. We have amended our processes to ensure swab results are available on the day of surgery.

Highlight

- Timeliness of care in the Emergency Department.
- Low number of PICU re-admissions within 48 hours of being transferred out.

Challenges

- Staff availability affecting cancelled operations for non-clinical reasons.

Delivery of Outstanding Care

Responsive

Referral to treatment times against the 18-week standard remain challenging but have improved for the third consecutive month to 54%. Access to diagnostics has also improved to 96.4% being undertaken within 6 weeks.

The number of patients waiting over 52 weeks has remained at 145 for the second consecutive month. There are 4 patients waiting for care in community paediatrics (a reduction on last month) and 141 patients waiting for care in surgical services. Therefore, at an aggregate level the number of long-wait patients is not reducing. In response to this we have agreed a new set of progress metrics to track improvement. Firstly, no community paediatrics patients will wait over 52 weeks by the 30 November 2020. Secondly, except for chronic pain, there will be no outpatients waiting > 52 weeks from December. Thirdly, to reduce the number of surgical inpatients waiting >52 weeks to 80 by 31 December 2021.

There has been a step-change increase in inpatient restoration with levels reaching 87% of last year's activity, up from 80% in August and September. 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 an increase in patient cancellations (n= 254, 12%) due to COVID-19 concerns. The new schedule has gone live and is providing additional capacity in November.

Satisfaction with our patients and families experience of care continues to be strong in relation to being treated with respect, knowing who is in charge of their care and knowing their date of discharge. The impact of COVID on play has been significant, specifically as staff where shielding or repurposed in the 1st wave. More work continues to ensure that CYP have access to sufficient learning and play activities. The play team have increased their ward based activity programme and their visibility in departments. Reintroduction of education following the 1st wave of the pandemic has led to improvements in this area.

Highlight

- Access to cancer care
- Diagnostics completed within 6 weeks
- Improvement in RTT

Challenges

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

The Best People Doing their Best Work

Well Led

From month 7 onwards the NHS financial regime has changed. In months 1-6 the Trust received a block payment plus a retrospective top up for expenditure over the block payment and Covid costs incurred ensuring the Trust broke even. From month 7 onwards we will receive a fixed block payment including an allocation for both restoration costs and Covid costs and we will be expected to achieve the plan agreed with NHSI which is £5.7m deficit for the remainder of the year.

In Month 7, the Trust is reporting a £1.3m deficit which is £0.3m behind the month 7 plan. This is due to the non clinical income for car parking, catering and R&D being lower than expected and non pay expenditure in Theatres and Critical Care being higher than planned due to the acuity of the patients.

October elective and daycase activity were at 87% of last year's level which is below the 90% target. October outpatients were at 84% of last year's level which is also below the 100% target

The mandatory training levels have dropped to just below the target at 88.6%. It is essential that this is improved and the target is achieved in future months.
The PDR deadline to achieve 90% has now passed. The percentage PDR's completed is below this target at 62.6% and it is important that all areas complete outstanding PDR's as soon as possible. Sickness has increased further and is now 6.1%.

Highlight

- Medical appraisals higher than target

Challenges

- Sickness Levels
- Mandatory training
- PDR
- Financial performance

Game Changing Research and Innovation

Research and Development

Recovery Programme

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

Visibility

- Newsletter, Divisional Briefing, Research Clinic

Partnerships

- 17 joint applications to the **Hugh Greenwood Legacy Fund**
- Approval and implementation of **Research Incentive Scheme for commercial research**

First Mentor and Researcher event for **future researcher programme**

Highlight

- Increasing activity levels

Challenges

- COVID-19 impact on portfolio

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Alder Hey Children's NHS
NHS Foundation Trust

Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis - A&E
0	1	0	2	0	74.07 %
Oct 2020	Oct 2020	Oct 2020	Oct 2020	Oct 2020	Oct 2020

Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
94.29 %
Oct 2020

CARING

Friends & Family: Overall Percentage Recommended Trust
94.74 %
Oct 2020

EFFECTIVE

ED: 95% Treated within 4 Hours
96.79 %
Oct 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 %	96.37 %
Oct 2020	Oct 2020	Oct 2020	Oct 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 %	53.97 %	145	10994
Oct 2020	Oct 2020	Oct 2020	Oct 2020

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
109084	-343.72	88.56 %	94.24 %	6.08 %
Oct 2020	Oct 2020	Oct 2020	Oct 2020	Oct 2020

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	100.0%	99.8%	99.2%	99.0%	99.8%	100.0%	99.6%	100.0%	100.0%	98.9%	99.1%	99.8%	99.8%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	62	70	43	73	72	49	39	49	59	88	56	49	84		No Threshold	
Clinical Incidents resulting in No Harm	D	333	296	222	340	335	236	138	260	286	377	314	343	320		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	D	88	89	92	89	82	62	48	57	89	93	83	69	71		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	D	0	1	2	4	1	0	1	0	0	6	1	0	0		No Threshold	
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	1	0	0	0	0	0	0	2	0	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	6	3	3	0	2	2	1	5	7	6	2	6	2		<=3 N/A >3	✔
Pressure Ulcers (Category 3)	W	0	1	0	0	0	0	1	0	0	2	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	0	1	0	1	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	78.4%	84.2%	76.7%	83.9%	86.5%	83.3%	60.9%	95.5%	96.2%	79.2%	77.3%	85.2%	74.1%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	100.0%	93.8%	87.5%	87.5%	88.2%	88.9%	93.8%	87.5%	90.9%	88.5%	85.2%	86.1%	94.3%		>=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	1	0	0	0	0	0	1	0	0	0	0	1	1		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	0	1	0	0	2	0	1	0	0	1	4	1	0		No Threshold	

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust W	92.9%	91.6%	92.2%	94.3%	94.3%		96.9%	94.2%	94.9%	94.6%	93.8%	90.6%	94.7%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust D	83.6%	80.9%	80.8%	88.0%	87.6%		96.1%	92.9%	92.3%	90.7%	91.5%	84.4%	92.1%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust D	95.0%	94.1%	91.9%	92.0%	91.8%		100.0%	100.0%	95.2%	95.2%	92.3%	89.1%	94.7%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust D	96.5%	95.9%	95.9%	97.1%	95.7%		94.4%	90.8%	93.3%	97.0%	95.1%	92.4%	94.5%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust D	66.7%	89.1%	73.1%	90.7%	80.0%		100.0%	90.9%	100.0%	100.0%	82.4%	92.3%	89.7%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust D P	95.3%	94.5%	95.7%	95.6%	96.1%		97.4%	96.9%	96.6%	96.0%	95.7%	94.1%	95.5%		>=95 % >=90 % <90 %	✔
Complaints W	4	15	8	10	10	9	8	6	10	4	20	11	20		No Threshold	✔
PALS W	120	105	67	124	114	74	45	44	86	105	105	77	97		No Threshold	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	1.2%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	86.8%	79.2%	85.6%	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%		>=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	34	44	36	20	41	36	6	5	3	7	18	17	19		<=30	N/A	>30	✔
28 Day Breaches	W	0	2	7	10	4	7	24	1	2	0	0	8	2		0	N/A	>0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	95.7%	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 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	97.7%	97.6%	98.5%	98.7%	97.6%	98.1%	100.0%	97.7%	94.1%	98.5%	97.9%	96.0%	98.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	92.2%	92.6%	90.2%	90.5%	89.6%	91.1%	87.3%	95.5%	95.8%	98.5%	93.2%	97.1%	96.7%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	93.7%	98.3%	96.8%	98.0%	97.6%	96.1%	88.7%	90.9%	90.8%	91.1%	99.3%	98.3%	100.0%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	92.1%	93.9%	91.2%	95.6%	92.5%	94.2%	60.6%	78.4%	64.7%	72.6%	81.5%	82.3%	83.3%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	73.5%	68.3%	85.4%	85.4%	78.0%	79.2%	74.6%	61.4%	84.0%	83.0%	78.1%	75.4%	88.3%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.0%	92.3%	92.0%	92.0%	86.7%	66.7%	58.1%	45.9%	39.6%	43.1%	48.0%	54.0%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,754	12,827	12,879	12,885	12,895	12,162	11,046	10,909	11,248	11,022	11,402	11,033	10,994		<=12899 N/A >12899	✔
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	0	5	15	52	82	149	127	145	145		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	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 % 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%	100.0%	0.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	42.8%	67.0%	81.9%	82.9%	78.9%	91.8%	96.4%		>=99 % N/A <99 %	✔
PFI: PPM%		99.0%	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 % 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

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	-240	-205	358	-172	-488	693	0	0	0	0	0	0	-344		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	1,909	-115	624	3,126	3,820	300	1,287	1,792	3,503	936	-483	4,518	187		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	81,847	77,896	75,657	76,536	76,536	90,030	107,738	111,270	107,221	107,221	107,763	108,756	109,084		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	1,103	1,387	1,479	1,439	30	6,889	3,146	-692	1,342	1,825	1,077	2,482	-792		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-254	-39	-89	394	-627	-709	-1,433	691	-312	-340	-291	-1,160	20		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-1,090	-1,552	-1,031	-2,005	110	-5,487	-1,713	1	-1,029	-1,485	-786	-1,333	429		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W	1,359	1,406	1,331	1,246	1,181	954	11	0	0	0	0	-349	-398		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W	436	451	361	429	410	321	0	0	0	0	1	49	9		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W	2,049	1,924	1,748	2,060	1,928	1,565	0	2	5	2	2	-62	-183		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W	24,461	22,066	17,837	23,882	21,026	17,979	158	268	1,009	1,324	1,303	1,021	-1,594		>=0	N/A	<0	✔
PDR	W	89.3%	89.3%	89.3%	90.1%	90.1%	90.1%	90.1%	1.3%	5.4%	13.4%	20.7%	29.5%	62.6%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	W	88.5%	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 %	>=90 %	<90 %	✔
Mandatory Training	W	91.3%	91.5%	92.1%	94.3%	95.1%	93.2%	92.1%	90.8%	91.0%	90.5%	90.6%	89.3%	88.6%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.8%	5.7%	6.5%	5.8%	5.7%	6.2%	5.9%	5.3%	5.0%	5.1%	5.0%	5.2%	6.1%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.8%	1.9%	2.0%	1.7%	1.7%	2.3%	1.6%	1.0%	0.9%	1.0%	1.1%	1.3%	1.8%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	3.9%	3.8%	4.5%	4.1%	4.0%	4.0%	4.3%	4.2%	4.1%	4.1%	3.9%	3.8%	4.3%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	840	928	833	775	974	1,514	990	740	565	934	946	1,015	1,061		<=800	<=960	>960	✔
Staff Turnover	D	10.0%	10.0%	10.3%	10.7%	10.8%	10.4%	10.0%	10.0%	10.2%	9.9%	11.5%	11.1%	10.7%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	92.2%	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	100.0%	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

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	162	167	172	166	165	146	21	23	43	47	50	61	66		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	42	45	46	46	46	42	21	19	20	25	27	28	34		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	2	5	6	3	1	0	4	3	3	1	3	4	1		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	2	6	3	0	1	0	1	0	0	1	2	0	2		>=1	N/A	<1	✔
Number of patients recruited	W	1,228	1,180	1,094	982	917	665	407	537	560	134	508	413	665		>=100	>=86	<86	✔

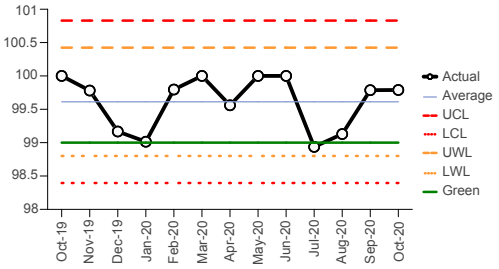
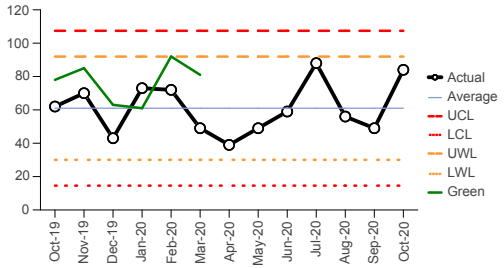
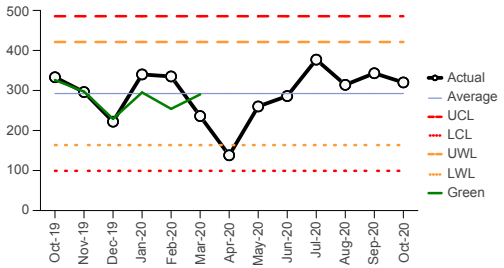
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

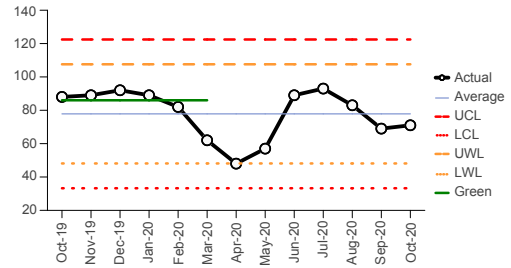
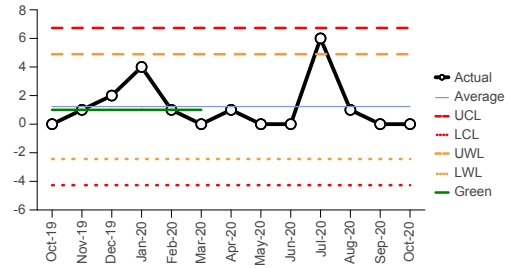
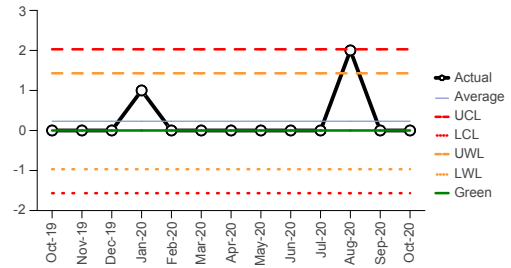
	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.79 %	R <99 % A N/A G >=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	84	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	320	No Threshold		

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

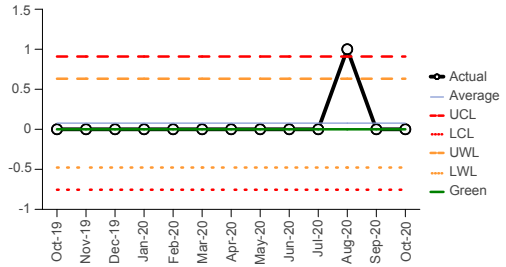
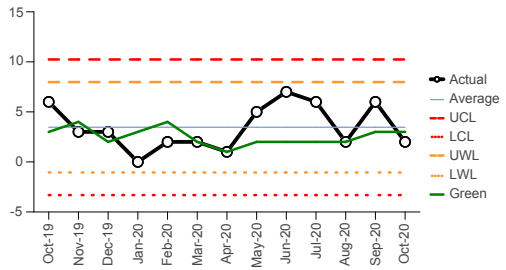
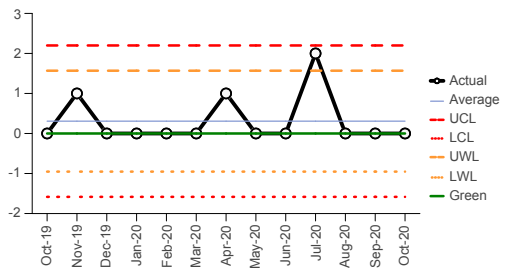
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	71	No Threshold		
Incidents: Reducing Harm	**Clinical 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		This realted to an alleged inappropriate clearance of a C Spine X Ray that has subsequently been steis'd but has been downgraded to a near miss

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

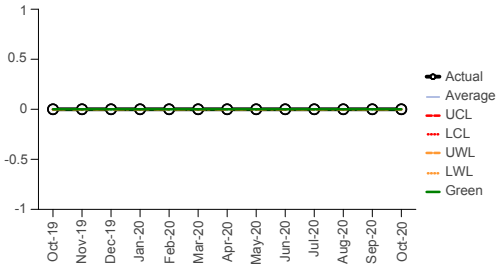
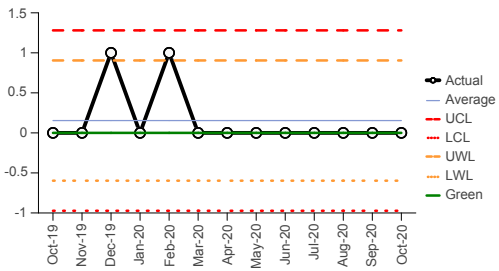
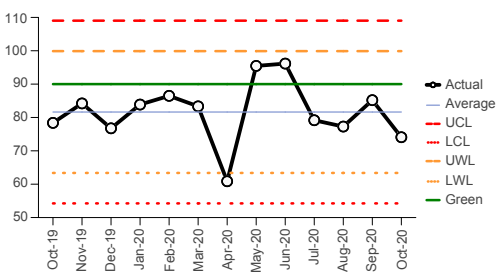
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **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	2	R >3 A N/A G <=3		Two incidents of minor harm were reported in October. One patient with low oxygen saturations and reduced blood pressure was found to have received their fentanyl infusion at a higher rate than intended – it is unclear whether the overdose caused this. Another patient received one dose of oral furosemide and spironolactone which was 10 times more than prescribed, however, only slightly higher than the maximum permitted dose. Both incidents are being investigated to identify learning.
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	74.07 %	R <90 % A N/A G >=90 %		The delays are generally related to acuity and more specifically venous access for those children requiring fluid resuscitation. There are also some issues specifically for ED in the way the data is captured which the team are addressing

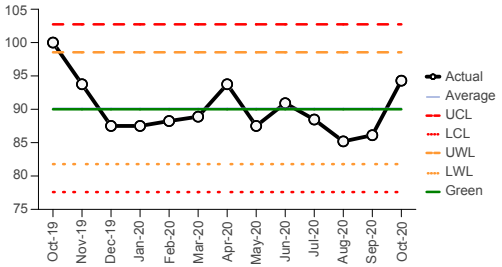
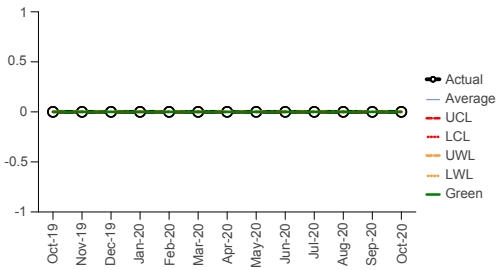
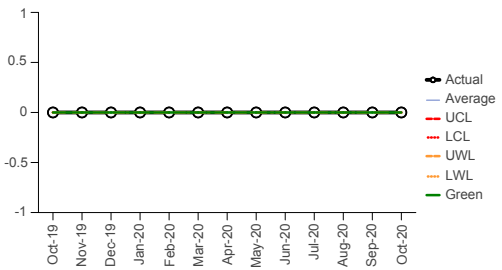
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

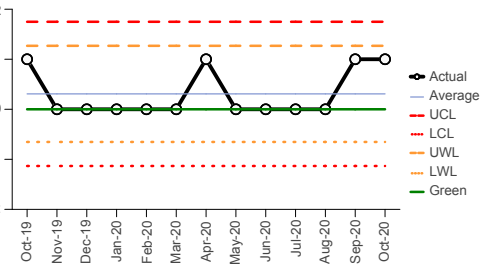
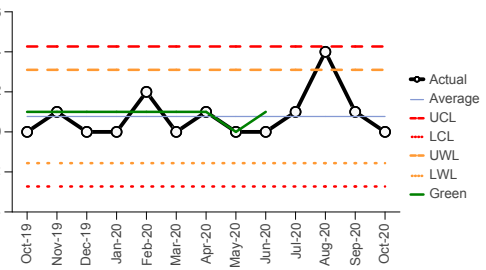
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 20/21 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.29 %	R <90 % A N/A G >=90 %		No Action Required
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	1	R >0 A N/A G 0		Review completed via the IPC bacteraemia review process and has been categorised as no lapse in care. This was an immunocompromised patient on multiple antibiotics.
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	0	No Threshold		

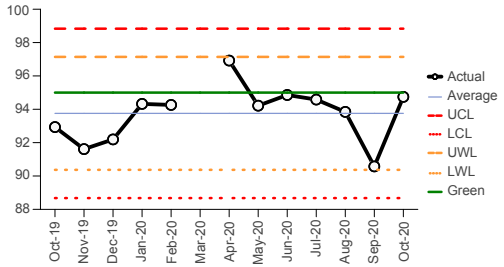
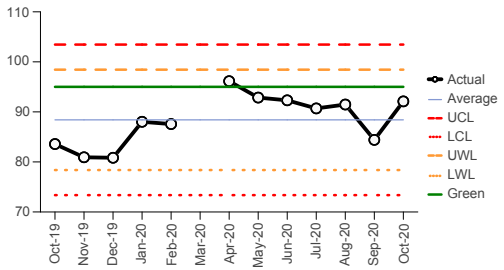
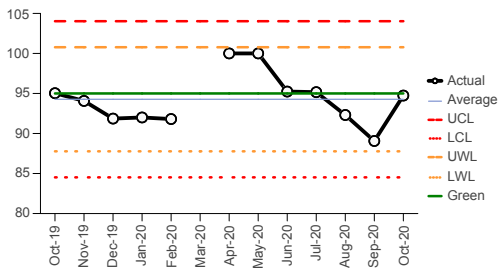
The Best People doing their best Work

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	94.74 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 4.1% from September 2020. Number of responses was the highest since March at 1719 due to the recording of feedback after online appointments/consultations. Response channel is predominately made up via SMS (70%) and surveys after online consultations (29.6%). In October 2020, Medicine had a total of 917 responses with 40 negative (4.4%), which is a reduction from the 53 negative responses in September 2020. Surgery had a total of 589 responses with 14 negative (2.4%). Community had a total of 192 responses with only 7 negative (3.6%).
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	92.09 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 7.7% from September 2020. There were 253 responses for October 2020, 74 less than September – 100% response via SMS. There are 16 (6.3%) responses that are poor or very poor, a decrease of 21 negative responses from September 2020. Comment analysis has identified three negative main trends in October. Out of the 16 poor or very poor responses, there were six instances of issues regarding waiting times and five instances of staff attitude reported. There were a total of 39 comments in relation to video consultations, with nine respondents against the idea
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	94.74 %	R <90 % A >=90 % G >=95 %		Percentage has increased by 6% from September 2020. There were 192 responses for October 2020 – 71.9% response via SMS and 27.6% via online surveys. There were 7 (3.65%) responses that were either poor or very poor and 4 responses (2.08%) which were neither good nor bad. An increase in amount of data has provided an opportunity to analyse survey comments. No evident theme when asked how the hospital could have improved their experience. When asked what was good about the visit, there was a positive themes surrounding the timely and prompt video consultations, and friendly attitude of staff.

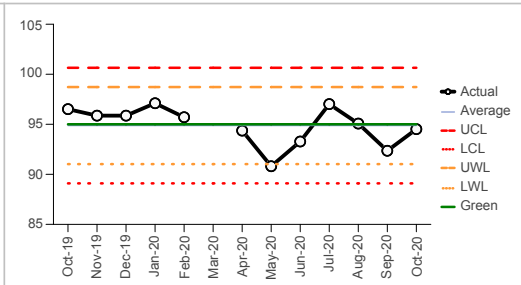
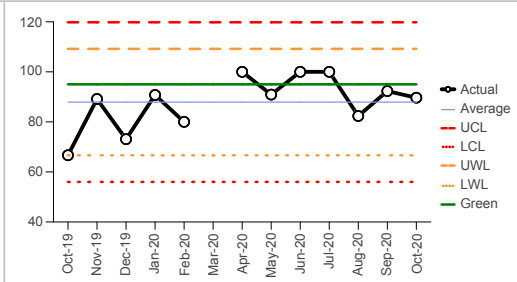
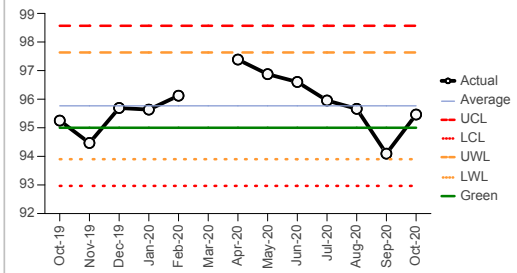
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.51 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 2.16% from September 2020 to 94.51%. The number of responses for October 2020 was 164. There are only four (2.44%) responses that are poor or very poor. 'Neither good nor poor' responses also accounted for 2.44% of the overall percentage. Comment analysis when asked how patients/families experiences could be improved highlighted communication between staff and parents, and Play activities for Children.
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	89.66 %	R <90 % A >=90 % G >=95 %		The percentage has decreased by 2.61% since September 2020. The completed number of surveys (29) is the highest number of responses since March. There have been zero poor or very poor responses in this area. There have been three responses which are neither good nor poor, accounting for 10.34% of overall percentage. Comment analysis of the three responses that were neither good nor poor has shown no theme. The negative comments attributed to these responses mentioned car parking availability and receptionist attitude, both at Sefton CAMHS, as the main incidents.
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	95.46 %	R <90 % A >=90 % G >=95 %		No Action Required

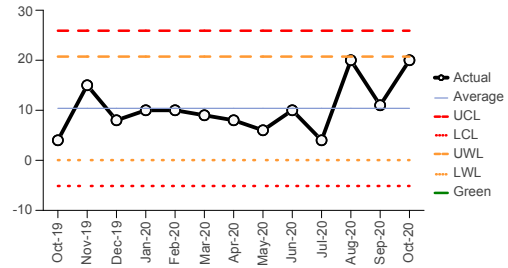
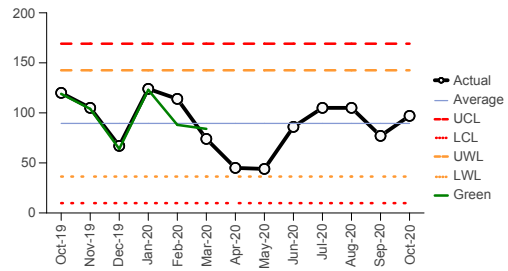
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

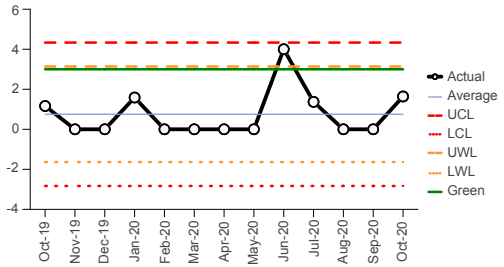
	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	20	No Threshold		20 complaints in October with the increase partly reflecting the ongoing issue in Neurology
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	97	No Threshold		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

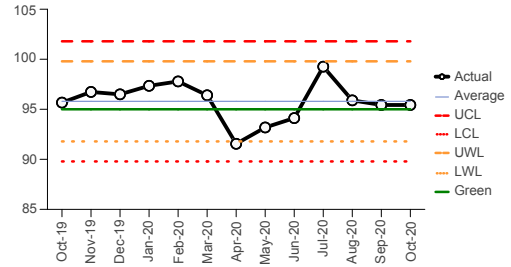
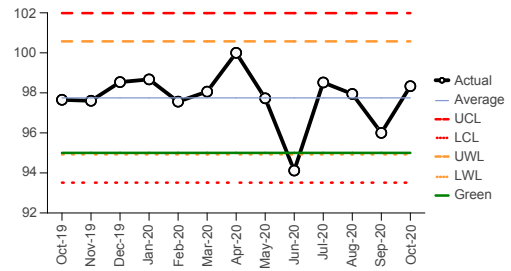
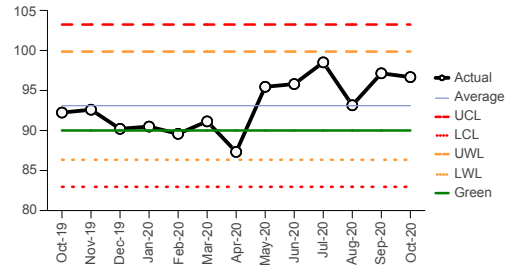
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally 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	1.64 %	R >3 % A N/A G <=3 %		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

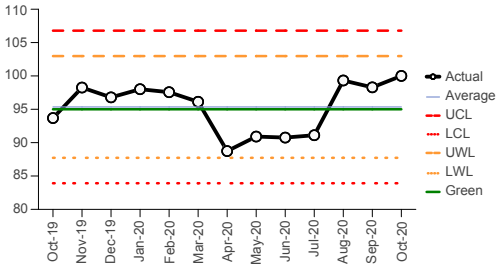
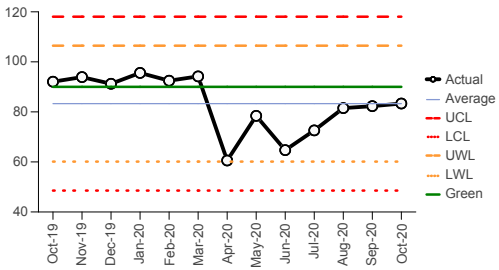
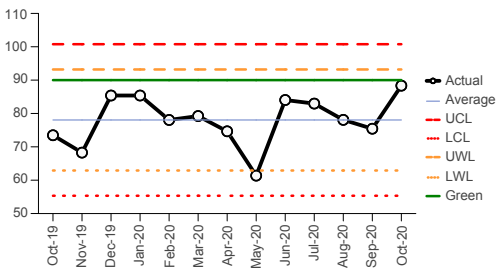
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.43 %	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	98.33 %	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	96.67 %	R <85 % A >=85 % G >=90 %		No Action Required

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	83.33 %	R <85 % A >=85 % G >=90 %		Percentage of patients that report engaging with play this month was 84.93%, an increase of 2.64% compared to September 2020. Percentage increase is due to increased capacity of Play specialists and the resumption of services. In Surgery, 101 out of 117 responses identified patients were involved in Play (86.36%). In Medicine, 40 out of 49 responses identified patients were involved in Play (81.63%). In comparison to September 2020, Surgery (80.45% in September) had an improvements but Medicine (86.04% in September) did not.
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	88.33 %	R <85 % A >=85 % G >=90 %		October has shown a decrease in the percentage of inpatient children / families reporting involvement in learning/teaching (72.89%) compared to September 2020 (75.43%). This percentage is continuing to follow a negative trend since June but still remains higher than May (61.4%) figures, during the height of the COVID-19 pandemic. Surgery's figures show that 77.78% of inpatient children/families report involvement in learning/teaching in October 2020. Medicine's figures indicate that 62.22% of inpatient children/families report involvement in learning/teaching in October 2020.

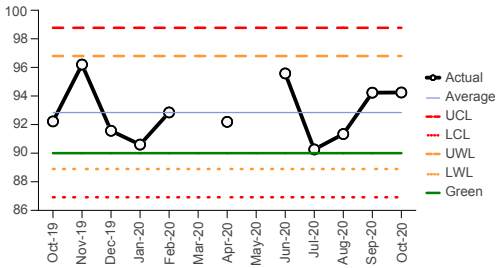
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

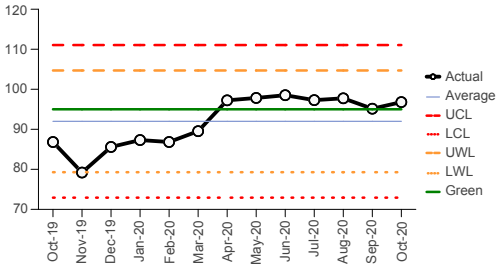
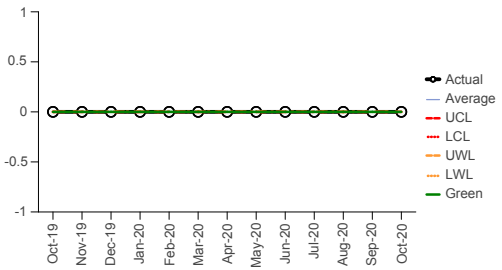
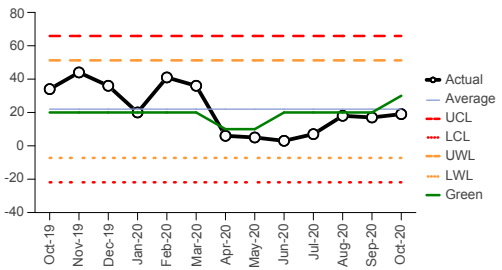
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	94.24 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

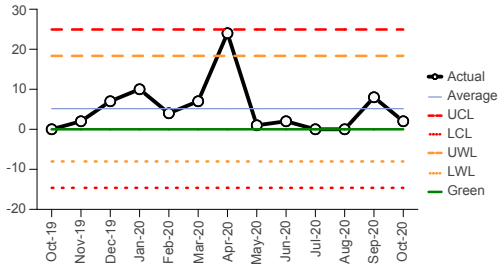
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	96.79 %	R <95 % A N/A G >=95 %		No Action Required
ED 12 Hr Waits	**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	19	R >30 A N/A G <=30		During October we experienced an increased number in patients whose procedures were cancelled on the day of their elective admissions. Unfortunately during October on two occasions speciality emergency on-call teams were called out during the night and were operating into the early hours which unfortunately resulted in cancelations the following day as the same team were unable to continue with there elective schedule. In addition there have been occasions where we have unfortunately had to cancel a theatre list owing to staff affected by Track and Trace and the requirement to isolate.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

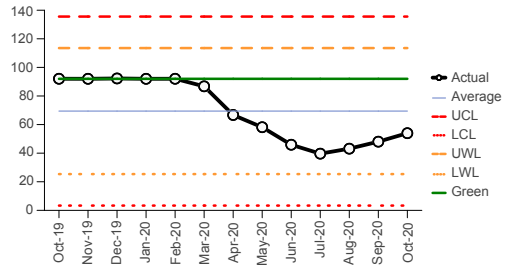
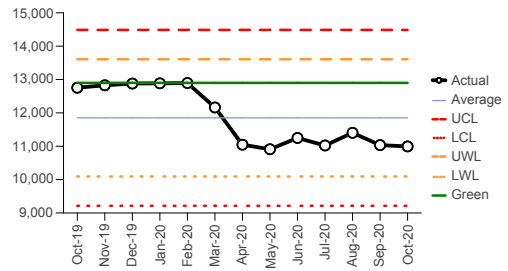
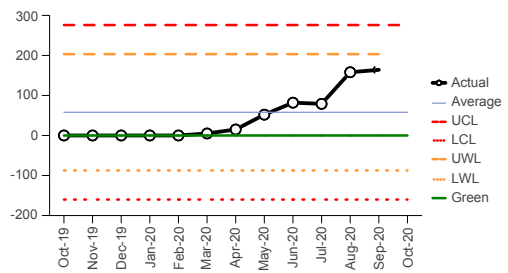
	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	2	R >0 A N/A G 0		Both of these patients consultant is Dr Nair, she currently only has 2 lists a month due to a list being taken away from the service. So we used to have 5 theatre lists a week, but we now have been reduced to 4 which is shared between 6 consultants on a rota basis. When this was cancelled we were fully booked in 28 days prior to their cancellations, which consisted some clinically urgent patients and some potential diagnostic breaches. Dr Nair was also off for 3 weeks in October, so we didn't have the opportunity to take up an extra list to accommodate these patients.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

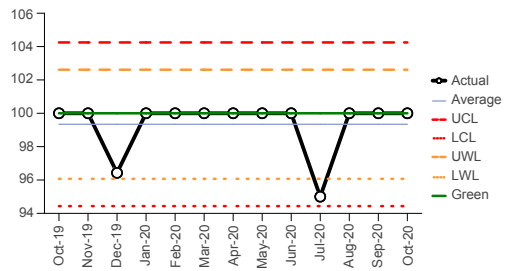
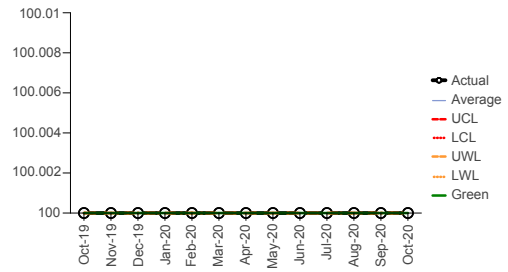
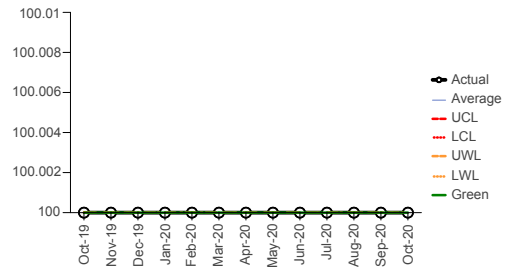
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	53.97 %	R <90 % A >=90 % G >=92 %		Performance starting 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	10,994	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	145	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. This level of 52 week waits is in line with our trajectory submitted to NHSE.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

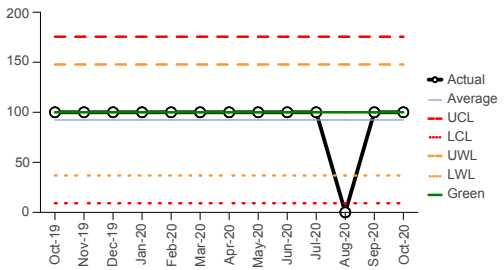
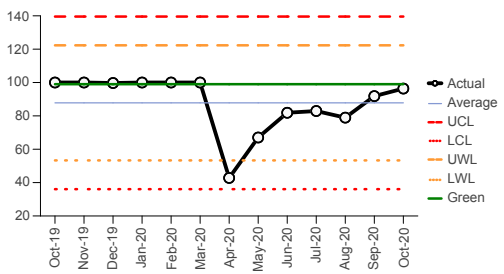
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % 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)
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
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	96.37 %	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.

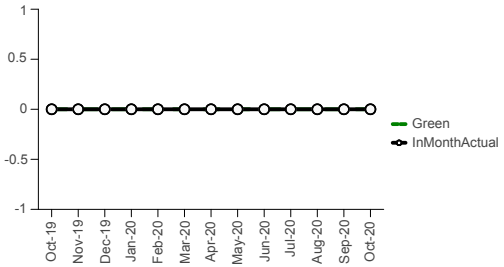
The Best People doing their best Work

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

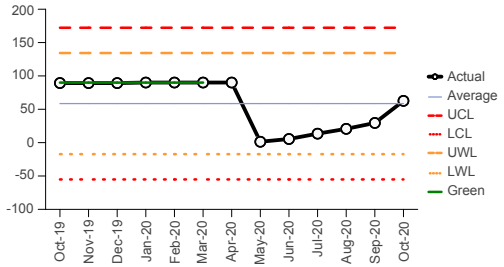
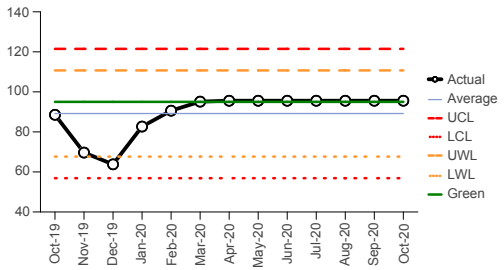
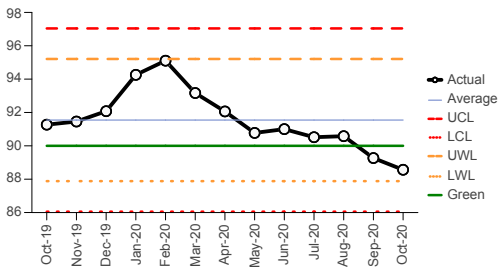
The Best People doing their best Work

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	62.58 %	R <85 % A >=85 % G >=90 %		This year in light if the pandemic, we both simplified and made the paperwork more meaningful for staff and provided training to managers to have effective and meaningful appraisal conversations throughout the revised window via MS Teams.Whilst we have not reached our target of 90% as yet, we will continue to promote the appraisal process and liaise directly with divisional and departmental managers to ensure as many staff as possible complete an appraisal this year, particularly given the challenges this year has presented.
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	88.56 %	R <80 % A >=80 % G >=90 %		Mandatory Training continues to sit just below target of 90%, this is being impacted primarily by topics that have annual refreshers such as Information Governance and in particular those that historically or still require face to face training such as Practical Moving and Handling training and Paediatric Life Support updates which are made more difficult given current social distancing challenges. Practical sessions have plans for delivery in Nov so we hope to see a change in their trajectory and we will continue to promote and push all topics alongside the relevant SMEs to managers and staff

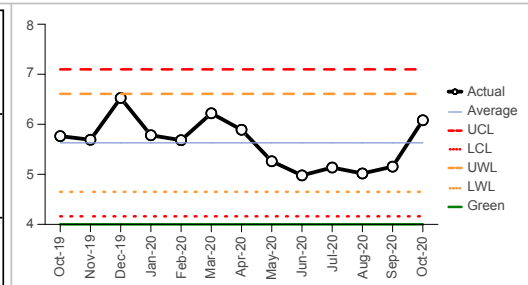
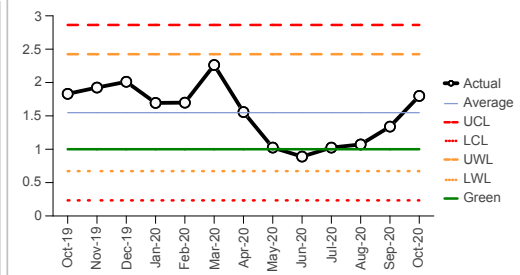
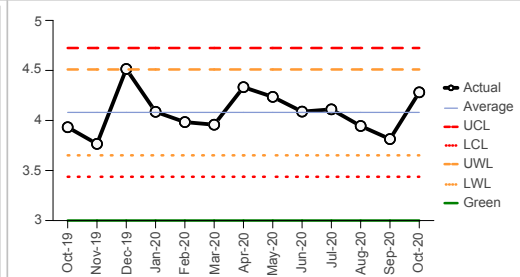
The Best People doing their best Work

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	6.08 %	R >4.5 % A <=4.5 % G <=4 %		Sickness continues to rise due to increasing absences relating to Covid, the HR team are working in collaboration with Divisions to support manager with staff absences, the SALS Team also providing support to managers and employees. We continue to have staff recorded in the special leave category for self-isolation and medical suspension due to Covid and a comprehensive guide to supporting managers with absences is available through Divisional HR Advisors.
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	1.80 %	R >1 % A N/A G <=1 %		as above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.28 %	R >3 % A N/A G <=3 %		as above

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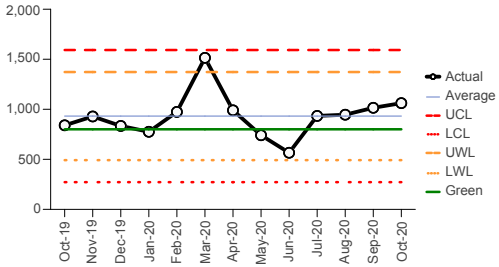
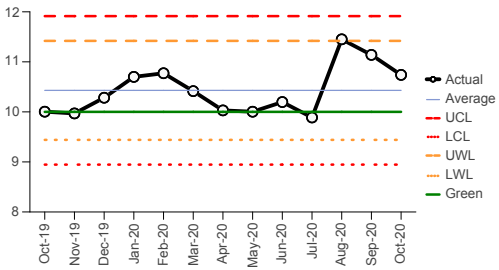
15.3 - PEOPLE - WELL LED

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	1061.31	R >960 A <=960 G <=800		Increased in October due to an increase in staff absences/ SI/sickness 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	10.74 %	R >11 % A <=11 % G <=10 %		Turnover has started to reduce, due to the high number of leavers in August (temp covid staff) this metric will take a bit of time to settle down. There were 18 leavers in October, the majority of leavers being in the Division of Medicine (9) The Nursing staff group saw the highest number of leavers (7).

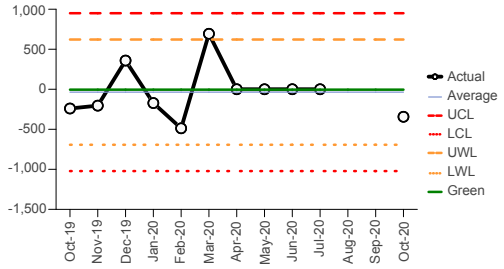
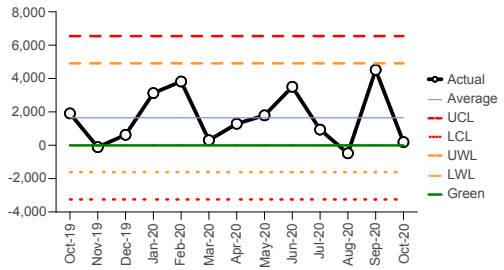
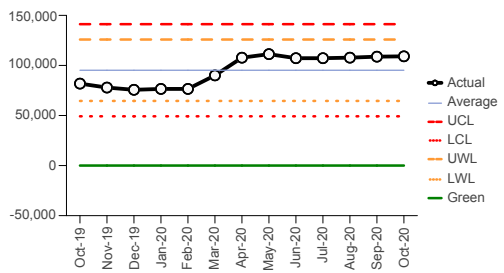
The Best People doing their best Work

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	-344	R <-20% A >=-20% G >=-5%		The Trust achieved a control total deficit in October of £1.3m. This is £0.3m higher than planned and is due to lower than expected income relating to car parking, catering and research and higher than expected non pay costs in Theatres and Critical Care relating to the acuity of the patients.
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	187	R <-10% A >=-10% G >=-5%		No Action Required
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	109,084	R <-20% A >=-20% G >=-5%		No Action Required

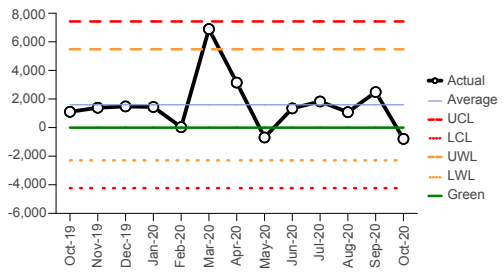
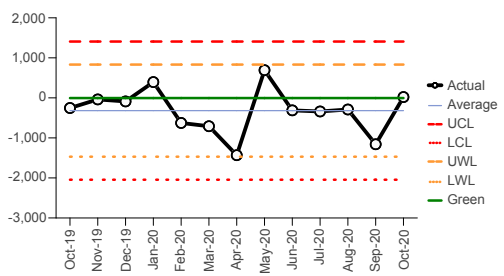
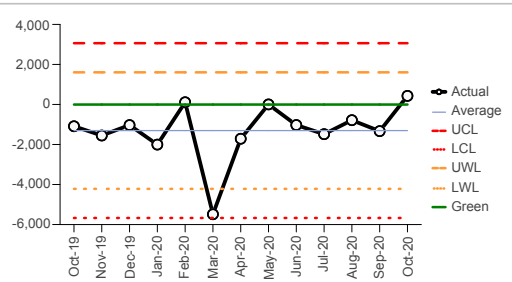
The Best People doing their best Work

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	-792	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	20	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	429	R <-20% A >=-20% G >=-5%		No Action Required

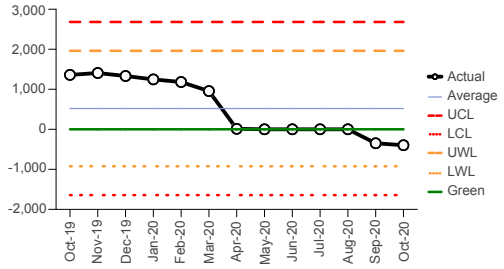
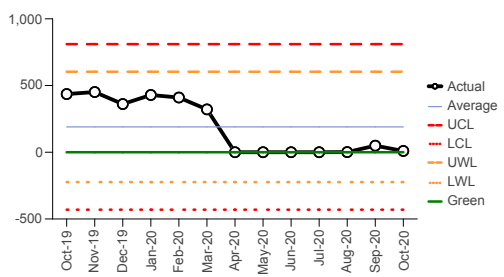
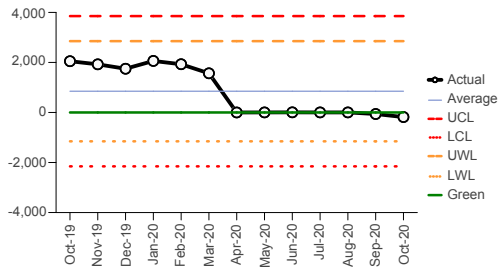
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

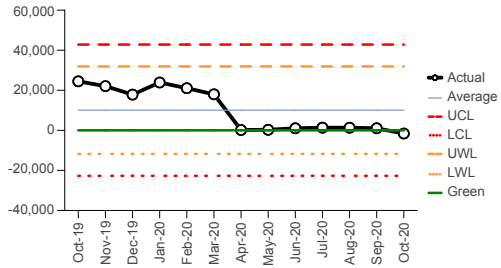
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-398.00	R <0 A N/A G >=0		Non Electives continue 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	9.40	R <0 A N/A G >=0		Oct electives were overall at 98% of last year's levels (adjusted for working days), ie exceeding the 90% target.
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	-183.20	R <0 A N/A G >=0		Oct daycases were at 85% of last year's levels (adjusted for working days), ie below the 90% target.

The Best People doing their best Work

16.4 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

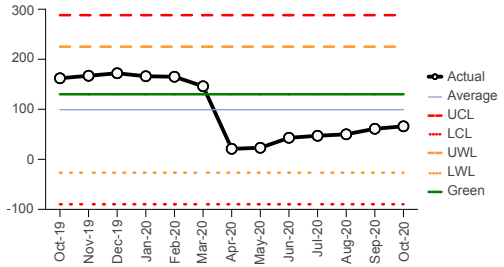
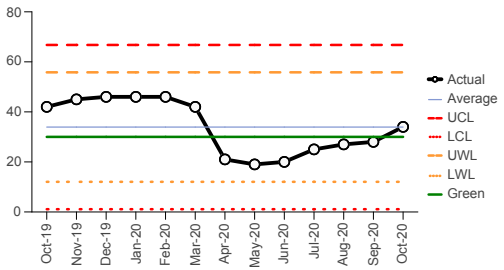
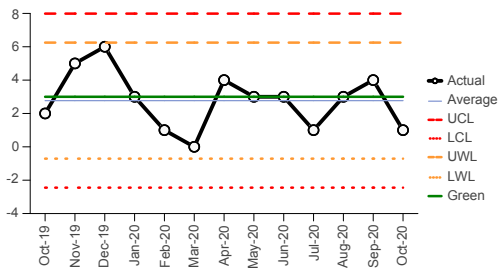
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-1594.00	R <0 A N/A G >=0		Oct outpatients were at 84% of last year's levels (adjusted for working days), ie below the 100% target.

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

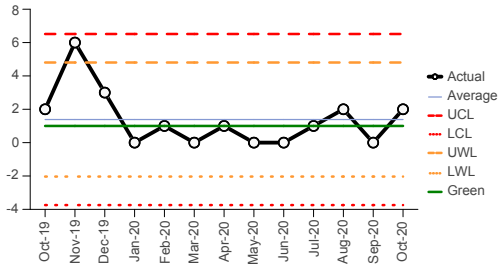
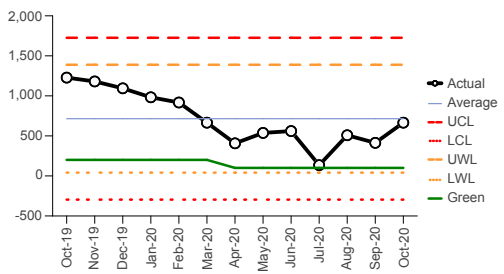
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	66	R <111 A >=111 G >=130		The process of ensuring that 1) the necessary preconditions to safely 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	34	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	1	R <2 A >=2 G >=3		The in-month focus has been on restarting suspended studies (see Number of Open Academic Studies) rather than opening new studies which is reflected in the progress with this metric.

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

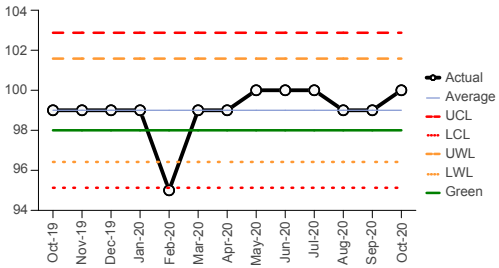
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	2	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	665	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	100 %	R <98 % A N/A G >=98 %		No Action Required

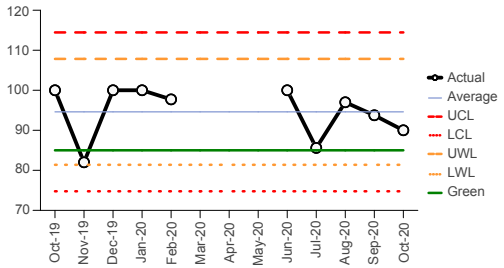
The Best People doing their best Work

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	90 %	R <85 % A N/A G >=85 %		Compliance for undertaking audits during October was at 90% due to low levels of available Supervision on site. The areas audited were of a good standard.

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	14	27	36	No Threshold
Clinical Incidents resulting in No Harm	D	85	67	147	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	10	10	43	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	2	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	0	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		100.0%	86.7%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	1	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	0	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	3	7	9	No Threshold
PALS	W	32	25	29	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			1.6%	<=3 % / N/A / >3 %
ED: 95% Treated within 4 Hours	D		96.8%		>=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	1	18	No Threshold		
28 Day Breaches	W	0	2	0	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		92.9%	96.2%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		97.2%	98.8%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		88.9%	100.0%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		100.0%	100.0%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		77.8%	85.7%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		63.9%	98.8%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	48.9%	68.0%	50.6%	>=92 %	>=90 %	<90 %
Waiting List Size	W	799	1,916	8,178	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	2	0	143	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		100.0%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks	W		96.2%	100.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	369	-264	-488	No Threshold
Income In Month Variance (£'000s)	W	397	-647	15	No Threshold
Pay In Month Variance (£'000s)	W	-81	-143	-69	No Threshold
Non Pay In Month Variance (£'000s)	W	53	525	-434	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		-333	-65	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	7	3	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		-5	-178	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	653	6	-3,745	>=0	N/A	<0
PDR	W	73.4%	60.2%	57.8%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	100.0%	96.0%	94.1%	>=95 %	>=90 %	<90 %
Mandatory Training	W	91.7%	90.2%	87.1%	>=90 %	>=80 %	<80 %
Sickness	D	4.1%	5.8%	6.9%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.4%	2.2%	1.8%	<=1 %	N/A	>1 %
Long Term Sickness	D	2.7%	3.5%	5.1%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	173	235	446	No Threshold		
Staff Turnover	D	9.8%	6.9%	8.9%	<=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 97.9%. • 100% Sepsis patients treated with 60 min • Pharmacy OP time for complex patients 100% • Zero never events, hospital-acquired infections (MRSA, C. difficile) for over 12 months. **Challenges**
CARING	7 complaint and 25 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 96.8 %. 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 **Challenges** • WNB rate has continued to remain high at 13.7% • Eliminating 28 day breaches
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 55.5%. There continue to be no patients waiting over 52 weeks for treatment. Diagnostic compliance has improved to 98.8% and has narrowly missed the 99% standard,	**Highlight** ▪ Consistent delivery of all national cancer standards ▪ Continued RTT improvement ▪ Continued recovery of the diagnostic target ▪ Pathology turnaround times **Challenges** ▪ OP imaging reporting times
WELL LED	Expenditure within the Division of Medicine remains 264k overspent due to pressures in pay. 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 89.9 %.	**Highlight** • Safer staffing fill rates • Reduced long term sickness rate • Mandatory training > 90% **Challenges** • Sickness rates overall • Finance

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	16	25	20	34	28	16	13	19	17	29	19	14	27		No Threshold
Clinical Incidents resulting in No Harm (D)	89	76	70	135	93	70	33	64	76	104	75	93	67		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	20	16	23	24	19	7	12	13	19	26	21	16	10		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	1	0	1	0	0	0	0	0	2	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	1	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 resulting in harm (D)	3	0	2	0	1	0	1	5	3	2	0	4	0		No Threshold
Medication Errors (Incidents)	30	21	22	48	30	15	13	25	29	26	23	19	24		No Threshold
Pressure Ulcers (Category 3) (W)	0	1	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	8	4	2	3	1	2	1	1	0	0	2	2	0		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	100.0%	90.0%	100.0%	100.0%	100.0%	88.9%	100.0%	83.3%	92.3%	100.0%	84.6%	91.7%	100.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	1	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	0	1	0	0	0	0	0	1		0 N/A >0
Hospital Acquired Organisms - CLABSI	1	3	1	1	1	0	1	1	1	0	2	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	97.9%	97.4%	98.3%	97.8%	97.6%				98.5%	97.7%	97.8%	97.9%			>=90 % >=80 % <80 %
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.	99.7%	99.7%	100.0%	99.9%	99.8%	99.7%	99.3%	99.3%	99.6%	99.8%	99.8%	99.8%			>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	58.9%	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	59.0%	50.0%	62.0%	47.0%	53.0%	58.0%	65.0%	65.0%	64.0%	78.5%	84.0%	77.3%			>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	100.0%	92.0%	89.0%	84.0%	88.0%	67.0%	67.0%	69.0%	100.0%	100.0%	100.0%	100.0%			>=90 % >=80 % <90 %

CARING

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Complaints (W)	0	1	2	7	5	4	7	2	6	1	11	7	7		No Threshold
PALS (W)	43	38	21	45	44	34	13	18	21	32	49	27	25		No Threshold

EFFECTIVE

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Referrals Received (Total)	2,103	1,933	1,825	2,012	1,956	1,545	832	984	1,426	1,657	1,554	2,258	1,874		No Threshold
ED: 95% Treated within 4 Hours (D)	86.8%	79.2%	85.6%	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	5.9%	9.3%	7.0%	4.0%	3.8%	2.7%	0.2%	0.8%	1.1%	1.5%	0.8%	2.0%	0.8%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0			0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0			0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	8.5%	9.6%	8.5%	8.3%	8.0%	7.4%	8.2%	8.4%	7.5%	7.8%	8.3%	7.0%	7.9%		No Threshold

Alder Hey Children's NHS
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Medicine

D Drive W Watch P Programme

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-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	83.9%	79.3%	78.9%	80.7%	85.8%	76.2%	73.9%	76.7%	75.4%	82.0%	82.1%	81.0%	83.9%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	3	4	1	2	5	0	1	2	0	0	3	2	1		No Threshold
28 Day Breaches W	0	1	0	0	0	0	0	1	2	0	0	3	2		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	38	42	26	22	41	67	175	1	2	12	55	20	33		No Threshold
OP Appointments Cancelled by Hospital %	15.0%	13.9%	15.1%	12.8%	15.2%	25.7%	46.0%	21.7%	15.5%	13.0%	11.2%	12.1%	11.1%		<=5 % N/A >10 %
Was Not Brought Rate W P	9.7%	10.0%	11.7%	9.1%	10.6%	11.0%	7.6%	9.1%	11.7%	12.2%	12.8%	12.5%	13.3%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	12.7%	11.8%	14.2%	11.3%	14.3%	14.9%	16.1%	14.0%	14.6%	15.2%	13.7%	16.5%	13.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	8.9%	9.4%	11.0%	8.5%	9.6%	10.1%	6.1%	8.2%	11.1%	11.6%	12.6%	11.8%	13.3%		<=14 % <=16 % >16 %
Coding average comorbidities	4.71	4.69	4.83	4.79	5.07	5.24	5.59	5.50	5.46	5.38	5.30	5.16	5.30		No Threshold

RESPONSIVE

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Convenience and Choice: Slot Availability	84.7%	85.6%	82.7%	95.9%	89.6%	66.7%									
IP Survey: % Received information enabling choices about their care W	93.8%	96.1%	94.6%	95.5%	97.1%	95.0%	95.0%	100.0%	81.5%	100.0%	95.6%	92.9%	92.9%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	97.2%	96.6%	97.7%	98.9%	97.6%	98.1%	100.0%	100.0%	88.9%	96.8%	97.8%	100.0%	97.2%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	87.7%	87.1%	92.7%	86.4%	83.5%	91.2%	90.0%	97.1%	85.2%	100.0%	93.3%	95.2%	88.9%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	97.6%	98.3%	92.7%	97.7%	97.1%	95.0%	87.5%	97.1%	85.2%	90.3%	100.0%	97.6%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D	88.6%	91.0%	90.4%	94.4%	92.9%	93.1%	60.0%	74.3%	63.0%	77.4%	80.0%	88.1%	77.8%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	72.0%	68.1%	81.6%	81.6%	78.2%	76.1%	77.5%	68.6%	77.8%	87.1%	82.2%	76.2%	63.9%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	93.5%	94.4%	94.2%	94.0%	92.2%	88.1%	68.8%	60.1%	46.3%	40.6%	45.0%	55.5%	68.0%		>=92 % >=90 % <90 %
Waiting List Size W	3,213	3,317	3,420	3,043	3,495	3,361	3,381	3,266	2,791	2,484	2,420	2,151	1,916		
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Waiting Times - 40 weeks and above	10	3	1	2	9	14	90	121	127	147	181	137	81		
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	100.0%	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 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks W	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	39.1%	64.9%	82.1%	84.6%	77.9%	91.4%	96.2%		>=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%	100.0%	0.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	91.5%	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 % >=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%	100.0%	99.9%	100.0%	100.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	100.0%	92.0%	82.0%	85.0%	88.0%	95.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	91.0%	85.0%	81.0%	86.0%	90.0%	86.0%		98.0%	98.0%	97.0%	97.0%	98.0%	93.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	87.0%	87.0%	92.0%	89.0%	95.0%	75.0%	100.0%	98.0%	97.0%	81.0%	69.0%	71.0%	74.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	92.0%	89.0%	82.0%	64.0%	86.0%	84.0%	16.8%	63.6%	62.6%	82.4%	59.1%	98.0%	98.8%		>=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%		>=99 % N/A <99 %

Medicine

D Drive W Watch P Programme

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks							21.6%	70.7%	83.8%	86.4%	95.0%	92.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	206	100	501	124	-361	-81	-2,544	-1,842	-1,048	278	-1,111	-1,201	-264		No Threshold
Income In Month Variance (£'000s)	W	595	678	869	1,315	80	271	-2,416	-2,220	-1,103	347	-1,170	-622	-647		No Threshold
Pay In Month Variance (£'000s)	W	106	150	-28	15	-67	-297	59	99	92	196	62	-211	-143		No Threshold
AvP: IP - Non-Elective	W	930	1,021	939	816	827	612	0	0	-1	1	0	-222	-333		>=0 N/A <0
AvP: IP Elective vs Plan	W	126	136	96	134	108	88	0	0	0	0	1	24	7		>=0 N/A <0
AvP: OP New		1,340.00	1,335.00	1,093.00	1,443.00	1,133.00	856.00	0.00	4.00	2.00	0.00	8.00	-462.00	-31.00		>=0 N/A <0
AvP: OP FollowUp		4,111.00	4,026.00	3,186.00	4,284.00	3,648.00	3,609.00	2.00	7.00	4.00	8.00	4.00	1,250.00	517.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	1,172	1,055	1,026	1,202	1,086	982	0	1	2	0	2	15	-5		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	6,913	6,650	5,410	7,163	6,073	5,594	2	11	6	11	14	535	6		>=0 N/A <0
PDR	W	87.8%	87.8%	87.8%	87.1%	87.1%	87.1%	87.1%	3.1%	10.7%	12.1%	23.0%	21.8%	60.2%		>=90 % >=85 % <85 %
Medical Appraisal	W	88.1%	69.8%	65.1%	84.1%	91.5%	94.9%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%		>=95 % >=90 % <90 %
Mandatory Training	W	91.6%	91.8%	91.6%	94.1%	94.6%	93.1%	92.3%	91.9%	91.6%	91.3%	91.3%	89.9%	90.2%		>=90 % >=85 % <80 %
Sickness	D	5.2%	5.6%	6.1%	5.8%	6.3%	6.0%	5.6%	4.9%	5.4%	5.6%	5.1%	5.0%	5.8%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.3%	2.2%	2.2%	1.9%	2.0%	2.4%	1.6%	0.9%	1.0%	0.9%	1.0%	1.4%	2.2%		<=1 % N/A >1 %
Long Term Sickness	D	3.8%	3.4%	3.9%	3.9%	4.3%	3.6%	4.0%	3.9%	4.4%	4.7%	4.1%	3.6%	3.5%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	277	242	222	250	265	347	201	157	108	167	217	266	235		No Threshold
Staff Turnover	D	9.6%	9.7%	9.5%	9.9%	9.8%	10.0%	9.7%	9.3%	8.4%	7.7%	7.7%	6.8%	6.9%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.3%	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 • Increase in clinical incidents resulting in near miss 44>31>23<36 • Clinical incidence resulting in No harm remain stable 172 > 142>143<146 • Slight increase in clinical incidents resulting in minor, non-permanent harm 48<49<51>38<44 • 2 medication errors resulting in harm. 4>1<2=2 • No cat 3 or 4 pressure ulcers. • No never events.	**Highlight** • Increase in patients treated for sepsis within 60 mins 75%<86.7% • No hospital acquired infections • Additional investment secured to increase sustainability and resilience within major Trauma Team **Challenges**
CARING	• Increase in formal complaints from 7>2<9 • Increase in PALS from 33>22<29 • 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** • Increase in emergency admissions of patients with complex additional needs which have been accommodated successfully through significant MDT working and ensuring a holistic approach to providing surgical care **Challenges** • Providing access within a timely manner for elective patients • Responding to complex formal complaints within a timely manner
EFFECTIVE	• 1 readmission to PICU within 48 hours 0=0<1 (1.6%) • Reduction in referrals received 2810>2565<3015 >2574 • Reduction in WNB rate 10.5%<10.8%>10.2%	**Highlight** • Theatre utilisation remaining consistent with plans in place to achieve 90%+ . 88.6%<89.1%>88.9%>89.9% • 0 28 day breaches. Despite increase in cancelled operations no patients waited over 28 days for treatment • CCAD cases 29>23<30<31 **Challenges** • Increase in children cancelled on the day of their elective admissions for non-clinical reasons. 15=15<18. Themes include cancelation due to staffing on the day owing to overrun theatre lists operating into the night before the elective theatre lists • WNB rate
RESPONSIVE	• 100% of patients noted that they knew who was in charge of their care • 100% of patients knew their planned date of discharge • Increase in patients involved with play 71.2%<82.2%>80.5%<85.7% • Slight increase in RTT performance (% of patients receiving treatment within 18 weeks) 43.2%<46.7%<50.6%	**Highlight** • Increase in patients who noted that they were treated with respect 99.0%>98.0%>94.7%<98.8% • Significant increase in patients involved in learning 81.7%>76.2%>75.2%<98.8% **Challenges** • Increase in waiting list size 7840>7765<8178 • Number of patients waiting over 52 weeks to receive treatment 121<135<143

WELL LED	• Increase in number of PDR's completed 24.7%<35.5%<57.8% • Reduction in mandatory training 89.3%>88.0%>87.1% • Increase in short-term sickness of 0.4% and increase in long-term sickness of 0.5%. overall sickness at 6.9% • Reduction in staff turnover 9.7% >8.9%	**Highlight** • Increase in staff who have received their PDR. • Successfully held virtual Neonatal Peer review **Challenges** • Ensure all staff have access to a meaningful PDR • Increase in short and long term sickness

Alder Hey Children's NHS
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Surgery

D Drive W Watch P Programme

SAFE

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	41	32	17	29	29	22	18	19	30	44	28	24	36		No Threshold
Clinical Incidents resulting in No Harm	D	146	143	111	143	166	115	76	95	114	172	144	143	147		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	43	52	47	40	40	38	22	26	48	49	51	37	43		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	2	3	0	0	1	0	0	4	1	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Medication errors resulting in harm	D	3	3	1	0	0	2	0	0	4	4	1	2	2		No Threshold
Medication Errors (Incidents)		41	55	27	43	38	38	16	22	34	59	36	38	36		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	1	0	0	2	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	0	1	0	1	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	100.0%	100.0%	60.0%	57.1%	80.0%	88.9%	88.9%	91.7%	88.9%	83.3%	85.7%	75.0%	86.7%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	1	0	0	2	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	1	0	0	0	0	0	0	0	0	0	0	1	0		0 N/A >0
Hospital Acquired Organisms - MSSA	D	0	1	0	0	2	0	1	0	0	1	4	1	0		No Threshold
Cleanliness Scores		97.9%	97.6%	98.0%	99.1%	96.3%				97.9%	98.4%	96.0%	98.2%			>=90 % >=80 % <80 %

CARING

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

EFFECTIVE

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	D	1	0	0	1	0	0	0	0	2	1	0	0	1		No Threshold
% Readmissions to PICU within 48 hrs	W	1.2%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%		<=3 % N/A >3 %
Referrals Received (Total)		3,859	3,318	2,837	3,724	3,637	2,813	1,370	1,780	2,245	2,824	2,574	3,147	2,808		No Threshold
Theatre Utilisation - % of Session Utilised	W	86.9%	85.6%	83.6%	89.7%	88.5%	86.2%	65.8%	68.1%	86.6%	88.6%	89.1%	88.9%	89.9%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	31	40	35	18	36	36	5	3	3	7	15	15	18		No Threshold
28 Day Breaches	W	0	1	7	10	4	7	24	0	0	0	0	5	0		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		70	57	11	29	41	140	194	2	0	16	70	52	58		No Threshold
OP Appointments Cancelled by Hospital %		12.6%	12.2%	12.9%	14.0%	13.0%	28.6%	55.9%	30.2%	17.3%	14.8%	11.8%	11.1%	10.8%		<=5 % <=10 % >10 %
Was Not Brought Rate	W P	9.6%	11.0%	12.6%	9.2%	9.7%	10.7%	9.6%	10.4%	7.8%	9.2%	10.4%	10.7%	10.1%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	W	10.1%	11.4%	11.9%	9.3%	10.6%	11.3%	9.9%	11.3%	9.0%	11.3%	11.7%	12.4%	10.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	9.4%	10.9%	12.9%	9.2%	9.3%	10.4%	9.5%	10.0%	7.3%	8.5%	9.9%	10.1%	10.2%		<=14 % <=16 % >16 %
Coding average comorbidities		4.11	4.14	4.26	4.15	3.97	4.19	5.19	4.84	4.19	4.10	4.59	4.45	4.27		No Threshold
CCAD Cases		35	27	26	33	28	36	21	26	24	29	23	30	31		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		96.9%	99.0%	98.7%	99.0%	89.2%	64.6%											
IP Survey: % Received information enabling choices about their care	W	96.8%	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 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	98.0%	98.2%	99.1%	98.5%	97.5%	98.0%	100.0%	96.2%	95.7%	99.0%	98.0%	94.7%	98.8%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	95.0%	96.1%	88.7%	93.1%	93.2%	91.1%	83.9%	94.3%	98.9%	98.1%	93.1%	97.7%	100.0%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	91.3%	98.2%	99.3%	98.2%	97.9%	97.0%	90.3%	86.8%	92.4%	91.3%	99.0%	98.5%	100.0%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	94.2%	95.7%	91.7%	96.4%	92.2%	95.0%	61.3%	81.1%	65.2%	71.2%	82.2%	80.5%	85.7%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	74.3%	68.4%	87.7%	87.7%	77.9%	81.7%	71.0%	56.6%	85.9%	81.7%	76.2%	75.2%	98.8%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	93.8%	93.6%	94.5%	93.5%	94.4%	89.0%	69.0%	59.6%	47.8%	40.3%	43.2%	46.7%	50.6%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,319	8,166	8,088	8,651	8,238	7,567	6,655	6,630	7,186	7,431	7,840	7,765	8,178				
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	0	0	7	31	60	137	121	135	143		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	66.7%	53.3%	100.0%	100.0%	100.0%		>=99 %	N/A	<99 %

WELL LED

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	-406	-65	154	-569	-142	-1,187	-4,228	-3,714	-1,774	-1,985	-1,541	-1,988	-488		No Threshold		
Income In Month Variance (£'000s)	W	242	556	541	-184	367	-503	-4,173	-4,172	-1,908	-1,964	-1,428	-1,460	15		No Threshold		
Pay In Month Variance (£'000s)	W	-267	-194	-18	58	-343	-240	-132	-111	30	65	34	-454	-69		No Threshold		
AvP: IP - Non-Elective	W	429	385	392	430	354	342	0	0	1	-1	0	-127	-65		>=0	N/A	<0
AvP: IP Elective vs Plan	W	309	309	265	294	302	232	0	0	0	0	0	25	3		>=0	N/A	<0
AvP: OP New		3,074.00	2,715.00	2,272.00	2,923.00	2,507.00	2,003.00	3.00	3.00	4.00	6.00	7.00	-690.00	-1,269.00		>=0	N/A	<0
AvP: OP FollowUp		8,472.00	7,136.00	5,766.00	7,881.00	7,136.00	5,626.00	0.00	1.00	0.00	1.00	9.00	-692.00	-1,763.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	875	867	720	856	842	581	0	1	2	1	0	-78	-178		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	13,428	11,416	9,330	12,518	11,111	8,782	3	4	4	6	17	-1,815	-3,745		>=0	N/A	<0
PDR	W	93.3%	93.3%	93.3%	94.3%	94.3%	94.3%	94.3%	0.0%	1.1%	17.1%	24.7%	35.5%	57.8%		>=90 %	>=85 %	<85 %
Medical Appraisal	W	89.6%	67.7%	65.2%	84.1%	89.7%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%		>=95 %	>=90 %	<90 %
Mandatory Training	W	90.3%	89.9%	91.1%	93.0%	92.9%	92.1%	90.6%	88.5%	89.6%	89.1%	89.3%	88.0%	87.1%		>=90 %	>=85 %	<80 %
Sickness	D	6.2%	5.9%	7.1%	6.3%	5.8%	6.3%	6.5%	6.7%	5.7%	5.8%	6.1%	6.0%	6.9%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.9%	1.8%	2.2%	2.0%	2.0%	2.2%	1.6%	1.5%	1.0%	1.4%	1.4%	1.6%	1.8%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.3%	4.1%	4.9%	4.3%	3.8%	4.2%	4.9%	5.2%	4.7%	4.4%	4.7%	4.4%	5.1%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	419	484	388	343	397	504	457	321	204	310	332	286	446		No Threshold		
Staff Turnover	D	10.1%	10.0%	10.5%	10.8%	11.2%	10.8%	10.5%	9.9%	9.5%	9.8%	9.7%	9.6%	8.9%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	89.6%	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: • Letters that are digitally dictated should be proof read extra carefully for errors e.g. incorrect patient details • Clinicians must ensure all changes to care plans are recorded in the required time frame and clearly to avoid any ambiguity with medication instructions	**Highlight** • 143 incidents recorded in October (increase) • Zero incidents recorded of moderate, severe or fatal harm • Zero never events • Zero pressure ulcers **Challenges** • Increase in medication incidents (33) predominantly 'lost prescriptions' (risk 2231) related to Royal Mail. Divisional Pharmacist undertaking work to look at alternative arrangements for sending prescriptions to families. • ANTT training compliance in OPD – improvement plan in plan • Lack of Tissue Viability support as per previous Trust Board reports
CARING	Lesson learnt from complaint: • Administrative staff to ensure that the appointment process is followed through completely when making appointment via email with other parties outside the Trust e.g. social care	**Highlight** • 28 excellence reports • 6 compliments reported • FFT reports show 95.5 % recommend Outpatients & 94.7% recommend Community Services **Challenges** • 3 formal complaints • 32 PALS
EFFECTIVE	• New outpatient schedule launched 26 October 2020	**Highlight** • Crisis care continue to provide 24/7 provision with an increasing number of calls to the service • Additional Mental Health in Schools Teams mobilising **Challenges** • Delay in referral logging turnaround – current position is 14 days above target. Improvement plan in place with weekly updates to be delivered at Access to Care delivery group.
RESPONSIVE	• Improved RTT position for Community Paediatrics (to 48.9%) and reduction in number of children waiting over 40 weeks • Activity restored for Mental Health Services and Community Paediatrics above 2019 activity levels	**Highlight** • No urgent and routine breaches of Eating Disorder waiting time targets • Improvement in Mental Health RTT position to 68.8% **Challenges** • Liverpool Speech & Language Therapy waiting times remain above 18 weeks but position continues to improve (92nd percentile wait reduced to 26 weeks). Robust action plan in place and weekly divisional monitoring

WELL LED	• Second BAME and White Allies Network meeting held across the Division. This includes changes to recruitment and selection processes within the division. • Discussions commenced with Community Leaders regarding work based opportunities for young people in local communities (BAME) • NHS Cadets programme commenced with Youth Forum and young people from across Liverpool and Sefton (Youth Violence) • National AHP day celebrated on 14 October 2020 • Celebration of World Mental Health Day 10 October 2020	**Highlight** • Flu immunisation rate 62% • Mandatory training 91.7% • Staff turnover rate at 9.7% (within Trust target for the first time in 12 month) **Challenges** • PDR rates at 42.18% at end of October, but position has now improved to 77% • Increase in staff sickness levels to 4.15% (short term absence increase)

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	1	6	2	8	5	5	4	6	6	8	4	8	14		No Threshold
Clinical Incidents resulting in No Harm	D	85	62	30	46	57	42	29	92	84	83	73	89	85		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	11	9	11	6	10	4	4	3	10	6	5	9	10		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)		11	8	9	1	2	6	6	7	6	11	10	20	33		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%					No Threshold
CCNS: Advanced Care Plan for children with life limiting condition		8	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%	100.0%						No Threshold
CCNS: Prescriptions		25	21	32	15	22	17	16	12	15						No Threshold

CARING

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Complaints	W	3	5	1	2	3	2	0	2	2	3	2	2	3		No Threshold
PALS	W	35	21	20	44	36	18	19	19	26	29	22	26	32		No Threshold

EFFECTIVE

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Referrals Received (Total)		1,097	933	769	915	950	794	432	464	612	870	633	853	886		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		20	19	11	18	18	19	17	0	0	4	25	25	18		No Threshold
OP Appointments Cancelled by Hospital %		13.9%	12.8%	12.8%	10.9%	11.3%	18.3%	24.3%	11.8%	6.4%	6.3%	10.5%	10.3%	9.8%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	8.9%	11.4%	11.7%	9.7%	9.5%	9.6%	9.3%	10.0%	11.5%	10.7%	10.3%	6.8%	12.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	10.4%	10.4%	13.5%	11.1%	10.2%	10.8%	13.0%	14.8%	14.3%	15.0%	13.6%	13.5%	15.1%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		10.1%	13.3%	14.0%	12.5%	11.7%	9.1%	9.3%	12.2%	11.7%	9.0%	12.3%	9.1%	16.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		9.8%	9.4%	11.3%	9.6%	7.8%	8.2%	13.2%	13.3%	11.0%	14.5%	14.0%	16.3%	16.9%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		13.5%	14.2%	16.5%	9.5%	13.1%	24.9%	26.1%	22.4%	28.3%	25.7%	23.6%	9.0%	12.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		11.0%	11.6%	15.4%	12.3%	11.9%	12.1%	13.6%	15.8%	16.0%	15.8%	13.9%	13.1%	15.1%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		58.1%	71.0%	77.9%	92.6%	76.8%	82.5%	90.5%	91.2%	85.7%	87.6%	75.6%	91.4%	107.8%		No Threshold
CAMHS: Tier 4 DJU Bed Days		192	238	278	340	256	296	322	386	360	380	328	384	470		No Threshold
Coding average comorbidities		4.00	3.00		3.00		5.00	3.00	3.00		2.00	6.00		4.50		No Threshold
CCNS: Number of commissioned packages		10	10	10	10	10	10	9	9	9						No Threshold

RESPONSIVE

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1		1	1	1	1	1	1		1	1	1			No Threshold
CAMHS: Referrals Received		418	342	258	354	383	315	110	163	258	262	258	356	346		No Threshold

Community

D Drive W Watch P Programme

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
CAMHS: Referrals Accepted By The Service	251	176	150	207	230	169	67	93	143	154	147	268	192		No Threshold
CAMHS: % Referrals Accepted By The Service	60.0%	51.5%	58.1%	58.5%	60.1%	53.7%	60.9%	57.1%	55.4%	58.8%	57.0%	75.3%	55.5%		No Threshold
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%							>=96 % N/A <96 %
RTT: Open Pathway: % Waiting within 18 Weeks W	76.1%	76.5%	74.3%	76.3%	75.1%	69.3%	44.3%	42.5%	34.0%	32.3%	38.1%	40.1%	48.9%		>=92 % >=90 % <90 %
Waiting List Size W	1,222	1,344	1,371	1,191	1,161	1,234	1,010	1,013	1,184	1,032	1,109	1,055	799		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	0	5	8	21	22	12	6	10	2		0 N/A >0
CAMHS: Crisis / Duty Call Activity							288	422	413	550	494	516	598		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks W	48.9%	49.6%	49.0%	58.3%	59.6%	58.6%	53.0%	53.6%	49.3%	44.0%	53.2%	59.1%	68.8%		>=92 % >=90 % <88 %
ASD: Completed Pathways	116	104	65	69	59	53	24	24	79	103	107	66	72		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	62.9%	57.7%	66.2%	81.2%	74.6%	69.8%	83.3%	70.8%	53.2%	60.2%	70.1%	65.2%	95.8%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) P			100.0%	87.5%	100.0%	90.9%	69.2%	90.0%	87.5%	100.0%	100.0%	100.0%	94.4%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) P			100.0%	100.0%	100.0%		66.7%	100.0%	100.0%	100.0%	100.0%	100.0%			>=95 % >=92 % <92 %
CCNS: Number of Referrals W	129	169	107	109	102	131	107	134	149	188	122	144	146		No Threshold
CCNS: Number of Contacts D	951	1,094	863	821	830	986	748	859	812	1,083	803	1,035	1,038		No Threshold

WELL LED

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	-36	22	-9	-58	-65	165	-92	-27	175	-26	0	-70	369		No Threshold
Income In Month Variance (£'000s) W	74	34	26	104	91	330	-30	-64	139	-49	-44	96	397		No Threshold
Pay In Month Variance (£'000s) W	-43	15	-30	-90	-87	412	18	131	-29	-64	-98	-31	-81		No Threshold
AvP: OP New	631.00	591.00	453.00	552.00	531.00	454.00	0.00	2.00	3.00	1.00	-1.00	179.00	110.00		>=0 N/A <0
AvP: OP FollowUp	2,885.00	2,878.00	2,195.00	3,079.00	2,767.00	2,760.00	1.00	9.00	4.00	0.00	5.00	649.00	547.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan W	3,520	3,470	2,650	3,631	3,299	3,214	1	11	7	1	4	818	653		>=0 N/A <0
PDR W	90.1%	90.1%	90.1%	91.3%	91.3%	91.3%	91.3%	2.1%	9.8%	16.6%	23.1%	41.3%	73.4%		>=90 % >=85 % <85 %
Medical Appraisal W	84.8%	78.8%	51.5%	69.7%	91.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %
Mandatory Training W	92.7%	93.5%	94.1%	96.7%	95.9%	94.7%	93.8%	93.0%	92.8%	92.1%	92.0%	91.4%	91.7%		>=90 % >=85 % <80 %
Sickness D	6.3%	6.0%	6.5%	4.9%	4.7%	6.3%	4.0%	3.5%	2.7%	2.5%	2.7%	3.7%	4.1%		<=4 % <=4.5 % >4.5 %
Short Term Sickness D	2.4%	2.1%	2.0%	1.2%	1.1%	2.8%	1.4%	0.8%	0.5%	0.6%	0.8%	1.1%	1.4%		<=1 % N/A >1 %
Long Term Sickness D	3.9%	3.9%	4.5%	3.7%	3.5%	3.5%	2.6%	2.7%	2.2%	1.8%	1.9%	2.6%	2.7%		<=3 % N/A >3 %
Temporary Spend ('000s) D	42	104	120	135	148	183	122	47	21	189	194	169	173		No Threshold
Staff Turnover D	10.5%	11.1%	11.6%	12.2%	12.2%	11.2%	10.6%	11.8%	11.9%	11.1%	11.1%	10.5%	9.8%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) W	87.6%	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 ward passed ICP audit • All patients screened for potential COVID 19 prior to hospital visit using telephone triage • CRF ward compliant with all standards on Trust Dashboard • All Areas have been certified Covid Secure	**Highlight** • Mandatory Training > 98% • GCP training 97% • ANTT compliance 100%-CRF Ward **Challenges** • All Covid RAs complete for CRD some amber actions to complete • X1 clinical incidents reported
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
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 33% • Overall Recruitment figures for UPH studies second highest • X 12 UPH studies open within Trust **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
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 period extended **Challenges** • Staff working offsite to support adult vaccine studies • Last minute requests for external support • Effective clinical space to deliver HCW study clinics
WELL LED	• PDR compliance increased to 79% • LTS absence rates have improved staff are supported through line managers and staff support. • Engagement with partners in relation to upcoming starting well initiatives.	**Highlight** • Sickness levels improving • Staff Shielding have returned. **Challenges** • Late requests for help can be challenging • Increased numbers of staff having to self-isolate with local increased infection rates

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th November

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

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

Digital and Information Technology Update

1. Introduction

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

2. Current Progress

Since the previous reporting period, progress against delivery plans has been excellent. Alder Hey has been recognised nationally for digital delivery as the 'Overall Winner' for the Health Tech News Awards in October. Additionally, the neonatal partnership received Highly Commended for the work on telemedicine. Finally, Alder Hey has been shortlisted for a Health Service Journal digital award for our work linked to the Global Digital Exemplar and HIMSS programmes.

A focus on digital inclusion has been in place with internal and external dialogue to develop plans within Alder Hey and across the wider City and region to support families without digital access to services.

3. Digital Transformation Progress

3.1 AlderC@re

AlderC@re is the programme of work which will see a significant upgrade to the Trust's Electronic Patient Record programme in 2021.

Progress to date is excellent with the development of the first prototype of the new system progressing well. Work is underway to give all staff access to the new system shortly. A new approach to training and engagement has been presented and supported through the Programme Board. The programme remains on track for go live by September 2021.

3.2 Digital Children, Young People and Families

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

- Version 2 of Alder Play app
- Virtual ED: Phase 1 onsite trial completed, phase 2 will see patients directed to 111 first and a digital solution will be deployed through Meditech to enable those patients to be directly booked into ED. This will then be expanded on to include the ability for 111 to book into Alder Hey's Virtual ED service
- Children and Young People as One: Good progress with referral forms and platform development

With regards to digital consultations, progress continues with video outpatient appointments through Attend Anywhere. Work is ongoing to support the increase in

capacity for Outpatients, including the implementation of digital pods planned for November.

Alder Hey performs well from a regional perspective with the second highest utilisation of Attend Anywhere across Cheshire and Merseyside. There were 4439 Outpatient appointments conducted virtually in October.

The utilisation of telehealth and telemedicine remains excellent with the neonatal partnership leading in this area. Work has progressed with an expression of interest process working with a local district general hospital for clinical support through telemedicine. Support for high dependency patients is being progressed with this partnership.

3.3 HIMSS Level 7

Work continues on plans for the achievement of HIMSS Level 7. The utilisation of bedside verification technologies linked to safety priorities continues and improvements are underway with regards to other areas across the Trust. It is anticipated that accreditation processes will progress significantly in early 2021.

3.4 Health Records and Transcription

Plans are progressing well with regards to health records and scanning transformation. These include the acceleration of scanning the live medical records library into a digital solution with the scanning service operating 24/7 over a 6 month period. To date, 5.5M of 18M planned images have been scanned.

Scanning of in and outpatient records are consistently within target of 48 hours service level agreement.

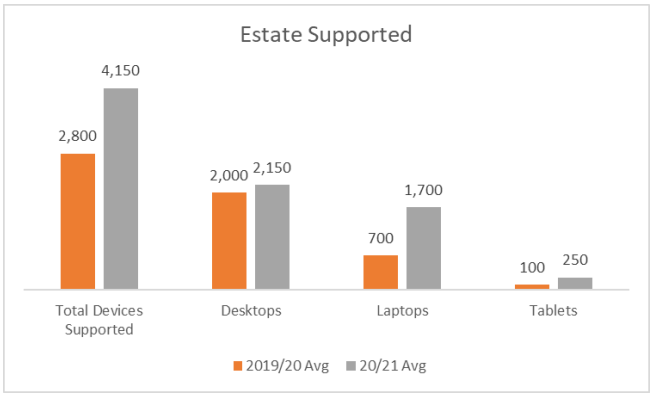
Work progresses with transcription developments with the prototype robotic process automation bot built and in test. Plans are for this to go live by April 2021.

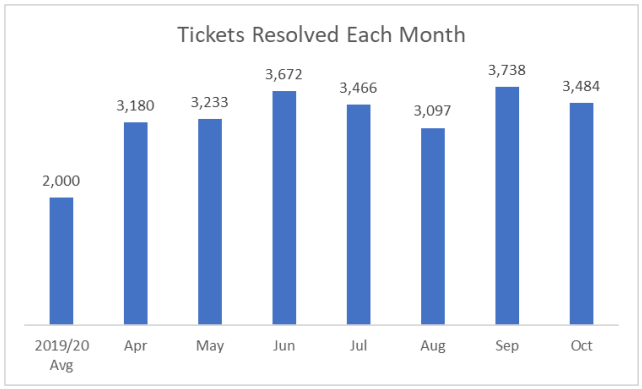
4. Operational IT Performance

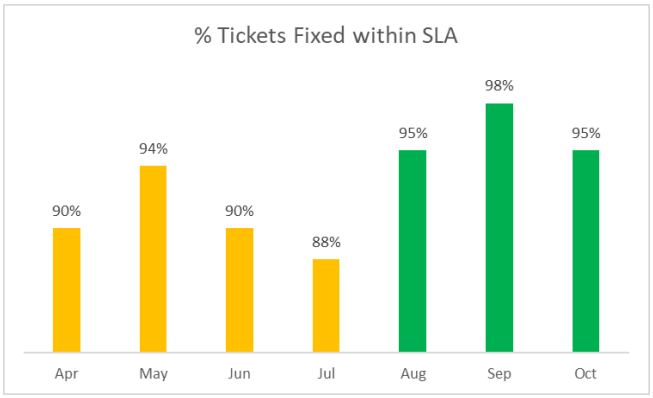
This report provides performance from October 2020.

Key highlights include:

- A reduction in the total number of tickets resolved
- Maintenance of 95% SLA target
- Call management processes are embedded, the results demonstrate work to sustain performance levels despite a 50% increase in activity over the last 12 months
- Due to Covid-19 and the mobilisation of staff working from home, we have had a significant rise in the number of Mobile devices that has increased the demands on the department.
- We continue to innovate to help reduce the overall calls to the Service Desk







In the last quarter a range of improvements were implemented including Self Service Password Rest, Self Service New Account Automation and a new Software Centre which allows the Service desk and staff themselves to install or re-install core applications to their device without the need for an IT Engineer.

Customer satisfaction levels from staff surveys are high, feedback from staff with regards to the digital support centre hosted on the Mezzanine is excellent.

5. Technology Programmes Update

There have been a significant amount of programmes and improvements delivered in terms of underpinning technology programmes including but not limited to:

- Completion of new data centres in partnership with Alder Hey and Clatterbridge. This will be extended to support the Liverpool Womens in due course
- Phase 2 Office 365 in pilot with testing with key clinical applications
- Reducing login times for staff progressing with configuration policies and changes
- Review of mobile phone coverage improvements underway

6. Digital Partnership

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

7. Summary and Recommendations

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

Trust Board is asked to:

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

Kate Warriner
Chief Digital and Information Officer
November 2020

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

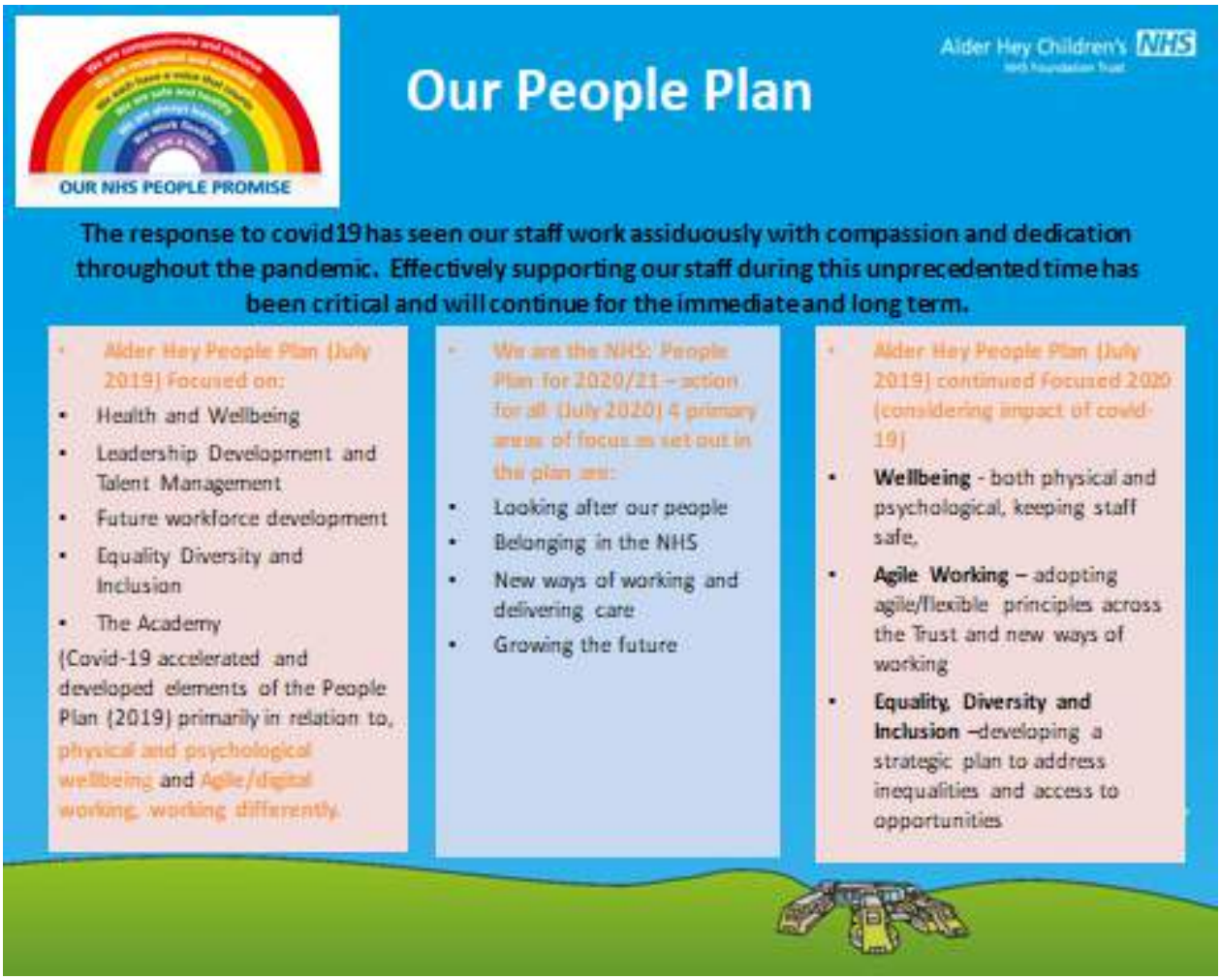
Thursday 26th November 2020

Paper Title:	**People Plan Update**
Report of:	**Director of HR & OD**
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 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.

Since March 2020, the SALS team have had over 500 contacts from across the organisation offering interventions, signposting and advice as well as supporting with the provision of stress risk assessments, coaching and leadership advice. In addition the SALS team have

supported the implementation of the Wingman Lounge and the associate Project Wingman initiatives with community and shielding staff. The team have also been able to open a dedicated safe space for all members of staff who need support

The team are working on growing the service further and undertaking a communication plan to ensure all staff are aware of the support available to them. In addition the team are also developing the network of Mental Health First Aiders prioritising providing training and development to our nursing and AHP colleagues in the first instance.

2.1 Leadership

Since March the OD team have been developing a 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. The leadership hub aims to compliment the Strong Foundations Leadership Programme. In response to COVID-19 the Strong Foundations leadership programme has been redeveloped for delivery via a virtual platform with enhanced content and was relaunched on the 28th September. Moving forward there are a further 6 cohorts scheduled during 2021. The programmes first 10 cohorts are due to complete the programme by the beginning of March 2021.

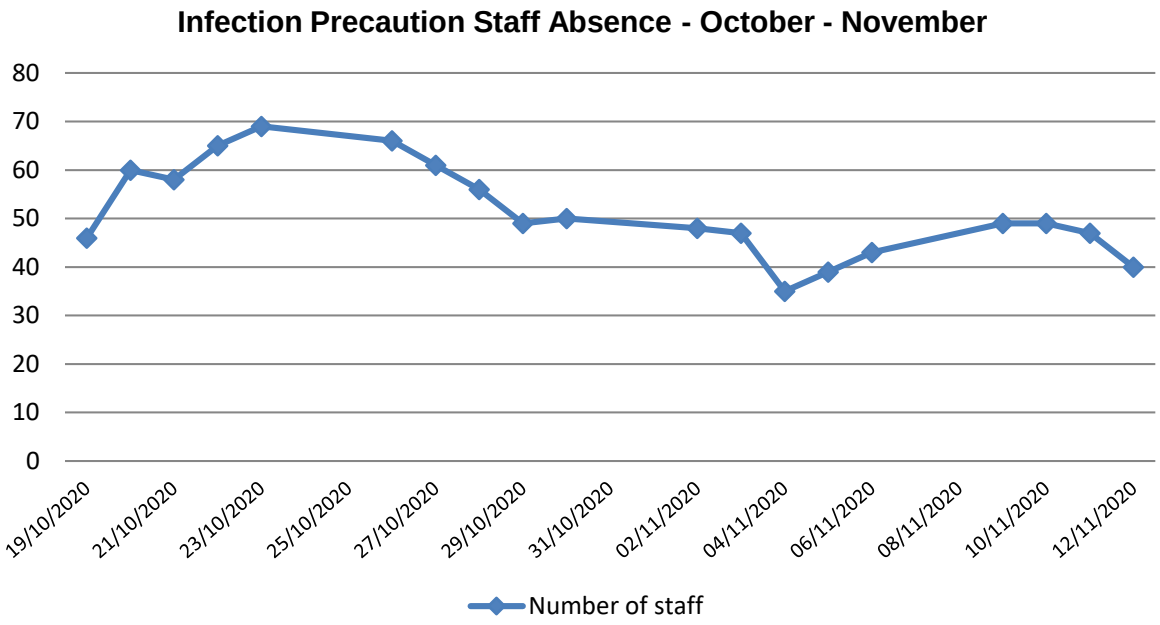
To further support leaders and mangers coaching framework is being established to provide access to support and development for all managers across the trust via coaching or mentorship. In order to support the development of the coaching framework a national apprenticeship in coaching is being explored which will enable a sustainable, continuous development pipeline of new coaches within accost effective framework. The team have also received funding from the Charity to support the development of 10 workplace wellbeing coaches.

2.2 Staff Availability

Table 1 - Sickness position 12th November 2020

Reason	Trust	
	%	No of Staff
Non Covid Related Sickness	5.30%	206
Covid Related Sickness	0.72%	28
Absence Related to Covid - not inc sickness	1.80%	70
Absence Related to Covid Inc Sickness	2.52%	98
All Absence (total of above)	7.82%	304

Following the announcement from the Government and changes to lockdown measures in England as of 5th November 2020 the numbers of staff shielding has increased. The advice around shielding is significantly different to March with only those classified as Clinically Extremely Vulnerable being advised to shield. The HR team are supporting the Trust to facilitate home working were possible and are facilitating temporary redeployment into alternative roles were possible.



The graph above demonstrates the fluctuation we have seen in regards to staff absence due to self-isolating as a result of contact for Test and Trace services or household infection. This continues to be a challenging issue and the HR department have developed guidance to support both staff and managers. Our data currently does not indicate an impact on staffing availability due to school closures; this will continue to be monitored.

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, it is anticipated there will be an increase in COVID-19 related absences. This increase in absence will either as a result of staff testing positive or due to households being required to self-isolate. The impact of this is currently unknown and 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 launched w/c 21st September 2020 and is open until 27th November 2020. 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 will

receive a survey and we will be encouraging all staff to tell us their stories and give us their feedback.

Table 2- Staff Survey Responses by Division

Directorate	% Returns					
	09/10/2020	16/10/2020	27/10/2020	03/11/2020	10/11/2020	Change
Corporate Other Department	40%	50%	60%	67%	**73%**	+6%
Finance	24%	36%	45%	56%	**59%**	+3%
IM&T	16%	34%	39%	46%	**57%**	+11%
Human Resources	25%	40%	49%	51%	**54%**	+3%
Research & Development	15%	29%	39%	44%	**52%**	+8%
Community	16%	30%	38%	45%	**49%**	+4%
Nursing & Quality	18%	24%	37%	42%	**47%**	+5%
Alder Hey in the Park	17%	24%	31%	34%	**45%**	+11%
Medicine	13%	20%	28%	33%	**38%**	+5%
Surgery	9%	14%	20%	26%	**32%**	+8%
Facilities	7%	13%	17%	19%	**23%**	+4%
Total	**13%**	**21%**	**28%**	**34%**	**39%**	**+5%**

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.

On 11th November 2020 all staff working from home received a letter from the Trust outlining that whilst we had anticipated a gradual return to the workplace for many from January 2021; it is now clear that we need to continue as we are for at least the next five months. We are aware of how challenging this new way of working has been for some and we are committed to ensuring that we everything possible to support everyone through the next few months and beyond to help individuals feel safe and connected to their team, and to the wider Alder Hey family. In particular a group dedicated to focusing of flexible working are;

- supporting staff to carry on working from home safely, through provision of equipment needed to do their jobs effectively,
- ensuring that everyone who continues to work from home is supported with the DSE risk assessment process
- helping staff to easily access the tax benefits the government have provided for homeworkers during the pandemic,
- working with line managers to help build their skills around effectively managing and supporting remote teams

3.1 E- Roster

The Trust has awarded Allocate Software the contract to supply our E Rostering system and the mobilisation of the project commenced Monday 9th November. The E Rostering team are currently carrying out a data collection exercise and the system will be configured w/c 23rd November and will be ready to start building areas from 30th November.

Phase 1 of the project will focus on rostering all of Medics for the purposes of leave entitlements (Annual leave, Study Leave, sickness, etc.). Phase 2 focuses on inpatient nursing with 4A & Ward 3C identified as implementation areas. To support the role out of E-roster a steering group and task and finish group have been established bringing together stakeholders from across the organisation.

The E Roster will provide an overview of all elements of people management across the organisation down to individual shifts from induvial members of staff, enabling the identification of hotspots needing intervention for staffing levels to remain safe and efficient. An effective enables the alignment of staffing and clinical needs and improved flexibility for employees via mobile technology allowing shift selection. It also facilitates improved governance controls for audit of safe staffing level and enables us to effective utilise resources. E-rostering is therefore essential across all staff groups for achieving the productivity gains described in Lord Carter's reports and the National Quality Board's expectations on safe, sustainable and productive staffing.

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. Governance and Ongoing Business

5.1 Case Management

The national Social Partnership Forum (SPF) issued an updated statement on the management of industrial relations during the pandemic in September 2020.The guidance confirms that disciplinary and other employment procedures will can commence and outlines the need for partnership working with our staff side colleagues to proactively and effectively

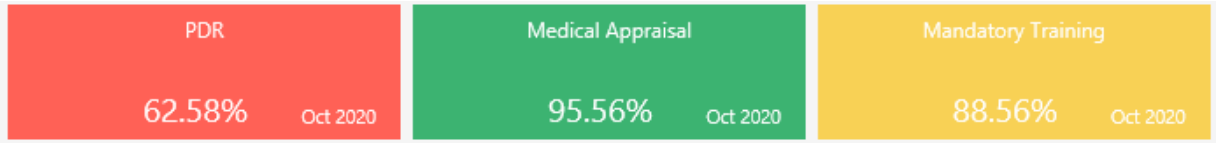
support staff. Cases continue to be managed on a case-by-case basis with appropriate measures and risk assessments but in place to ensure staff health and wellbeing continue to be prioritised.

In November we have seen an increase in employee relations cases, with 23 cases currently ongoing as detailed below.

Table 2- Employee relations activity per division as of 12th November 2020

Division	MHPS	Disciplinary	Grievance	B&H	ET	Total
Surgery	3	3	2	1	0	**9**
Medicine	2	1	1	1	0	**5**
Community	0	3	1	1	0	**5**
Corporate	0	3	0	1	0	**4**
Grand Total	**5**	**10**	**4**	**4**	**0**	**23**

5.2 Workforce Key Performance Indicators – October 2020



Training

At the end of October 2020, Mandatory Training was at 88% overall, 2% below our target of 90%. This is primarily caused by the reduction in compliance across topics that have annual refreshers such as Information Governance and in particular those that require some or all of the training to be delivered face to face such as Practical Moving and Handling and Resuscitation Training which have 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 small 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	**87.96%**
Division	Overall Mandatory Training
411 Alder Hey in the Park	**80.25%**
411 Community	**91.61%**
411 Corporate Other Department	**91.25%**
411 Facilities	**69.68%**
411 Finance	**92.09%**
411 Human Resources	**90.23%**
411 IM&T	**93.78%**
411 Innovation	**98.41%**
411 Medicine	**89.82%**
411 Nursing & Quality	**85.09%**
411 Research & Development	**95.68%**
411 Surgery	**86.22%**

Further training detail by topic can be found in Appendix 1

Appendix 1- Training data by Topic

	Trust	Alder Hey in the Park	Community	Corporate Other	Facilities	Finance	Human Resources	IM&T	Innovation	Medicine	Nursing & Quality	Research & Development	Surgery
Overall Mandatory Training	87.96%	80.25%	91.61%	91.25%	69.68%	92.09%	90.23%	93.78 %	98.41%	89.82%	85.09%	95.68%	86.22%
Overall Resus	77.44%		84.67%	100.00%	45.45%		80.95%			77.84%	85.14%	87.10%	74.75%
Advanced Paediatric Life Support	83.25%									79.55%	100.00%		83.85%
Basic Life Support	81.81%		84.43%	100.00%	45.45%		80.95%			82.74%	75.00%	75.00%	78.57%
PLS/APLS Annual Update	66.34%		83.33%	100.00%						64.37%	86.96%	79.31%	65.80%
Paediatric Life Support (4 years)	87.83%		93.33%	100.00%						90.94%	94.74%	96.55%	85.07%
Sepsis	79.39%		87.27%	100.00%						78.89%	40.91%		78.58%
Equality, Diversity and Human Rights - 3 Years	94.57%	85.00%	95.49%	97.96%	81.68%	96.05%	94.20%	95.54 %	100.00%	96.75%	90.74%	100.00%	94.15%
Fire Safety - 2 Years	90.43%	90.00%	94.04%	77.55%	60.40%	89.47%	94.20%	94.64 %	100.00%	92.47%	90.74%	98.51%	91.27%
Health, Safety and Welfare - 3 Years	94.62%	80.00%	95.33%	93.88%	83.17%	96.05%	92.75%	94.64 %	100.00%	97.12%	93.52%	98.51%	94.06%
Infection Prevention and Control - Level 1 - 3 Years	92.58%	84.21%	92.92%	95.35%	79.70%	95.95%	94.12%	97.00 %	100.00%	98.44%	86.49%	100.00%	94.41%
Infection Prevention and Control - Level 2 - 2 Years	88.93%		93.50%	100.00%		100.00%			100.00%	88.11%	80.60%	94.44%	88.25%
Information Governance and Data Security - 1 Year	77.77%	55.00%	83.09%	81.63%	29.21%	72.37%	72.46%	84.82 %	87.50%	80.86%	80.56%	89.55%	79.74%
Moving and Handling - Level 1 - 3 Years	93.78%	85.00%	95.17%	93.88%	82.67%	94.74%	95.65%	94.64 %	100.00%	96.19%	92.59%	100.00%	92.31%
Moving and Handling - Level 2 - 1 Year	63.36%	66.67%	66.25%	100.00%	44.87%		42.86%			74.10%	51.22%	68.18%	62.31%
Safeguarding Children (Version 2) - Level 1 - 3 Years	93.89%	75.00%	95.97%	93.88%	75.25%	96.05%	98.55%	93.75 %	100.00%	96.28%	89.81%	100.00%	93.71%
Safeguarding Children (Version 2) - Level 2 - 3 Years	90.59%		91.58%				85.71%			91.16%	89.47%	100.00%	89.60%
Safeguarding Children (Version 2) - Level 3 - 3 Years	85.71%		88.03%	100.00%					100.00%	88.42%	63.64%	100.00%	83.39%
Major Incidents - 3 Years	93.33%	90.00%	95.49%	93.88%	87.13%	96.05%	98.55%	95.54 %	100.00%	93.59%	89.81%	97.01%	92.40%

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th November 2020

Paper Title:	**Board Assurance Framework 2020/21 (October)**
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

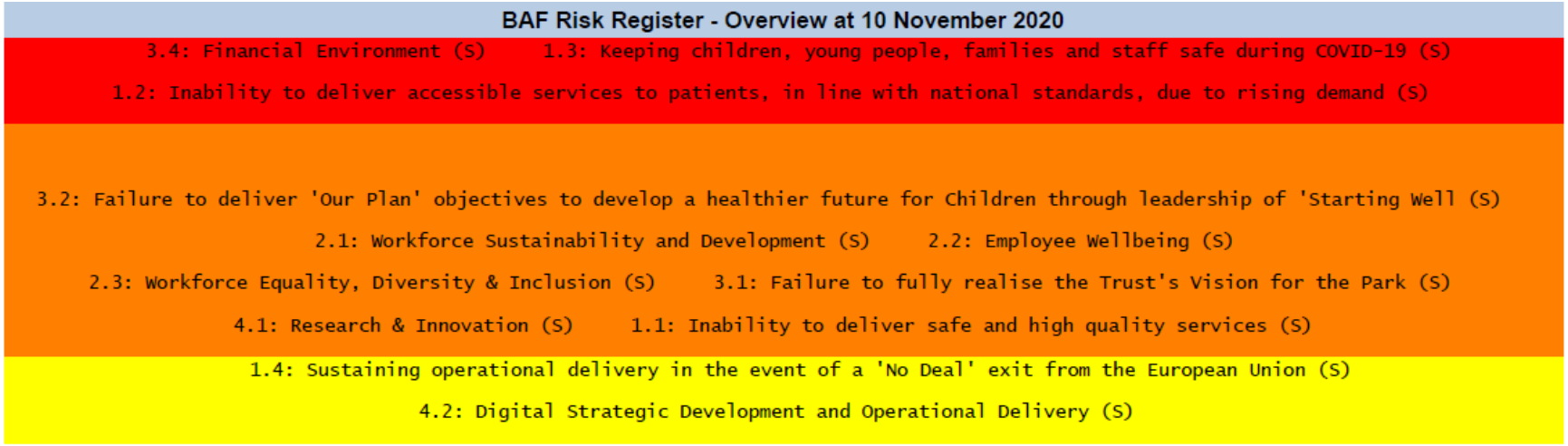
Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF Risks ensuring a holistic joined-up approach. Responsibility to review and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

	from EU	

Overview at 10th November 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 6th November 2020

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

Ref, Owner	Risk Title	Board Cttee		Risk Rating: I x L		Monthly Trend	
				Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care							
1.1 PB	**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		**3x5**	3x2	STATIC	STATIC
1.3 JG	**Keeping children, young people, families and staff safe during COVID-19**	Trust Board		**5x3**	3x3	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	Trust Board		3x2	3x1	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work							
2.1 MS	**Workforce Sustainability and Development**	PAWC		4x3	4x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**	PAWC		3x4	3x3	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC		3x4	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	IMPROVED	STATIC

8. Summary of September 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. Second wave of Covid underway - significant system planning. Progress made in Liverpool and Sefton on alignment of plans and programme resource for C&YP.

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

  Actions reviewed and updated. Good progress being made in the BAME Taskforce.

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

  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.

Internal risks:

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

  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 (i.e. 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.

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

  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 is improving access to services for C&YP.

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

- ***Financial Environment (JG)***
  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.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Incorporation of Eaton Road Masterplan.

- ***Digital Strategic Development and Operational Delivery (KW)***
  BAF reviewed, good progress against plans.

- ***Workforce Sustainability and Development (MS)***
  Actions updated and progress monitored through the PAW Committee.

- ***Employee Wellbeing (MS)***
  Risk and associated actions reviewed. good progress in development of SALS and wider MH support.

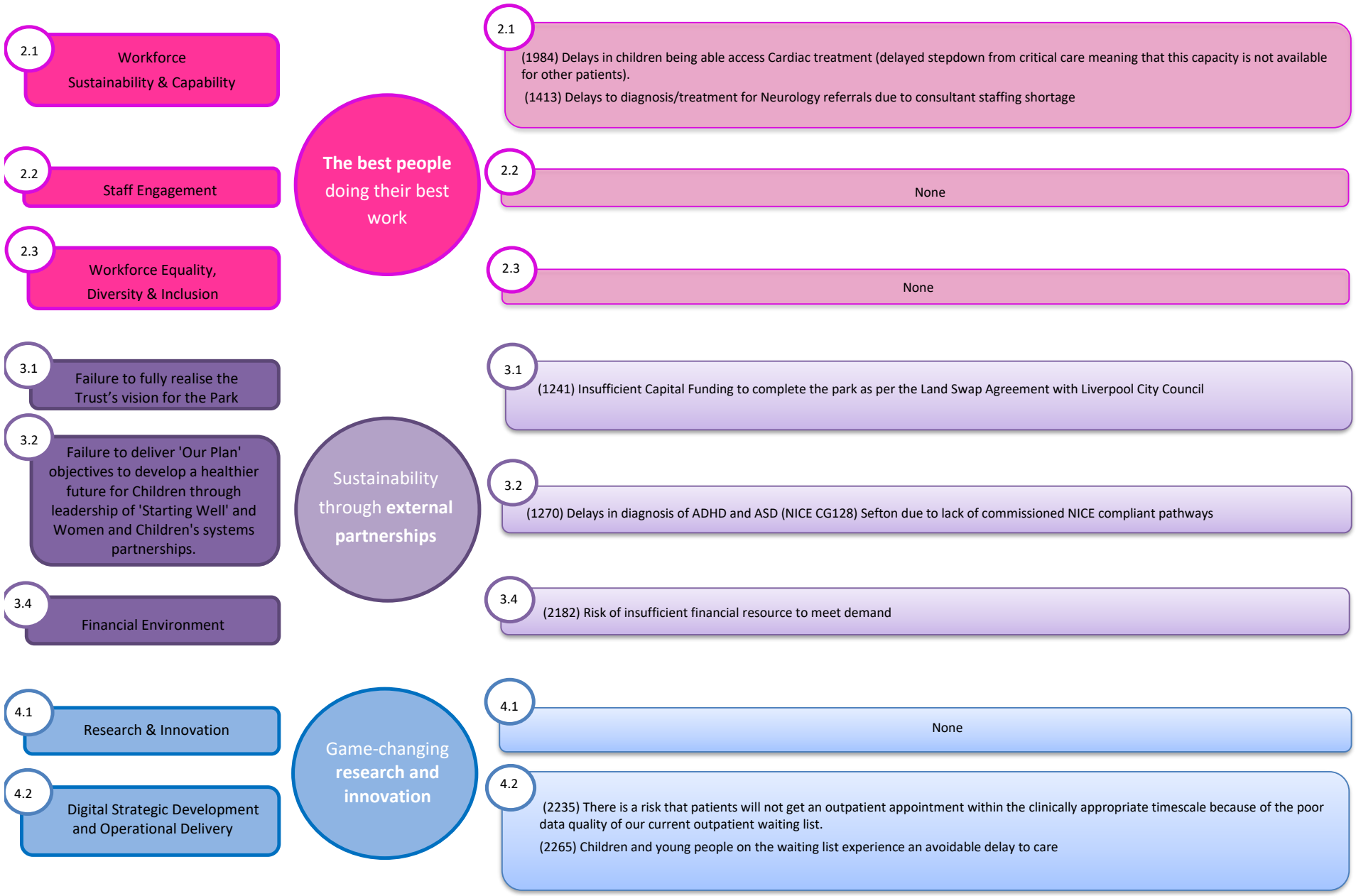
- ***Research & Innovation (CL)***
  Risk reviewed - no change to score in month. All actions remain on track

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 9th November 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. (1984) Delays in children being able access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other 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
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
2.1
(1984) Delays in children being able access Cardiac treatment (delayed stepdown from critical care meaning that this capacity is not available for other patients).
(1413) Delays to diagnosis/treatment for Neurology referrals due to consultant staffing shortage
2.2
None
2.3
None
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.
3.4
Financial Environment
Sustainability through external partnerships
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
(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
Research & Innovation
4.2
Digital Strategic Development and Operational Delivery
Game-changing research and innovation
4.1
None
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 1984, 1413, 2235, 2242, 2265, 1159, 2233, 2192		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Quality Impact 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

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

August 2020 - Pauline Brown
CQC report published and associated comprehensive action plan submitted and underway to address the 1 "must do" and 51 "should do's" - number of actions already completed including the specific action plan to address the "must do".

CQC have conducted an assessment of IPC BAF in August to identify themes, trends and risks that will inform the regulatory response and national oversight. The report is not a published report however has been shared with the Trust and is positive. High quality assurance reports received and presented at CQSG from Divisions including lessons learned and thematic analysis. Trust wide Quality Summit arranged for September to review systems in place to prevent avoidable Category 3 pressure ulcers as 3 have occurred this year.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to rising demand		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2270, 2233, 1524		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand. A loss of capacity during COVID-19 has made access to care extremely challenging.

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	- Daily reports to NHS England - Daily performance summary - Monthly performance report to Operational Delivery Group - Performance reports to RABD Board Sub-Committee - Bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	- Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee - Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	- Significant decrease in waiting times for Sefton SALT - Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	- Monthly performance report to Operational Delivery Group - Corporate report and Divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	- Monthly oversight of project delivery at Programme Board - Bi-monthly transformation project update to CQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - Operational Delivery Board as a forum to collectively address challenged areas and to submit cases for investment where access to care is challenged
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes

Gaps in Controls / Assurance

1.ED workforce plan aligned to demand and model of care aligned to type of presentations
2.Enhanced paediatric urgent care services required in primary care and the community
3.Additional capacity required in Specialist Mental Health Services and Community Paediatrics (ASD & ADHD). Request submitted to Sefton CCG for urgent investment and commissioning of NICE compliant ASD & ADHD diagnostic pathways.
4.Comprehensive, real-time and digital access times dashboard for Community Paediatrics and Specialist Mental Health Services.
5.Dynamic emergency demand and capacity model to reduce cancelled operations and more precisely predict surges in demand

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
i. New theatres, radiology and outpatients future service offer ii. Integrate workforce plan into the service plans so it is aligned to the goals of the service, the capacity they require and their new model iii. agree pay arrangements for additional work	28/09/2020	The outpatients schedule is on track to go-live on Monday 26 October 2020. Due to issues with staff availability we will not achieve 120% restoration. Initially, we are focused on delivering the NHSE submission of 90% restoration . Recruitment and productivity

iii. PPE sourcing strategy to ensure adequate suppliers		activities are commenced to support this
Actions to reduce waiting times in ASD & ADHD -ASD Dashboards signed off in October 20, weekly Operational planning & performance meetings in place -Neuro Development Programme Board initiated to ensure the ASD & ADHD are solution focused to addressing NEW and Backlog pathways. -ASD Clinical Lead (1day a wk - Nov 20) and Nurse Consultant wte (Jan 2021) Actions -Standardised referral forms across the Alder Hey ADHD and ASD pathways have been implemented which increases the quality of information received from the outset. -Neuro Development Clinical Leads Group initiated, the group is working well have started to approve elements often NEW ASD & ADHD Pathway SOP's. -Significant amount of work reviewing Axia and Healios backlog cohorts, cleanse of the pilot cohort; clinical reviews identifying new cohorts. New letters agreed and the first tranche will go out to CYP and families this week.	10/11/2020	
Assessing incentivised models to drive up restoration activity	31/12/2020	remains ongoing

Executive Leads Assessment

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.

September 2020 - Adam Bateman
Through the hard-work, determination and ingenuity of our teams we have made significant progress in restoring clinical services to children and young people. This is illustrated in the table and charts below. At the end of August 2020 we were ranked first in Cheshire & Merseyside for progress in restoring services.

Level of capacity restored in August 2020 as a percentage of pre-Covid capacity:

Outpatients	Consultations	88%
Emergency Department	Attendances	88%
Planned care	Operations	80%
Diagnostics	Examinations	83%

Despite this good progress, the number of patients waiting a long time (including over 52 weeks) is high and is not yet reducing. The patients are reportable in line with NHS guidance are waiting to access care in the Division of Surgical Care.

We have experienced an issue relating to a reporting inaccuracy of long wait patients. Risk 2265 has been created to assess this risk and record our response to the issue. Our Safe Waiting List Management Programme is diagnosing the root causes of some of the challenges, which includes data quality, complex EPR and sub-optimal training, and our response to ensure no child experiences an avoidable delay in our care.

August 2020 - Adam Bateman
The effects of the increase in waiting times caused by COVID-19 have led to non-compliance with the referral to treatment time standard and 52 week standard. The services most significantly affected are learning disabilities, paediatric surgery, spinal surgery and ENT. We are now ensuring all patients who have had waited over 52 weeks have had a clinical review to expedite treatment where required or confirm they are safe to wait longer. We will continue to increase capacity in outpatients and surgery to ameliorate the waiting times being experienced. We have stabilised the number of children and young people waiting over 52 weeks for treatment. There were 91 patients waiting over 52 weeks in specialties reportable under national guidelines. 85 patients have had a clinical review with the remaining 6 patients being tracked for review within 7 days. In learning disability services (ASD & ADHD) we remain significantly concerned about the number of long waiting patients. In ASD there is 920 patients waiting over 52 weeks. In ADHD there are 670 patients on the waiting list for a new patient appointment or MDT assessment. In June we continued to make good progress in re-introducing surgical services and the full theatre schedule (n= 139 theatre sessions per week) is restored. We are now seeing improved utilisation (85.4%) of the operating lists, which is closer to pre-Covid-19 levels. In operative care, 68 our inpatient operating levels are at 71% of last year's activity. In day case. we are operating at 78% of last year's activity The Emergency Department is seeing attendance levels at 75% of our pre-COVID activity for this time of year. The highest day for attendances last week saw 130 patients treated. Radiology has restored c. 80% of pre-Covid 19 capacity. In outpatients we provided 1,989 face to face consultations last week compared to 4,854 pre-Covid-19. However, we have increased significantly the number of digital consultations and telephone consultations, which when added to the face-to-face consultations takes the total outpatient consultations 92% of pre-COVID levels.

June 2020 - Adam Bateman
The effects of the loss of capacity for planned and urgent care during COVID-19 continue; waiting times are increasing and in the Division of Community & Mental Health and the Division of Surgical we have some patients waiting over 52 weeks for care.

Presently we focused on the safe management of children and young people on the waiting list by getting the following components of the system right:
? Maximise capacity, safely
? Effective clinical review and prioritisation
? Provide a scorecard with helpful and accurate information against defined clinical and safety standards
? A single-version of the truth waiting list, with excellent data quality
? Good administration/ documentation of a patient's pathway
? Capacity & demand model that projects trends in waiting times

We continue to make progress in restoring services with an increase in face-to-face outpatient capacity of 300 patients per day from the 29 June 2020. From the 8 June our operating capacity increased to 110 session per week, from 70 sessions.

May 2020 - Adam Bateman
In May significant focus has been given to safely opening up access to care for children.

To support access to care we have:

opened up urgent face-to-face appointment capacity (190 per day)
Increase the use of virtual appointments
From the 26 May increased the number of urgent operating lists to 8, from 5 during Phase 1 of the COVID-19 response

In order to safely open up
* PPE availability
* Patient testing
* Safe environment

We have changed the physical environment and patient pathways to achieve safe access to care:
* new pre-operative pathway
* new waiting room layout and patient flows in OPD
* re-configuration of ED to segregate patient waiting and flow

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

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 Plan agreed and being deployed	
Work programme on keeping our staff safe enacted	
Plan to establish adult invasive capacity progressed	
COVID Specific Scorecard in place	Scorecard to Strategic Meetings
Work Programme established looking at keeping Children & Young People safe	Agendas / Minutes / Actions
Access to Care Group re-established to monitor waiting lists	
24/7 CAMHS crisis line in-situ	Staff rota
Access to emergency and urgent operating theatres	Weekly capacity plan
Clinical review of waiting lists to identify clinically urgent patients requiring assessment and/ or intervention	Electronic patient record
Urgent face-to-face outpatient appointments maintained and digital outpatient consultations established	Outpatient schedule
Waiting list monitoring via weekly Access to Care Delivery Group	Minutes
All vulnerable patient cohorts across specialities (Medical and Surgical) identified	
Specialities have populated vulnerable patient template to outline risk, considerations that may affect current pathway and identify alternative	
Continued to update vulnerable shielding patients with guidance and support as per government advice	
Face masks introduced for staff and visitors	
New environment designed in the hospital and community setting to sustain social distancing and achieve high standards of IPC	
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

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
complete risk assessments for staff who are shielding	30/09/2020	merged with action 11218
Increase awareness and vigilance around keeping staff safe from Covid-19 by maintaining social distancing.	31/12/2020	Awareness campaign of core messages relating to keeping staff safe from Covid-19 Programme of audits in local teams to check that compliance with core standards relating to keeping staff safe remains ongoing.
Ensure actions that have been identified through COVID-secure risk assessments take place	31/12/2020	Work continues regarding the installation of protective screening
Oversight Group initiated focussing on redeployment, temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment	31/03/2021	

Develop a new a-symptomatic staff testing protocol	30/11/2020	

Executive Leads Assessment

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.

September 2020 - Adam Bateman
On keeping staff safe: Over the month of August we have seen a reduction in the numbers of staff who had previously been shielding. Ongoing individual risk assessments and environmental assessment are enabling staff to return to work in some capacity be that to site in own roles with measure in place to mitigate risk, or redeployed or working from home. There are currently 48 staff still shielding and these are all under review.

We have made good progress in completing environmental risk assessments. However, in September our level of concern relating to potential hospital transmission amongst staff has increased following an incident on ward 3B and then in theatres which has led to a number of staffing having to isolate. Additional action will be taken around vigilance relating to PPE and environment.

Our PPE predictor models shows adequate supplies, or appropriate mitigation, for the next 4 weeks.

On keeping patients safe: We have had no hospital acquired cases of COVID-19. We have had one inpatient with Covid-19 since the last review.

In terms of patients waiting a long-time for treatment, we continue to have high rates of clinical review for patients waiting over 52 weeks.

The number of ED attendances is rising but we continue to provide timely care to these patients.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.4	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive		Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: External,	Current IxL: 3x2	Target IxL: 3x1	Trend: STATIC

Risk Description

Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity. 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020. No further updates received from NHSE as of at 12/10/2020. Keith Willett webinar on the 9th Nov confirmed requirement to prepare for a No Deal exit on the 31st Dec

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
each lead aware of the above requirement To feedback formally to the group To develop plans where required	30/11/2020	
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

Executive Leads Assessment

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

September 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 o9ut current guidance and feedback on any risks/issues for the group to consider. No new National Guidance has been issued.

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: 1984, 1413		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

1. Not meeting compliance target in relation to some mandatory training topics
2. Sickness Absence levels higher than target.
3. Lack of standard methodology to workforce planning across the organisation
4. Succession plans Board to Ward

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	30/11/2020	Mandatory training available for all mandatory topics, reporting has been re-established. Further work ongoing to provide more access for those topics that require / benefit from face to face interaction such as Resus / Moving and Handling. We are currently working closely with these topics' Subject Matter Experts as well as topics under 90% to improve compliance and delivery models.
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

Executive Leads Assessment

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

September 2020 - Sharon Owen Action plans from the NHS people plan are being worked through by specific leads.
August 2020 - Zoe Connor Activities related to this had been paused until end of June 2020. Action plans are being drawn up to implement key requirements to progress mitigations against this risk.
June 2020 - Sharon Owen Activities related to this have been paused until end of June 2020. During July a action plan will be drawn up to implement key requirements to progress mitigations against this risk.

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: 3x4	Target IxL: 3x3	Trend: STATIC

Risk Description
Failure to support employee health and wellbeing which can impact upon operational performance and achievement of strategic aims

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Strategy. Wellbeing Steering Group ToRs
Action Plans for Staff Survey	Monitored through WOD (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
Staff Temperature Check Reports to Board (quarterly)	Board reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Listening into Action Guidance and Programme of work	Dedicated area populated with LiA info on Trust intranet
Staff surveys analysed and followed up (shows improvement)	2018 Staff Survey Report
Reward and Recognition Group schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.	Reward and Recognition Meetings established; reports to Wellbeing Steering Group
BAME, Disability and LGBTQI+ Staff Networks	Meetings minuted and an update provided to WOD
LGBTQI+ Network launched December 2018	Monthly network meetings established and open to any staff member or volunteer who identifies as LGBTQIA+.
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Time to Change implementation	Time to Change implementation

Gaps in Controls / Assurance
1. Staff Advice and Liaison Service (SALS) not yet implemented 2. Wellbeing team to support sickness absence not yet implemented 3. Junior Doctor experience not as positive as it should be

Executive Leads Assessment
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.
September 2020 - Sharon Owen Work on wellbeing continues via HR, SALS and the wellbeing team - there are a number of specific actions from the NHS People plan in relation to Wellbeing which are currently being addressed by allocated leads.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 3x4	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.

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

Gaps in Controls / Assurance

1. Workforce not representative of the local community we serve
2. BME staff reporting lower levels of satisfaction in the staff survey

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	31/12/2020	WDES and WRERS action plans developed and published.
1. Work with Community Engagement expert to develop actions to work with local community	31/12/2020	collaboration still being pursued

Executive Leads Assessment

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.

September 2020 - Sharon Owen
EDI action plans as identified through the NHS people plan are being addressed with specific leads

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

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

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	30/11/2020	Discussions with LCC continue and most recently positive feedback on an agreement to lease additional car park space off site at Thomas lane sports field/car park. This is to be be agreed within the next month and lease put into place. A whole internal process on management of this is currently under discussion
Prepare Action Plan for NE plot development	30/11/2020	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust
Complete Eaton Rod Masterplan	31/01/2021	

Executive Leads Assessment

November 2020 - David Powell
Incorporation of Eaton Road Masterplan

Board Assurance Framework 2020-21

October 2020 - David Powell Review prior to October Trust Board
September 2020 - David Powell Prior to September Board
July 2020 - David Powell Prior to Campus Steering Group

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

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
2. Develop Sefton and Knowsley plans for C&YP - align with One Liverpool where possible/appropriate	30/10/2020	Sefton C&YP priorities agreed with C&YP leaders and reported into Sefton Provider Alliance 9th September. Inclusive of C&YP MDTs and Mental Health in schools - alignment with One Liverpool.
5.Develop Business Model to support centralisation agenda and Starting Well	30/10/2020	Programme resource identified through Liverpool Provider Alliance. One Liverpool C&YP priorities refreshed and complete (evidence attached to controls). Approved at Liverpool Provider Alliance 9th September 20 and reported through ICPG. Starting Well governance under agreement with LCC PH, LCC D. of Childrens and AH CEO. Inaugural board to be scheduled for Oct/Nov 20. Business Plans and developments to follow.
6.Develop Operational and Business Model to support	30/11/2020	Paused due to Covid. Consideration to take place following Phase

Board Assurance Framework 2020-21

International and Private Patients		3.
1. Strengthening the paediatric workforce	30/11/2020	Continuation of mutual aid planning and joint system working ongoing throughout 2nd wave of Covid - multiple services and partner organisations inc. S&O, StHk, RMCH etc.

Executive Leads Assessment
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

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
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.
3. Cost of Winter	30/11/2020	£1m winter funding has now been allocated to divisions from the central funding received. Monthly monitoring will take place through care delivery board and any risks areas will be highlighted.
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	30/11/2020	Alder Hey submitted phase 3 plan for M7-12 to NHSI, current gap against the breakeven target however the issues highlighted have been recognised. Awaiting confirmation on if any further improvement is required to meet target. Alder Hey have activated cost reduction programme in non clinical areas to support.

Executive Leads Assessment

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
June 2020 - John Grinnell Financial arrangements beyond M4 still remain unclear as national guidance awaited. Significant work underway with all divisions to create a new financial framework that will be fit for purpose in this new environment.

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

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 established.
Establish Innovation Board Committee	Committee oversight of Innovation strategy with NED expertise
Innovation team re-organised and funded to ensure adequate capability. Establish role of Managing Director of Research and Innovation to provide unified vision.	
Alder Hey Innovation LTD governance manual established	
Plans for joint research & innovation clinical leadership being explored	

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.

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 Covid restoration planning	31/03/2021	

Executive Leads Assessment
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.
September 2020 - Claire Liddy risk review - no change

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

Risk Description

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

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

Gaps in Controls / Assurance

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

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

August 2020 - Kate Warriner
BAF reviewed. Good progress against plans. Risk likely to reduce to target rating in next reporting period.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th November 2020

Paper Title:	**Audit and Risk Committee – Chair's Highlight Report**
Date of meeting:	19th November, 2020
Report of:	Kerry Byrne, Committee Chair
Paper Prepared by:	Kerry Byrne, Committee Chair

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 19th of November 2020, along with the approved minutes from the Audit Committee meeting that was held on the 17th September 2020.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

The Audit & Risk Committee (ARC) 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 shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Presentation from KPMG on the Brilliant Basics project
- Fraud risk matrix
- Analysis of the Trust Risk Register
- Key Issues Report from the Care Delivery Board (CDB)
- Minutes from the CDB of their meeting on 5th November which focused on risk
- Corporate Risk Register
- Board Assurance Framework
- Risk Management Strategy (to be reviewed in detail at January 2021 ARC meeting)
- Update on CQC Actions being overseen by ARC
- Progress report on the Internal Audit Programme
- Report on the implementation of agreed internal audit recommendations
- Presentation on the actions taken to implement the recommendations from the Consultant Job Planning internal audit report
- Progress update from external audit
- Treasury Management Policy (for approval)
- Progress against the actions from the self-assessment of ARC
- Update on the further development of the gifts and hospitality process
- Losses and special payments report
- Report of waivers of financial regulations

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

None

4. Positive highlights of note

The Committee recognised the significant risk discussions that had taken place at the CDB on 5th November which had drawn out risk themes, interdependencies between risks and links to the BAF. ARC recognised that the involvement of the Executives in this discussion had drawn out substantive action plans to reduce the high risks. The presentation of the (new) Key Issues Report was useful in directing ARC's focus on the key risk

areas. The Chair commented that the allocation of risk responsibilities between ARC and CDB was already paying dividends.

The Committee recognised again the significant progress in delivering the Internal Audit Plan, despite audits being de-prioritised in Q1 due to the Trust's Covid 19 response. The Committee asked for its thanks to be passed on to those staff involved in accommodating audits in this period.

Good outcomes from the Key Financial Controls audit – high assurance for Accounts Receivable, Treasury Management and Financial Reporting and substantial assurance for Accounts Payable, General Ledger and Budgetary Control. Substantial assurance was also provided for the audit of PFI Compliance.

Significant progress has been made in implementing previously agreed internal audit recommendations with only those relating to Consultant Job Planning being overdue for a considerable time period. Urmi Das presented to ARC on the work being undertaken in this area and a detailed update report will be provided to the January ARC meeting.

5. Issues for other committees

There are no items to be referred to other committees.

6. Recommendations

The Board is asked to note the Committee's regular report.

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 17th September 2020**
Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance:	Mr G Baines	Assistant Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms. U. Das	Director of Medicine	(UD)
	Ms. R. Greer	Assoc. COO	(RG)
	Mrs R Lea	Assoc. Director of Finance	(RL)
	Mr. K. Jones	Associate Finance Director – Financial Control and Assurance	(KJ)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
	Ms. C. Umbers	Assoc. Director of Nursing and Governance	(CU)
Apologies:	Mr. A. Bass	Director of Surgery	(ABAS)
	Ms. L. Cooper	Director of Community Services	(LC)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs. F. Marston	Non-Executive Director	(FM)
	Ms. J. Preece	Governance Manager	(JP)
	Mr R Tyler	E&Y Accounts Manager	(RT)

20/21/27 Welcome and Introductions

The Chair welcomed everyone to the meeting and noted the apologies that were received. A request was made for members of the Committee to send a representative in the event they are unable to attend a future meeting.

20/21/28 Chair's Introduction

The Chair welcomed members to the inaugural meeting of the Audit and Risk Committee. As part of the committee re-set exercise we have looked at how we oversee risk at both a non - executive and executive level. We have discontinued IGC and brought the non-executive element into this combined Audit & Risk Committee and the executive element is being dealt with by the Care Delivery Board. The risk element of the agenda will predominantly focus on the organisation's strategic risks, for example, the Board Assurance Framework (BAF), risk strategy, culture and policy. It was pointed out that the Committee will receive the Corporate Risk Register (CRR) for an interim period of time although the detailed oversight will be undertaken by the Care Delivery Board. The Chair informed the Committee that the covering reports for the CRR and Trust Risk Register are new documents which will evolve over time as risk becomes embedded into the Committee. The Chair requested feedback on the reports following the meeting.

Running alongside the Audit and Risk Committee and the Care Delivery Board work is taking place to embed risk management into the 'Operational Excellence' work that KPMG have been supporting the Trust with. As a result of this the Committee will receive updates on this throughout the year.

20/21/29 Presentation on the Risk Management Process

A presentation on the Risk Management process was shared with the Committee to provide an overview/update for new Committee members. Information on the following items was provided:

- Governance and Risk Management Framework.
- Risk Management Strategy.
- The common sources of information used to identify risks to populate risk registers.
- Members of the Governance and Quality Assurance Team.
- Available risk management support.
- Surgical Division Governance Structure.
- Medical Division Risk Management.
- Community and Mental Health Division Risk Management processes.

Anita Marsland felt that the presentation was really informative and asked as to whether it should be circulated to other Non-Executive Director (NED) colleagues. In response, the Chair suggested sharing the key Risk Management Strategy documents with Anita Marsland, Fiona Marston and other NEDs who will find this information beneficial.

20/21/29.1 Action: CU

Anita Marsland queried as to whether the Governance and Assurance Quality Team is appropriately resourced. The Chair pointed out that it is part of the Committee's remit to assess the effectiveness of Risk Management in order to offer assurance to the Board, one of the areas that would need to be considered is resources and whether they are sufficiently skilled. Attention was drawn to the 'Devolved Governance' model within the Trust that needs to be taken into consideration when discussing skilled resources. It was reported that the Trust has a number of Governance and Risk Leads with expertise. There have been some deficits which have recently been addressed to ensure the Divisions are in a better position to support governance and risk management going forward. The Chair advised that this would be a discussion for a later date.

The Chair raised a matter for future discussion once the risk appetite statement has been agreed by Board. The Chair highlighted the importance of understanding how tolerances are set in line with the risk appetite to ensure consistency across the organisation.

The Chair asked as to whether best practice is shared across the Divisions. It was confirmed that a lot of sharing takes place as a result of the Divisions reporting into the Clinical Quality Steering Group on risks, incidents, audits and all elements of the governance framework. Following discussion, it was agreed to invite the Divisions to provide further detail on the delivery of risk management within their respective Division to future meetings.

20/21/29.2 Action: CU

Resolved:
The Audit and Risk Committee received and noted the presentation on the Risk Management Process.

20/21/30 Board Assurance Framework Report

The Audit and Risk Committee received an overview of the Board Assurance Framework (BAF) as at the 9th of September 2020. The following points were highlighted:

- Attention was drawn to the importance of updating the BAF continuously to ensure that risks to the organisation are captured as the Trust enters the second wave of the pandemic. There are elements of risks that will start to gain pace as the current profile indicates; people related risks, quality, diversity and inclusion, the financial environment and operational issues linked to Brexit.
- It was reported that two of the three highest risks to the organisation have been re-appraised during the last two weeks and have been increased to likelihood of 5.

    - *Inability to deliver accessible services to patients, in line with national standards, due to rising demand* – The likelihood RAG rating for this risk has increased as the Trust is experiencing longer waiting times due to the pandemic. The update in the BAF highlights the hard work that is taking place by teams to restore services and the level of capacity restored as a percentage of pre Covid-19 capacity is between 80% and 90%. The reporting issues relating to patients waiting over 52 weeks has been addressed and a specific risk has been included on the risk register.
    - *Keeping children, young people, families and staff safe during Covid-19* – Personal risk assessments have been conducted for staff to ensure they are working in the right environment. The Trust has also been supporting staff to return to work following the changes to shielding guidelines which has helped towards restoring services. Environmental risk assessments have taken place to ensure the hospital is Covid-19 secure and PPE has played a big factor in keeping staff safe. It was reported that the Trust has adequate PPE for the next four weeks as a result of good procurement and innovation. It was reported that the disease burden in children remains low and there has been no hospital acquired cases in this reporting period.
    - *Financial Environment* – The Trust has received the guidance for the Financial Framework for October 2020 through to March 2021. The risk that has been highlighted is real in terms of the Trust working as part of the system. Cheshire and Merseyside have been allocated funding but it is not necessarily prescriptive in respect to the element of funding that the Trust will receive. It was confirmed that further clarity on this matter will be provided in due course.

The Chair felt that the BAF provides a consistent message and assurance on the areas of focus and acknowledged the on-going work that is taking place to address the likes of HR, staff and diversity that is yet to be updated in the paperwork. The Chair drew attention to the outstanding actions required to mitigate risk such as Estates and queried as to whether a deep dive should take place in order to understand the reason for the lack of updates from the risk owner since May 2020.

The Chair drew attention to the gaps between current risk scores and target scores and felt that the identified actions are not capable of bridging the gaps. At strategic level, risks tend to be allocated longer periods of time in which to be addressed, with some never reaching target. It was queried as to whether an alternative term should be used in the context of the BAF, for example, maximum level risk/aspirational level risk. It was felt that the need for clarity is also required in respect to the risk responsibility of each Assurance Committee in

order to avoid duplication. The Chair agreed to discuss this matter at a forthcoming meeting with the Chairs of the Assurance Committees.

20/21/30.1 Action: KB

Reference was made to the point that the Chair raised in relation to identified actions not being capable of bridging gaps. It was pointed out that the work of the Resources and Business Development Committee is framed around its' identified top five risks and has been for a number of years. Similarly, the quality risk has been articulated as a single risk but there will be a number of substantive items that will address gaps and form part of an action. The Committee was advised that the mitigation of risk is an ongoing process and it is important to draw in best practice which is done via MIAA, who provide the Trust with an annual report and recommendations. It was pointed out that there have been no deficits reported in the Trust's process over the last few years, and it was highlighted that Alder Hey is always willing to learn from best practice. In terms of the language in the BAF it was felt that this could be reviewed but would need to remain aligned with the strategy as it is linked to the risk appetite.

Resolved:
The Audit and Risk Committee received and noted the BAF update.

20/21/31 Corporate Risk Register

The Audit and Risk Committee was provided with the opportunity to scrutinise and discuss the current CRR. The report covers the reporting period from the 31st of July 2020 to the 31st of August 2020.

The Committee was provided with an overview of the new governing process for managing the risks on the CRR which will be via the Care Delivery Board and the Divisions. The Chair felt that the CRR is now reflective of the organisation's substantial risks whilst being a live and up to date document, and thanked the Executive Directors and Divisional Leads for the work that has taken place to progress this in such a short space of time.

The Chair recommended that information be included in future reports on the risks that are difficult to address and the risks that may need to be escalated to Board level. It was also felt that amber risks should be tracked via the Committee to ensure they don't turn red and to see if there were any missed opportunities that could have been recognised earlier.

20/21/31.1 Action: CU/AB

Attention was drawn to the risks that have interim mitigations that tend to be manual to be introduced whilst a longer-term "proper" fix is introduced. When the interim mitigations are introduced this can reduce the risk level to below 15 (and the risk therefore removed from the CRR) when the longer term fix is outstanding and attention is still needed to ensure its' delivery. The Committee was advised of the importance of developing a mechanism for keeping these risks on the radar to enable risks to be fully mitigated.

20/21/31.2 Action: CU

Resolved:
The Audit and Risk Committee received and noted the contents of the CRR for the period from the 31.7.20 to the 31.8.20.

20/21/32 Trust Risk Register

The Audit and Risk Committee was provided with the opportunity to scrutinise and discuss the Trust Risk Register. The report covers the reporting period from the 31st of July 2020 to

the 31st of August 2020. The following points were raised:

- Attention was drawn to the importance of focussing on the "high moderate" risks that have been on the register for a long period of time to ensure that they don't turn red.
- The Committee discussed the risk position of Divisions and Corporate Functions. It was pointed out that 23% of risks are overdue. As there are 245 risks ranked as "moderate amber" a number of these risks can be assumed to be overdue. It was felt that further thought needs to be given to this matter to look at how it can be addressed within the Divisions and services.
- It was pointed out that the Committee's main focus going forward will be on strategic risks. The Committee is also responsible for providing an opinion on the effectiveness of risk management across the Trust and at the present time it was felt that it would be difficult to offer an opinion given the volume of overdue risks. The Chair highlighted the importance of ensuring that the Divisions are aware that analysis and discussions are taking place at Committee level.
- Anita Marsland felt that the Committee's best contribution is when discussion is kept at a high level rather straying into an operational discussion, and pointed out that this will evolve during future meetings.
- The Chair was of the opinion that the risk management process has progressed and will continue to do so under the management of the Care Delivery Board. The Chair thanked all those involved for their hard work in mitigating the organisation's risks.

Resolved:
The Audit and Risk Committee received and noted the contents of the Trust Risk Register for the period from the 31.7.20 to the 31.8.20.

20/21/33 Follow-Up Audit Report

(The recommendations from the Divisional Governance Audit Report were discussed at this point in the meeting with the remainder of the recommendations discussed later in the meeting).

The Committee was advised of the outstanding actions from the Divisional Governance Audit Follow-up which was conducted by MIAA in 2018. The Chair asked for a report to be compiled by the Divisional Leads in order to provide an update on the outstanding actions during November's meeting.

20/21/33.1 Action: CU

Resolved:
The Audit and Risk Committee received and noted the outstanding actions from the Division Governance Audit Report.

20/21/33 Self-Assessment of the Integrated Governance Committee

The Committee was provided with an overview of the Integrated Governance Committee's (IGC) self-assessment evaluation into the year-end committee review process for 2019/20. Following discontinuation of the IGC and allocation of its' responsibilities between the Audit & Risk Committee and Care Delivery Board, the actions arising from this self-assessment will be added to those previously identified from the Audit Committee's self-assessment to produce a combined action plan for the Audit & Risk Committee. This will be added to the committee's Work Plan.

The Chair advised that six responses were received out of a total of eight and pointed out that any comments fed back from Committee members/Divisions following circulation of the report will be included in the action plan.

Resolved:
The Audit and Risk Committee received and noted the contents of the IGC self-assessment evaluation report for 2019/20.

The Chair made reference to two actions that were on the IGC action log from its last meeting and requested that they both be followed up by the Care Delivery Board; action 19/20/83 and summary report that covered Corporate Services.

20/21/33.2 Action: AB

Following the close of the risk element of the agenda, a discussion took place on the outcome of this part of the meeting. Committee members felt that further work is required in respect to the delivery of key issues at the meeting, and that it is necessary to be systematic to enable risk owners to report to the Committee which will provide an opportunity to provide feedback around key concerns/issue so that they can be rigorously discussed.

The Committee was of the consensus that it is important to remain strategically focussed on risk. It was also felt that the reports were informative and helpful as a result of including trends and analysis.

The Chair thanked the Divisions for their attendance at the meeting.

20/21/34 Minutes of the Audit Committee meeting held on 16th June 2020

Resolved:
The minutes from the meeting that took place on the 16.6.20 were agreed as an accurate record of the meeting.

20/21/35 Matters Arising and Action Log

(Where appropriate actions outstanding from the final IGC meeting were incorporated into the Action Log for this meeting)

Action 19/20/51: *Follow-up Audits (To include a summary table showing the percentage of recommendations implemented, partly implemented or not implemented and also for the individual recommendations followed up, details of who they had spoken to for the follow up process, a summary of information received and a clear description of the information outstanding)* – This action has been implemented. **ACTION CLOSED**

Action 19/20/83: *Risk Management Reports (Update the Risk Management Report template to include in the "Risks Escalated to the Corporate Risk Register" table when each risk is expected to reduce to target)* - This action has been allocated to the Care Delivery Board. **ACTION CLOSED**

Action 19/20/07: *Draft Counter Fraud Annual Report 2019/20 (to provide an update on the identification of fraud risks within Ulysses to enable compliance with the annual self-assessment)* – It was reported that work has been taking place to progress the Fraud Risk Matrix but it was proposed to submit the matrix to the Committee in November upon completion, and provide a more thorough update. **ACTION TO REMAIN OPEN**

Action 20/21/03.1: *Non-Clinical Claims Review – (liaise with the Director of HR to agree a reasonable timeframe in which to conduct a review of non-clinical claims)* – The non-clinical claims audit is in the final stages of completion. **ACTION CLOSED**

Action 20/21/03: *Corporate Risk Register/Appendix A* (*allocate a different colour per Division so that there is a clear difference between them. Group the risks by Divisions*) - Appendix 1 of the Corporate Risk Register has been updated accordingly. **ACTION CLOSED**

Action: *Meeting Effectiveness Review (Corporate Services Overview – Chair and Cathy Umbers to discuss the format and content of this new report outside of the meeting)* – This action has been allocated to the Care Delivery Board. **ACTION CLOSED**

Action 19/20/50.6: *Progress Report MIAA – (To suggest a mechanism to review the effectiveness of External Audit for 2019/20 accounts)* – The appointment of External Auditors is carried out by the Trust's Governors. In respect of the evaluation and retendering of the contract, evidence will be required of the position that the management team and Audit and Risk Committee have taken in order to assist Governors to make a decision. It was agreed that a meeting will take place between Erica Saunders, Rachel Lea and Simon Hooker and an update on this action will be provided on the 19.11.20. Hassan Rohimun agreed to share assessments to identify the processes that other organisations have used to undertake this. **ACTION TO REMAIN OPEN**

Action 19/20/69.2: *Audit Committee Self-Assessment (Audit Committee Chair to ensure co-ordination between IGC and Audit Committee during the ongoing review of risk management within the Trust)* – This action is no longer relevant following the ceasing of IGC. **ACTION CLOSED**

Action 20/21/03.3: Internal Audit Progress Report *(additional column to be included in the Annual Plan and Progress Report to highlight the process that has been used to carry out individual audits and the agreed dates of fieldwork)* – An additional column has been included in the Annual Plan and Progress Report. **ACTION CLOSED**

Action 20/21/05.4: Final Internal Audit Plan *(Audit Committee to be involved in the scoping discussions for the Risk Management Audit, DMO Audit and the Clinical Audit Review)* – Discussions have commenced in respect to the Clinical Audit Review. The Trust may have to defer the Risk Management Audit until the end of the financial year due to the amount of work that is taking place as a result of the second wave of Covid-19, or ask MIAA to review the work of the Audit and Risk Committee/Care Delivery Board to ensure that all respective workstreams are being addressed and that there is no duplication of work. **ACTION TO REMAIN OPEN**

Action 20/21/09.2: *E&Y Technical Update - As per page 4 of the NHS Health Audit Committee Briefing, incorporate the good practice recommendation statements/disclosures in the Quality Account for 2019/20, if possible, and future reports* – It was confirmed that the good practice recommendation statements/disclosures will be used appropriately in the Quality Account for 2019/20. **ACTION CLOSED**

Action 20/21/12.1: ***Gifts and Hospitality*** *Liaise with Claire Liddy to discuss the development of a process for gifts and hospitality that will ensure checks are robust without restricting colleagues. Submit a report to the Audit Committee in September* – Whilst an update on this item has been included on the agenda a more detailed report will be provided to the November meeting **ACTION TO REMAIN OPEN**

Action 20/21/21.1: *Amendments to Internal Audit Plan (Mandatory Training - Exec Team to discuss a plan for managing Mandatory Training in order to appropriately progress this area of work across the Trust during the pandemic)* – Mandatory training has been re-instated by the Trust. The Workforce and Organisational Development Committee are going to drill down into the analysis to identify any hotspot areas, and the Board is receiving high level reports on this area of work on a monthly basis. **ACTION CLOSED**

Action 20/21/22.3: *E&Y External Audit Year End Report on the Trust's Accounts for 2019/20 (Data Analytic Work - Ernst and Young to provide a detailed report of the data analytic work that has taken place)* – This has been included on the agenda. **ACTION CLOSED**

Action 20/21/22.4: *E&Y External Audit Year End Report on the Trust's Accounts for 2019/20 (Planned External Audit Fee* - Discuss the overall fee for the 2019/20 statutory audit work that was conducted by Ernst and Young) – Rachel Lea agreed to circulate the relevant information relating to the planned external audit fee to Kerry Byrne and Anita Marsland for discussion outside of the meeting. **ACTION TO REMAIN OPEN**

Action 20/21/23.2: *Committee Annual Reports for 2019/20 (Update the Workforce Organisational and Development Committee Annual Report with membership and quoracy)* – The Workforce and Organisational Development Committee Annual Report has been updated accordingly. **ACTION CLOSED**

Action 20/21/24.1: Update on the Recommendations within the Acorn Report *(update to be provided in September to advise on the outcome of each of the recommendations in the Acorn Report* – This item has been included on the agenda. **ACTION CLOSED**

20/21/36 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on assurances, key issues and progress against the Internal Audit Plan for 2020/21.

It was reported that work has commenced on the delivery of the 2020/21 Plan with work progressing in respect of:

- Board Assurance Framework (Stage 1) – Report was issued on the 17.9.20.
- Key financial controls.
- Data Quality – Processes and A&E targets.
- Clinical Audit process.

Final reports have been issued for the Covid-19 Expenditure Review and the Project Management Review. Both reviews resulted in a substantial opinion.

MIAA has undertaken fieldwork for the 2019/20 review of Non-Clinical Claims which was delayed from last year. A draft report has been issued to the Trust and the results will be shared with the Committee on the 19.11.20.

The Committee was advised that during the first quarter of 2020/21 MIAA supported the wider NHS system via the deployment of its staff members to maintain the effective delivery of services. MIAA provided support to Alder Hey predominantly within the IT and HR departments and received good feedback from the Trust. MIAA also continued to keep the Trust updated on the latest key guidance and Covid-19 fraud threats, which was well received by the organisation.

MIAA are starting to plan for quarter three reviews. It was confirmed that information will be provided in the report to identify the dates of forthcoming reviews.

Gary Baines referred to the general performance indicators in the report and pointed out that timeliness had been RAG rated as amber due to the planned start of the Internal Audit Plan being at quarter two as a result of the pandemic. Both Gary Baines and the Chair advised how pleased they were with the progress that has been made in unprecedented times. The Chair thanked MIAA and management for being accommodating and flexible which enabled reviews to take place.

The Chair queried as to how aggressive, or otherwise, the Trust was in relation to claiming Covid-19 expenditure. It was reported that there was a sentence in the report that hadn't been extracted into the Progress Report that states the Trust had been appropriate in claiming everything that it could.

The Chair drew attention to the five sample projects referred to in the Project Management Assurance Report and highlighted that they were all construction projects. It was felt that construction projects tend to follow a structured process therefore a request was made by the Chair for the audit to be repeated during 2021/22 with a focus on non-construction projects, in order to gain an alternative view from an assurance perspective.

20/21/36.1 Action: KS

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

20/21/37 Follow-Up Audit Report

The Committee received an update on the status of implementation of recommendations and action plans for recommendations outstanding. The following issues were raised:

- *Consultant Job Planning*

  It was pointed out that recommendations made by MIAA in respect to consultant job planning are very overdue and it was felt that a report should be submitted by the Action Owner to the Committee in November to provide an update on progress. The Committee was advised of the work that is taking place around the implementation of a job portal to introduce a full electronic system across the Divisions. The feedback on this area of work will incorporate an update on the outstanding recommendations as part of the new plan going forward.

  Anita Marsland asked as to whether this type of issue occurs in other organisations. It was reported that this is a regular problem for lots of Trusts due to the lack of a clear electronic system, but it was confirmed that this area of work is starting to progress across Trusts.

  Following discussion, it was agreed that the Committee will receive an update on the recommendations for consultant job planning to its' November meeting.

20/21/37.1 Action: NM

- The Chair drew attention to the recommendations in the report where the Action Owners did not respond to MIAA's request for information and therefore MIAA are unable to confirm the status of the recommendations; CIP/QIA and Sickness and Absence. It was agreed that contact will be made with the respective owners to request an update.

20/21/37.2 KS/RL/KJ

- The Chair referred to the Inventory Management Audit and queried the progress with the automated inventory management system that was agreed would address the overall recommendations made by MIAA. It was reported that as a result of the pandemic the Trust developed a predictor tool to manage stocks of PPE. Procurement has agreed to look towards expanding this solution for all stocks rather than purchasing an off the shelf inventory management system. The Committee was advised that the Procurement Department are working with the Innovation Team to look at an application to support the predictor tool. Following discussion, the Chair felt that the trajectory in the report was appropriate taking into account the update and that there weren't any high risk recommendations made as a result of the audit review.

- The Chair highlighted the areas of positive progress as a result of recommendations being fully implemented; Fit and Proper Persons and Financial Systems Key Controls.

Resolved:
The Audit Committee received and noted the contents of the Internal Audit Follow-up Report.

20/21/38 Anti-Fraud Progress Report, Q2

The Committee received an update on the progress of the anti-fraud work undertaken during the period from the 1.4.20 to the 9.9.20. The following points were highlighted

- *Government Functional Standard: Counter Fraud (Functional Standard)* - In April 2021, all NHS organisations will be required to provide a return against the new Counter Fraud Functional Standard which will formally replace the existing NHS standards for SRT submissions. There is a risk that by the Cabinet Office and the NHS Counter Fraud Authority (NHSCFA) implementing these new standards in 2021, it will not allow NHS Trusts the necessary time needed to be able to comply with all the new Functional Standards by 2021, when an assessment return has to be completed.

  It was reported that the NHSCFA is working with stakeholders, including MIAA who are part of a group that is looking at how this new standard is going to be implemented across the NHS. The NHSCFA is also planning to submit a proposal to the Cabinet Office in October 2020 to request that the new standard be implemented via a similar process that is being used presently by NHSCFA standards so that good practice can continue to be built upon. The Chair felt that the change to this standard creates a big step up in expectations. It was pointed out that further clarity should be received by November 2020 which will provide time in which to compile an action plan and submit the return in April 2021. The Committee was advised that a further update regarding this matter will be provided on the 19.11.20.

20/21/38.1 Action: VM

- *Fraud Champion for Alder Hey NHS Foundation Trust* - The NHSCFA has launched a network of Fraud Champions across NHS organisations. The Anti-Fraud Service (AFS) has requested that the Trust consider the nomination of a Fraud Champion at Alder Hey to help raise awareness of this area of work. It was reported that nominations can still be submitted.

20/21/38.2 **Action: JG**

- *Prevent and Deter* - It was reported that fifteen local fraud alerts have been circulated within the reporting period. The majority of the alerts were Covid-19 related and bank mandate alerts.
- *Corrective Actions Required* - There are two standards that have been assessed as having an amber level of compliance with standards in the Self Review Tool (SRT) submission on the 1.6.20; 1.4 and 2.4

  - 1.4 relates to the Risk Fraud Matrix, of which, the Committee will receive an update on the 19.11.20.
  - 2.4 relates to Conflicts of Interest 'code of conduct for the declarations process'. It was reported that progress has been made since the last reporting period in April 2020 with a 17% increase in compliance. Attention was drawn to the 195 members of staff who are yet to submit a declaration. The Committee was advised of the sessions that Virginia Martin has undertaken with doctors, consultants, therapists, etc. in order to raise awareness.

  It was reported that a review of standard 2.1 and 2.4 will take place with the view to turning the standards green before the end of 2020.

- *Summary of Investigations* - The Committee was provided with a summary of the active investigations recorded on FIRST, as well as the Information Reports (IRs)/Information Management Officers (IMOs) that have been closed in the current year. It was reported that there is one case open on FIRST and one IMO open on FIRST.

The Chair raised a query with management as to whether there is a plan in place to address the 195 members of staff who are non-compliant with the declaration process. It was reported that work is taking place via the Divisions to improve the position and it was highlighted that the issue seems to relate to the nil declaration on the new electronic system. The Chair suggested addressing this matter as part of the Divisional Governance Review.

Resolved:
The Audit and Risk Committee received and noted the contents of the Anti-Fraud Progress Report for Q2.

20/21/39 Data Analytic Report

The Committee received the Data Analytic Report submitted by Ernst and Young, which provided information/data on journal entry testing and payroll. It was reported that the quarterly Technical Update will be submitted during November's Audit and Risk Committee meeting.

The Chair highlighted the benefits of using data analytics, and felt that analysis identifies exceptions that require further perusal, for example, 'manual journals posted at the weekend' as this has increased three fold this year in comparison to 2019/20.

It was reported that Ernst and Young use data analytics to assess risks, complete audit work, target sample selection and look at trends and transactions that are outside the normal course of expectations. Attention was drawn to the sample testing of leavers that took place to see if they were in line with expectations/payments in accordance with relevant criteria to ensure ex-employees aren't being paid. It was confirmed that there were no additional points as a result of this testing.

The Chair asked as to whether Ernst and Young provide the details of exceptions to the the Trust's Finance Team for information purposes. It was confirmed that this hasn't taken place in the past but can be shared going forward. It was agreed that a discussion should take place outside of the meeting regarding this matter.

20/21/39.1 Action: HR/RL

Resolved:
The Audit and Risk Committee received and noted the contents of the Data Analytic Report.

20/21/40 Audit and Risk Committee Terms of Reference and Work Plan

The Chair presented the Audit and Risk Committee Terms of Reference and Work Plan for approval purposes. It was reported that the information incorporated in both documents remains largely unchanged with the main changes relating to addition of the risk items. The following points were highlighted:

- A review of the combined Work Plan will take place at the end of the financial year.
- An additional meeting will take place each July to solely discuss risk. This will ensure the Committee is sighted on risk in between the April and September meeting cycle.

20/21/40.1 Action: KMC

- A report on 'Going Concern' is to be submitted to the Committee in April, on an annual basis. The report will lay out the key facts and judgements as to why the going concern basis is appropriate. It was agreed to include this item in the Work Plan.

20/21/40.2 Action: KMC

Resolved:
The Committee approved the Audit and Risk Committee Terms of Reference and Work Plan.

20/21/41 CQC Action Plan 2020

The Committee received the actions from the CQC Action Plan for 2020 that fall within the remit of the Committee. It was agreed to incorporate this item under the risk element of the agenda going forward.

20/21/41.1 Action: KMC

Following discussion, it was felt that it would be beneficial for the Divisional Team to provide an update on the actions in the plan that are due for completion in October/early November. This can be included as part of the presentation on governance/risk management by the Divisions. The Chair agreed to liaise with Cathy Umbers regarding this matter.

20/21/41.2 Action: KB

20/21/42 Policy "Engagement of External Auditors in Non-Audit Work":
The Committee approved the policy for the Engagement of External Auditors in Non-Audit Work and the Equality Analysis.

20/21/43 Development of a Robust Process for Gifts and Hospitality

The Committee was advised of the significant increase in compliance as a result of colleagues making declarations via the relatively new electronic system. It was reported that the majority of activity relates to conferences and professional activity. It was pointed out that the initial action related to innovation and it was felt that a further discussion is required with

Claire Liddy to ensure that all innovation focussed activity is being declared by members of the team.

There has been an increase in small gifts as a result of the pandemic and a decrease in attendance at conferences, etc. in comparison to 2019/20.

The Chair pointed out that whilst you are able to see a number of lines on the system for one person, individually it looks fine but once the data is compiled as a whole it presents a different view. The Committee was advised that there has been a lot less activity this year and the only provider that stands out at the present time is a company called Kiokirin who are offering places at a one off conference on child bone health and guidance around a new drug therapy. Other than that, declarations are clinically/innovation focussed.

20/21/44 Losses and Special Payments Report

The Committee was provided with an overview of the Losses and Special Payments made in the period April 2020 to August 2020.

It was reported that the Trust has incurred four cases of losses and special payments with associated costs of £8,451 relating to the period April 2020 to August 2020. The Committee was asked to note that the personal injury claims information relates to Q1, as the NHSLA update on a quarterly basis. It was pointed out that the Authority hasn't asked the Trust to reduce its provision that is in place for the end of the year. Erica Saunders advised of the delay in terms of the length of time that it is taking to settle the more complex negligence cases, plus the Trust is not yet seeing the outcome of the delayed treatment to patients that may have resulted in harm, due to the pandemic.

Resolved:
The Audit and Risk Committee reviewed and noted the contents of the Losses and Special Payments Report.

20/21/45 Update on the Recommendations within the Acorn Report.

The Committee was provided with an update on the ACORN action plan that was developed following a review undertaken by KPMG. A total of 20 recommendations were made, categorised as high, medium and low and work has been underway to put in place the necessary actions and processes to meet the recommendations. The Trust has closed the pipeline to the ACORN partnership; therefore no further companies or ideas will be passed to the software developer.

The three live companies that the Trust has an equity interest in are active and regular progress updates are provided to the Innovation Committee. The live companies are as follows:

1. Hand Hygiene Solutions Ltd
2. Audiology Metrics Ltd
3. Optimising Care Ltd

It was reported that 16 of the initial 20 recommendations are classed as complete, and 4 have had action taken but are ongoing with further work required.

The Chair noted the updates that were provided to the Committee in respect of the recommendations and the three existing companies, but requested assurance that any new arrangements will be fully cognisant of the issues that were raised as a

result of the review. The Chair drew attention to the importance of revisiting this area of work from an audit perspective and queried a date in which to do this. Rachel Lea agreed to discuss this matter with the Innovation Committee in order to agree a date.

20/21/45.1 Action: RL

The Committee was advised of the additional oversight this area of work is receiving as a result of the governance element that is being implemented along with the processes around subsidiary companies. It was pointed out that Ken Jones and his team in the Finance Department are overseeing the set-up of companies, which includes acquiring appropriate advice. In addition to this, assurance is also provided to the Innovation Committee which is monitoring commercial innovation.

Resolved:
The Audit and Risk Committee received the Acorn Action Plan and noted the update.

20/21/46 Any Other Business

The Chair informed the Committee of her poor experience with ELFS in respect of non-payment of expenses for an extended period of time and their response when the matter was reported. It was agreed that the Director of HR will be asked to progress to a satisfactory solution through contract meetings with ELFS in order to gain assurance that other members of staff won't experience the same problem.

20/21/46.1 Action: KB

20/21/47 Review of the Meeting

Members of the Committee felt that the inaugural meeting went really well, but attention was drawn to the importance of ensuring discussions remain strategically focussed.

Date and Time of the Next Meeting: Thursday 19th of November, 2:00pm-4:00pm, via Teams

NHS
Alder Hey Children's
NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the last meeting held on Wednesday 21st October 2020
Via Microsoft Teams

Present:	Anita Marsland	(Chair) Non-Executive Director
	Fiona Beveridge	Non Executive Director
	Lisa Cooper	Director - Community & Mental Health Division
	Urmi Das	Interim Divisional Director for Medicine
	Jacqui Pointon	Associate Chief Nurse/Safety Lead for Community Division
	Nicki Murdock	Medical Director
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR & OD
	Abby Peters (on behalf of DJ)	Associate Director Strategy & Partnerships
	Robin Clout (on behalf of KW)	Interim Deputy CIO
	Phil O'Connor	Acting Director of Nursing
	Tina Bogle (on behalf of AB/CT)	Interim Governance Lead, Division of Surgery

In attendance:

	Adrian Hughes	Deputy Medical Director
	Beatrice Larru	Consultant, Infectious Diseases
	Jill Preece	Governance Manager
	Cathy Umbers	Associate Director of Nursing & Governance
	Julie Creevy	Executive Assistant (Minutes)

Agenda item:

20/21/38	Tony Rigby	Deputy Director of Risk & Governance
20/21/43	Michelle Perrigo	Clinical Legal Services Manager

Observing:	Dr. Nikki Thorbinson	Parent & Carer Governor

20/21/33 Apologies:

Alfie Bass	Divisional Director, Division of Surgery
Adam Bateman	Chief Operating Officer
Pauline Brown	Acting Chief Nurse
Kerry Byrne	Non Executive Director
John Grinnell	Director of Finance/Deputy Chief Executive
Dani Jones	Director of Strategy
Christopher Talbot	Safety Lead, Surgery Division

AM welcomed all to the Safety & Quality Assurance Committee (SQAC), AM extended special welcome to Fiona Beveridge, Non Executive Director who had joined SQAC. Fiona welcome Nikki Thorbinson, GP who was observing SQAC, in her role of Governor at Alder Hey

20/21/34 Declarations of Interest

CQAC noted that there were no items to declare.

20/21/35 Minutes of the previous meeting held on 23rd September 2020

Resolved: The minutes of the previous Safety & Quality Assurance Committee meeting held on 23rd September 2020 were agreed as a correct record.

20/21/36 Matters Arising and Action Log

Action Log

19.20.74 - 'Quarter 1 DIPC report' –this item is on the agenda, action to be closed and removed from the action log.

19.20.161 –'CQSG Key issues report' – meeting to discuss agreed process regarding performance indicators. POC reported that PB has confirmed that she has a plan regarding deep dives going forward, however this would not be included in the CQSG report for today's meeting and would be included in November CQSG key issues update. AM stated that there is a plan for the future for AM, PB and NM to discuss this issue and that it is important that SQAC remains at high strategic level, and does not replicate what has been discussed at CQSG.

19.20.165 – 'Chaperone Policy', POC advised that this had been discussed at CQSG and that this item could be closed and removed from SQAC action log.

20.21.09 –'BAF Offline discussion regarding 'Deep Dives', ES confirmed that this had now moved through to ARC and could be closed and removed from the action log.

29.9.20 – 'SEPSIS update to be provided to the Board', this action was now complete and could be removed from the action log.

20.21.21 - POC stated that the three actions associated with Clinical Audit had been completed and could be removed from the action log.

20.21.22 – 'SQAC workplan to be amended to include 6 monthly review regarding Alder Hey Young Violence Programme to SQAC' – this item has been included on the workplan and could be closed and removed from the action log.

20.21.23 SQAC noted CQC Action log is on the agenda, SQAC noted that offline discussions with regards to audit process and consent audit had taken place and that the two actions had been completed and could be removed from the action log.

20.21.24 & 20.21.25 'Never Events Action Plan and NATSIP Action Plan' - plan – NM advised that the first pilot is due to commence in November 2020, team are looking to finish first pilot in Juanuary 2021, NM confirmed that funding had been secured. NM confirmed that this item should be closed and removed from the action log.

20.21.27 – BAF –'Offline discussions to take place at Executive Team regarding interfaces between committees in terms of clinical risk Offline discussion with Execs regarding data reporting – support required from BI team'– SQAC noted that discussion had taken place as appropriate, as well as discussion within the new Care Delivery Board that included Divisions. AP advised that NM, CL & DJ had agreed a new process for the safety dashboards, and that the BI team would scope out requirements, this would be a 3 month project which is due to commence in January 2021, SQAC noted that this item could be closed and removed from the action log.

20.21.28 – 'Corporate Report Quality Metrics – Benchmarking data' – UD confirmed that she had received two responses from those Trusts approached, however colleagues from other trusts were reluctant to share the 'Was Not Brought rate data'.

20.21.30 – 'Amended SQAC workplan' – SQAC noted that this was on the agenda and could be removed from the action log.

20/21/37 **To agree top 5 risks**

AM confirmed that due to the number of apologies received that this item would be deferred until November SQAC meeting.

Quality Improvement Progress Report

20/21/38 **Quality Account for 2019/20**

T Rigby presented the Quality Account for 2019/20 and requested formal approval of the Quality Account. TR requested acceptance of the '5 breakthrough objectives.

TR advised that the Medical Director & Interim Chief Nurse had presented the Quality Account to CCG colleagues on 9th October 2020. SQAC noted that the Quality Account had also been circulated to external stakeholders for comments, and comments were currently awaited, and would be included upon receipt.
The Quality Account featured key highlights for 2019/20 as follows:-

- Maintaining high reporting levels for Medication Safety
- Innovation and digital solutions created to date which included Lifesaving use of 3D printed model of a tumour, virtual reality for play & distraction, Inaugural Festival of Innovation with over 400 staff, achievement/contributions from Children and Young people and partners.
- Award winning Asthma mapping project
- COVID 19 response – Rapid prototyping alternative PPE. Creating Distancer, establishment of virtual visiting and virtual ward rounds.
- Highlights regarding patient experience, arts, performance & play,
- Achievements from the Forum at Alder Hey – Digital futures, Alder Play/Virtual reality/video production/AGM rap, xmas lights/pathway redesign/supporting recruitment and regional and national improvement work
- Place Report
- Leadership Development – Strong Foundation programme, which 30 staff had completed the programme, with a further 52 staff who commenced the programme pre COVID. Mary Seacole Leadership Programme which is a 6 month in house course for new leaders and managers. Creation of Leadership hub which is an online and interactive hub, which also provides advice and guidance on managing self and others.
- Equality & Diversity achievements

Quality Priorities for 2020/21 included Safe Care, Access to Care, Great Place to Work, Advocate for Children & Young People, and 'The Safest Place'.

FB stated that the Quality Account is extremely clear, FB referenced the cleanliness within the Trust and queried how the Trust strived to maintain a high standard of cleanliness in the future. SQAC agreed that high standards of cleanliness should be maintained.

TR stated that he would be happy to present the Quality Account to Governors if this would be helpful, ES advised that there is a mtg in December and TR could provide an update at the December meeting.

SQAC recognised the significant achievements that had taken place to date throughout the Trust.

SQAC received, noted and accepted the Quality Account report and approved the Quality Account for 2019/20.

SQAC accepted the '5 breakthrough objectives' as the key quality priorities for 2020/21.

AM thanked TR for collating and drafting the Quality Account and extended SQAC's thanks to those colleagues involved in creating the draft.

20/21/39 ICON Programme Update

LC presented the ICON Programme Proposal report regarding the implementation of the ICON programme across the Trust key issues as follows: -

- LC provided an overview of Nationally, abusive head trauma (AHT) which affects 24: 100,000 babies aged less than 1 year and is a form of child abuse, which is 100% preventable, with research showing that around 70% of babies who are shaken are shaken by men. During 2019, 11 infants were admitted to Alder Hey with abusive head trauma. This figure had increased during 2020 with 20 infants (January – September) being admitted to Alder Hey with this injury. ICON Programme is a national programme of work, that Safeguarding Boards have adopted, the ICON proposal presented that as well as Alder Hey being involved in the wider ICON programme, that a specific programme just for Alder Hey with the National team.

  The ICON Programme Proposal included detail regarding the background, proposed implementation arrangements of ICON across the Trust, and what monitoring arrangements would be in place to support this programme.
- SQAC noted that the ICON programme would be implemented across the Trust in conjunction with the promotion of 'Safe Sleep' which supports the prevention of unnecessary harm and death in infants, there would be a bespoke programme of work that would be implemented across the Trust. SQAC noted that there is no resource required, the ED team are keen to implement, along with neonatal community nursing services. SQAC noted that the ICON programme would be implemented across the Trust in an opportunity to create an integrated research partnership with the national ICON lead and Primary Care Services.

  NM queried whether the Trust had any future to publicise this initiative e.g. through a shaking baby advert on tv/nationally – LC advised that there is a meeting planned with the implementation lead on 23rd October 2020 and that this could potentially be explored further, in order to address any future opportunities in order to raise awareness.

SQAC received, noted the contents of the ICON Programme.
SQAC approved the implementation of the ICON brief intervention framework across the Trust.

SQAC agreed that they would receive a 6-monthly update in order to review progress, and that this would be included on the SQAC workplan

AM thanked LC for update.

20/21/40 Positive Behavioural Support Update

LC presented the Positive Behavioural Support – Reducing Physical Intervention Update, which proposed a model for Alder Hey Children's NHS Foundation Trust

regarding physical intervention/clinical holding that supports children, young people, families and staff. The paper considered the needs of all children and young people who access services from Alder Hey.

Key issues as follows: -

- LC reported that there had been a rise in the number of reported 'physical intervention 'related incidents across the Trust. LC advised that Incidents could be reported under numerous cause groups which make it difficult to evidence recorded incidents for physical intervention. An initial review of the proposed pilot areas reported approx.149 incidents as 'patients being held / injuries to staff' during 2019/20. It should be noted that often incidents are not reported as "clinical holding", but under other categories e.g. violence, harassment, abuse. Further work is needed to accurately record these incidents. SQAC noted that there had also been a rise in the number of admissions of 'complex' children and young people to the trust, often related to risk and a 'place of safety'. For some of these children and young people their 'safe' care has necessitated the use of security and/or agency staff. Additional 'support' staff had also been required to support Alder Hey clinical staff to deliver effective care due to the presentation of behaviours that 'challenge' staff and the physical environment.
- SQAC noted the proposed model to deliver a holistically evidence-based approach to the 'physical' support of children and young people across the Trust. The model would initially be piloted within Tier 4 unit, Outpatients, ED and Ward 4C and would require the identification of a lead clinician within the Trust to support the training for staff and teams. Consent would need to be considered.
- The resources required for the pilot equated to £12,800 for the Pilot phase – 'Train the Trainer' model to train 8 staff (2 per area). The hope is to tender this. On evaluation of the pilot proposal in terms of long term trust financial investment would be required, with regards to a potential trainer who could review on a regular basis and who could continue to update on a regular basis regarding positive behavioural support. and there would need to be a Business case for long term investment to be made. The proposal detailed the risks and benefits which SQAC noted. LC confirmed that the Trust is part of two research pilots nationally.

LC stated that it isn't around children and young people with complex mental health issues, could apply to all patients who attend Alder Hey either in the hospital or in the community. TB stated that this is an excellent proposal.
FB stated that this is a great initiative, and queried re a parent present, and wondered if there was any prospect to roll training out to parents of frequent attenders. LC stated that as part of the training is to ensure staff feel confident in holding the child, and part of this training could include shared learning to include dialogue with parents with complex needs and challenging behaviour. AM queried what measures would be in place to ensure that the Trust knows that the proposal is working satisfactory. LC stated that in signalling that this issue required addressing is a first step in improving, and that improvements are required in terms of the under reporting on Ulysses, and that once this is addressed, and that once training for staff has taken place, this will help when piloting to support staff and patients. LC stated that in the future that this training should be mandatory for all clinical staff within the Trust, as a wide number of staff would benefit from this training.

Action: ES agreed to follow up offline with LC with regards to the most appropriate route to discuss the resources required.

ES stated that it is important to protect staff, during stressful admissions and that there is a need for a longer-term plan. FM stated that this is a very modest investment to enable significant improvement for patients and staff.

SQAC received and approved the proposed model and noted that ES & LC would undertake offline discussion to agree the most appropriate forum to seek funding for resources.

20/21/41 **Delivery of Outstanding Care**

Safe

CQC Action Plan

ES presented the CQC Action plan and commended the Divisions for continued progress.

ES confirmed that the Consent Policy had been reviewed and that this previous action had been completed. ES stated that she was assured that there is a robust policy, which is fit for purpose in terms of Mental health capacity. ES advised that she had discussed the audit programme for Surgery with the Divisional Director for Surgery, there is work already taking place within the Division, and both agreed that there is a need for assurance to assure that there is a system to ensure that systems and processes are in place. ES stated that work is continuing in terms of the actions within the CQC Action plan, and that the Divisional Directors are extremely focussed on adhering to the agreed timeframe for sign off.

SQAC received and noted the CQC Action Plan
AM thanked ES for update**.**

20/21/42 **DIPC Exception Report**

B Larru presented the DIPC exception report which provided a brief summary of the position to date.

AM congratulated BL on her recent appointment to her role as Director of Infection Prevention which BL commenced on 19th October 2020

Key issues as follows: -
BL referred to Hospital acquired cases, in terms of exceeding targets for MSSA and C Difficile, and voiced her concern that the targets had been exceeded, BL was unable to provide clinical input regarding why the Trust was exceeding target, given that BL was new to post and not have the clinical data.

BL stated that the targets are being met in terms of hospital acquired MRSA, CLABSI'S and RSVs.

NM stated that the Trust Target figure should be zero, and colleagues should not be aiming for higher targets. NM made a plea for all for colleagues to accept the target of zero. AM questioned what the rationale for a higher target is, NM advised that originally colleagues preferred to go for a 10% reduction. SQAC agreed with this approach that colleagues should strive to reach a zero target, however noted it was also a cultural issue to fully embed across the Trust. NM advised that there is a planned safety day on 24th November 2020 and that the targets/measures that the Trust should aim towards would be discussed. NM stated that executive colleagues appreciate that it is difficult in reaching targets of zero, however NM advised that there is no commentary that makes aiming for anything less than zero acceptable.

FB stated that it is reassuring to hear that both NM & BM have plans to address this issue, and that it is positive to hear that NM & NA plan to discuss further with clinical colleagues at the planned safety day, in order to address this issue, with the aim to ensure progress is made, whilst acknowledging that it is a significant cultural change which would take time to embed. AM confirmed that SQAC are fully supportive of IPC.

AM acknowledged that discussion would take place regarding targets at the Patient Safety Day and that she felt assured regarding the current position.

- Report detailed an update on the 5 work streams which covered PPE, Trust Guidelines, Patient Testing, Environmental cleanliness and Patient treatment.
- IPC staff member for Community continue to work on the IPC work plan for 2021/21 which included identifying how IPC would be integrated into the Community Division during the next year. This would include development of specific audits and an audit programme.
- Inadequate Isolation Facilities in ICU & ED - The installation of Biofuel isolation pods with HEPA filtered air has taken place within HDU cubicle 40 and 2 PICU cubicles in the Green B pod. The conversion of an additional three cubicles in PICU to HBN compliant negative pressure isolation cubicles was due to start in September but has been postponed because of bed pressures. IPC team had secured funding for 6 air cleaners which are devices used to improve the efficiency of the ventilation within the Hospital, and will assist departments such as outpatients, Dental, ENT and respiratory departments, to ensure that an increased number of patients could be seen quicker.
- Fit testing - The Portacount machine, which is an automated method for assessing fit testing of FFP3 masks, was found to have been set to US rather the UK standards, resulting in an enough staff having to be re fit tested. This was immediately rectified, and an RCA had been performed. LB confirmed that the training of Fit Testing staff was not as stringent as required by HSE, the Trust had worked with HSE to ensure that staff are trained correctly, there are now two Fit2Fit accredited Fit Testers – and there are appropriate SOPs and competencies in place. Significant work taken place to address this.
- False positive COVID 19 outbreak - During Quarter 2 , there had been a false positive outbreak of COVID19 on the Critical Care Unit. Four children on Critical Care were reported as COVID19 Positive by LCL on a Friday evening. These were surveillance samples. This led to a chain of events including contact tracing of patients and staff; sending home 85 staff who had been in contact with the patients who tested positive (out of a total nursing complement of 330); Informing parents and excluding parents from the ICU; Informing Public Health England and NHS England; temporary suspension of cardiac surgery. By Sunday evening it had become clear that the four results were all false positive. A StEIS was initiated at LUHFT and an RCA is in progress. Since that episode, positive results from children without COVID19 related symptoms, are reconfirmed using a different platform by LCL.

BL provided an update on her top three priorities in her role as DIPC going forward: -

- A data driven programme based on scientific evidence, and ensuring targets are meaningful for a paediatric hospital.
- That strengthens its capacity and capability by embedding human factors principles and tools.
- Creates a collective mindfulness that health care-associated infections (HAIs)

and antimicrobial resistances (AMR) are not an inevitable complication of medical care.

- BL stated that in order to provide meaningful surveillance, plans are to recruit a data scientist to the IPC team (6 PA). IPC to Lead a national benchmarking survey to select appropriate IPC metrics for children and complete an ongoing research study for HAI's surveillance system using Artificial Intelligence.

LC congratulated BL on her appointment, LC queried whether BL had plans to review Trust compliance with the Statutory Code of Practice and CQC regulations. LC stated that there may be some work to do from Divisional point of view, to ensure that the Trust is fully compliant with the HCA Statutory Code of Practice. LC stated that it may be beneficial for an offline divisional discussion with BL and Divisional Directors/Leads to review, which would result in a report to be shared at future SQAC meeting, in order to demonstrate compliance and share any update on any areas that may require improvement. BL confirmed that SQAC would receive an update as appropriate, however discussions with Divisions would need to take place prior to any further update provided to SQAC.

Action: Offline discussion to be held with BL and Divisional Directors. Following offline discussion BL to provide report/update on HCA Statutory Code of Practice, when appropriate (date of BL presenting report to be confirmed).

SQAC received and noted the DIPC Exception report. SQAC noted that an offline discussion would take place with Divisional Directors and BL would provide an update report to SQAC in due course regarding HCA Code of Practice compliance – date to be determined.

AM thanked BL for informative update.

20//21/43 Clinical Claims Report

M Perrigo presented the Clinical Claims Report, key issues as follows: -

- 19 New claims had been received for the period 1st October 2019-30th September 2020. 9 letters of claim, 3 inquest funding. No particular themes identified. There had been an increase in cardiac and claims noted.
- 10 closed cases with damages, and 9 closed with no damages, but could be reopened.
- 4 ongoing cases that are going to inquest with staff required to attend, 2 cases closed from February and March this year. MP advised that Inquests are getting busier in terms of complexities and numbers of staff required.
- MP advised that she had requested support from IT team, to ascertain whether they could assist in terms of the Score card, to ensure that this is more user friendly for the divisions, in order to identify themes or lessons learnt, which would add to the wealth of data within the organisation. AM queried whether MP had ambition regarding timescale for improving the scorecard, MP stated that she would circulate this to exec leads in its current format, and that there is no reason why the scorecard could not be shared with divisions in its current format. MP is hopeful that IT team could review and address within the next 3-4-week period, however if this is not possible, and in order to avoid delay MP would circulate scorecard in current format. ES referred to benchmarking information. ES requested further information, and queried whether Birmingham could be featured, ES sought clarification whether NHS Resolution could assist, in terms of trying to understand the figures in greater detail. MP stated that since Birmingham combined into a larger Trust, that the data does not display paediatric information. MP

confirmed that she would contact NHS Resolution to ascertain if they could provide further information and would update ES thereafter.

Action: MP to contact NHS Resolution to investigate whether they could provide further information.

Offline Conversation with MP & NHS Resolution, MP to feedback to ES, should any escalation be required to SQAC MP to update SQAC as appropriate.

NM stated that when reviewing information and reviewing when incidents occurred there is a wide range of information. NM queried whether it would be feasible to create a table within the report relating to when incidents happened, to ascertain if there are any trends, whilst acknowledging that claims could be influenced by numerous issues such as lawyers, self-help groups etc. MP stated it is difficult in terms of the claim's perspective given that claims for adults have a 3-year period, however for Children claims could be made up until the patient reaches 21. MP stated that some complex cases could take significant lengths of time due to complexity of reports. MP advised that it was difficult, as the Trust have no control on when claims are made.

Action: MP agreed to reflect offline and liaise with her colleagues, MP to update SQAC as and when appropriate.

SQAC received and noted the Clinical Claims Report.
AM thanked MP for comprehensive report.

Effective

20/21/44 **CQSG Key issues report**

CU presented the CQSG key issues report from the CQSG meeting, which was held on 8th September 2020, key issues as follows: -

- 9 assurance reports presented to CQSG members. Overall good level of assurance presented, with good governance processes in place.
- Division of Surgery reported 3 STEIS reported incidents in August 2020, all 72 hour reviews had been completed, comprehensive investigations had commenced, currently awaiting outcomes of these investigations, leads had been identified.
- 7 new complaints received in August 2020 – no themes identified.
- Division of Medicine reported 1 STEIS reported incident, Investigation undertaken, currently in draft. RCA almost completed, CU advised that the RCA is extremely comprehensive and involved a signicant MDT team participation.
- The Division of Medicine received 10 complaints in month, majority of complaints related to neurology and the cessation of services for patients with tourettes syndrome, significant work had taken place within the division in terms of these complaints.
- Division of Medicine, - Sepsis Compliance – 83% which is below target -(12 patients identified, with 10 treated in <60 mins), 4 patients on 3C, 7 patients on 3B and 1 on EDU, with significant focus within the division to address this issue.
- CQC Action plan is progressing to target for all Divisions.
- Community Division noted no significant issues raised, with a comprehensive assurance report presented by the Division. 1 formal complaint had been received in August 2020. No moderate harm incidents or above had been reported.
- DETECT study report presented to CQSG which highlighted progress made

within12 months of using Vitals technology in the 10 inpatient study wards and 6 associated areas, no concerns were raised to CQSG and highlighted key benefits to patients at Alder Hey.

- Duty of Candour Report – there were 7 incidents in total, where Duty of Candour applied. There were 4 STEIS reported incidents and 3 moderate harm incidents where Duty of Candour applied. Duty of Candour was met in line with regulation 20 in 6 cases, however Duty of Candour was breached in 1 case, with an investigation underway to determine how this breach had occurred in order to prevent any future potential breaches.
- Quarterly key issues report from the Patient Safety meeting was also presented to CQSG, CQSG noted the comprehensive report, key themes included significant lessons learnt and numerous impovements.
- CAS alerts report was presented – all alerts were actioned and closed within deadlines and outstanding alerts are on schedule for completion by expected deadline.
- Infection Prevention & Control Quarterly Report was received at CQSG Quarter 1. Report outlined 5 different workstreams developed as a result of COVID 19.
- NATSSIps audit and actions for improvement, with a good level of improvement, work still do to, a working group had been established, new policy due to be raitifed, expected at next CQSG meeting.
- Reports deferred included Accessible Information Standards – as presenter called to an emergency meeting, Drug & Therapeutics/CDEG Committee, NutritionSteering Group Update Report and Raidiation Protection Committee – all deferred reports were presented at October CQSG meeting.
- SQAC noted that the Picker Survey for 2020 had been cancelled, due to COVID 19.
- CQSG raitifed the Research Policy

Key issues for escalation to SQAC detailed as follows:-

- Incidents in relation to management of patients with mental health crisis on general paediatric wards, volume and complexity of Neurology formal complains and PALS received in relation to cessation of services for Tourettes Syndrome and other conditions and Three serious incidents reported in month within the Department of Surgery.

FB – referred to the 3 key issues identified for escalation and asked for clarity regarding the timeline regarding any follow up actions. AM confirmed that the issues escalated to SQAC from CQSG, would be continued to be dealt with by CQSG. CU confirmed that these issues are being very well managed and are regularly reviewed and addressed as appropriate, with no concerns raised regarding how these are being managed.

SQAC received and noted CQSG key issues report.
AM thanked CU for comprehensive report.

Well Led

20/21/45 **Board Assurance Framework**

ES presented the Board Assurance Framework, key issues as follows:-

- ES stated that the it would be helpful to utilise the BAF in future to review as a tool, in order to identify what SQAC focus should be on for the next 12 month period. ES asked committee members to note the work that has taken place to address priorities to ensure safe access, restoring activity and keeping patients safe, with particular emphasis on staffing. ES questioned whether SQAC

collectively are satisified that the risk scores are in the correct place. AM stated that she had fully reviewed the BAF, and stated that it did merit a comprehensive 'deep dive'. ES advised that some 'deep dives' should be scheduled within SQAC, and queried whether IPC should be a focus for a potential 'deep dive' in the future.

- POC provided an overview on challenges which the Trust currently has in terms of nurse staffing, which had been discussed at Strategic Executive Team meeting on 20th October 2020. POC updated SQAC with regards to the winter period in terms of resilience and robustness relating to nurse staffing, given that nursing staff are quantineed, isolating or are commencing maternity leave earlier than usual and the impact that this is having. POC advised that both PB & POC have worked with the finance team in order to review figures, which are significant. PB & POC are working with matrons, ward manager's, wider senior nursing teams and Divisions regarding what nurse staffing may look like across the Trust during peak winter COVID period, and agreeing some triggers that may lead to us moving to a level that is less than the agreed standard. This would be dependent on the risk assessment and other sets of circumstances, such as acuity and would take account of professional judgement. General agreement was provided by Executive Team, based on some of the processes that the Trust already have in in place, e.g. the daily safer staffing huddle, whereby a decision could be reached in order to obtain absolute sign off by Chief Nurse and DON if there is a need to go below what has been agreed are the minimum nurse staffing levels, dependent on professional judgement and local set of circumstances. There would be a requirement for QIA and EIA to be undertaken. Challenge regarding escalation and decision making processes relating to 2nd on call responsibilities – POC following this up with PB.

  CU stated that this is a high risk on the risk register, however it is not evident if there are similar challenges for other staff groups AHP's, medical professionals, etc or whether further consideration had been given to other staff groups. POC stated that this particular element was not discussed during Strategic Executive Team discussion, and that the challenge/risk would be that there may be a need to rely on utilisation of allied health workforce, and that in terms of risk, this could be a significant risk in terms of service delivery, should there be a need to seek assistance from allied health professionals.

  POC sought agreement from Executive colleagues on 20th October, regarding the plan for trigger levels and subsequent escalation regarding the minimum staffing levels for winter, POC confirmed that the Executive Team provided agreement to the proposal, pending work on QIA & EIA and senior staff sign off in terms of the escalation process.

  Action: POC agreed to undertake an offline discussion with PB with regard to impact on allied health professionals/service delivery and 2nd on call role in signing off the reduced staffing out of hours and EIA/QIA completion

AM confirmed that she is confident that there is a plan in place to address this Issue.

CQAC received and noted the BAF update.
AM thanked ES & POC for update.

20/21/46 Corporate Report – Quality Metrics Divisional Update Community & Mental Health Division

LC presented the Community & Mental Health Divisional update, key issues as follows for month of September 2020.:-

Safe

- Division had an increase in reporting incidents for the month of September 2020.
- Zero incidents recorded of moderate, servere or fatal harm
- Zero never events
- Zero pressure ulcers
- 20 medication incients reported relating to lost prescriptions. Significant issues with Royal mail, with regards to prescriptions which are posted to the local phamary or to the childs home address, LC advised that she envisaged that given the continued challenges with Royal mail that this risk is likely to continue.

Caring

- Lessons learned from complaints included - 14 excellence reports, 26 Compliments
- Friends and Families Test - comments had been positive with regards to Attend Anywhere. LC stated that the Corporate report did not contain the Friends and Family Test comments relating to Attend Anywhere, and should be incorporated, as over 3,000 responses had been received from the Attend Anywhere online feedback. SQAC agreed that is is important going forward that this information is captured within the Corporate Report going forward.
- 2 formal complaints received, with 25 PALS (Community Paediatrics)

Effective

- Crisis Care continue to provide a 24/7 service, seeing increasing number of patients presenting.
- No Child or young person is waiting over 52 weeks in Mental Health Services
- Significant work undertaken with schools in terms of children returning to school regarding enhanced risk assessments.

Responsive

- Mental Health services were successful in obtaining National Lottery funding bid to create a COVID support team, providing group and individual sessions for Children and Young People presenting with deteriorating mental health following lockdown.
- 100% compliance for urgent and routine Eating Disorder targets for third consecutive month
- Improvement in Referal to Choice metric to 74.3% of young people waiting within 6 weeks (mental health)
- Improvement in Referral to First Partnership metric to 59.1% of young people waiting within 18 weeks (mental health)

Challenges

- Decrease in Was Not Brought rates in Community Paediatrics, compared to previous months, but still remains a challenge
- Increase in referrals in Locality Based Mental Health Services

Well Led

- Divisional Development Day and launch of BAME and White Allied Network across Division. This included changes to recuirtment and Selection processes within the Division.

- Staff sickness remains below Trust target at 3.7%
- Mandatory training above trust target at 91.4%
- PDR rates at 41.3% and expected to reach target by end of October 2020.
- Ongoing discussions continue with commissioners to secure permanent funding for 24/7 Crisis care service and Sefton funding that was agreed pre-covid (ASD pathway, eating disorers and crisis care) – on Risk Register.

SQAC received and noted the Community & Mental Health update.

Division of Medicine

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

Safe

- Zero Never Events
- Zero clinical incidents resulting in severe, moderate or permanent harm
- Zero grade 3 or 4 pressure ulcers
- Zero hospital-acquired inections for MRSA and C Difficile
- Cleanliness score of 97.9%
- Sepsis patients treated within 60 minutes had improved to 91.7%
- Pharmacy outpatient time for complex patients 100%
- Zero never events, hospital-acquired infections (MRSA, C.difficile) for over 12 months.
- Challenges regarding Outpatient Pharmacy dispensing remains over 30 minutes for >16% of patients.

Caring

- 6 complaints and 27 PALS responses received.
- Challenges – increased numbers of complaints that are linked to the Tics and Tourette's patients within neurology. Regular meetings take place with CCG, this is a region wide issue.

Effective

- ED performance continued to meet the national standard of 95.1% As emergency attendances continue to increase, consistent delivery of the Emergency Care standards and resilience for winter continued to be one of the Divisions top operational priorities.
- Highlights - Emergency Care Performance and improved theatre utilisation.
- Challenges remain regarding Zero 28 day breaches, Was Not Brought Rate had continued to remain high at 13.1%, and is particularly high at 17% for new appointments. UD referred to the last SQAC meeting and the request to obtain benchmarking data regarding Was Not Brought Rate, UD confirmed that she had contacted Warrington to obtain DNA rate which is 10%, UD had also contacted colleagues at Bristol which has a 10%-11% rate, UD had tried Birmingham and other Trusts, colleagues however they were not keen to share data.

Responsive

- RTT compliance remains challenging at 53.9% however with the Divisions intense focus on restoring capacity and expanding access to care, this had improved on the August position of 45%. There continue to be no patients waiting over 52 weeks for treatment.
- Diagnostic compliance had improved to 91.4% from 77.9 in August 2020.
- Highlights included consistent delivery of all national cancer standards, (with one breach for 2 patients, but still within the 93% national standard).

Continued recovery of the diagnostic targets and Pathology turnaround times. Challenges remain regarding outpatient imaging reporting times, Associate Chief of operations is reviewing this position.

Well Led

- Expenditure within the Division remains £1.2M under recorvered due to reduced activity and income. There is a focused effort to control expenditure through significant reduction in temporary pay.
- Medical Appraisals, plan to commence in January 2021.
- Mandatory training is at 89.9%
- Highlights – Safer staffing fill rates and reduce long term sickness rate
- Challenges – sickness rates overall and mandatory training <90%, with the Division reviewing this further.

SQAC received and noted the Division of Medicine update

Surgery Division

TB presented Surgery key issues update, key issues as follows:-

Safe

- Reduction in clinical incidents resulting in near miss from 44>31>23
- Clinical incidents resulting in no harm remain stable
- Reduction in clinical incidents resulting in minor, non perment harm
- Zero clinical incidents resulting in moderate, semi- permanent harm or severe permanent harm or catastrophic death
- 2 medication errors resulting in harm
- Zero category 3 or 4 pressure ulcers
- Zero never events
- 2 hospital-acquired infections: 1 C dificile and 1 MSSA.
- Highlights – reduction in clinical incidents resulting in minor, non permanent harm, Reduction in MSSA. & Cleanliness score of 98.2%
- Challenges – Reduction in patients treated for Sepsis within 60 minutes
- Level of Multi disciplinary report is good indicator from colleagues reporting through ULYSSES.
- Challenges relate to a considerable number of incidents which are not yet closed, the Division have a comprehensive action plan to address which is going to be shared with Ward Managers with timelines applied to the action plan, in order to address and close off those outstanding actions.

Caring

- Reduction in formal complaints received from 7 in the previous period to 2, both of which were complex complaints.
- Reduction in PALS from 33 to 22
- Overarching themes included access to care within anticipated time frames and communication within teams and across specialties and divisions.
- Highlight related to a reduction in PALS and formal complaints
- Challenges related to staffing and responding to complex complaints when staff are absent/isolating etc, in terms of extending deadlines.
- Challenges in terms of providing access within a timely manner for elective patients.
- Friends and Family Test responses - 94.6% good, or very good.

Effective

- 0 readmissions to PICU within 48 hours, consistent for two month period

- Recruitment within surgery recruiting matron and 2 band 7 posts, hopefully commencing in post soon.
- Theatre utilisation consistent with last two months
- 15 children cancelled on the day of their elective admissions for non clinical reasons, themes include cancellation due to staffing on the day
- 55 patients cancelled on the day did not receive their operation within 28 days of the cancellation
- Highlight – no readmissions to PICU within 48 hours for second consecutive month. CCAD cases – 30.
- Challenges – Significant increase in referrals received

Responsive

- CQC Action plan is upto date within the Division of Surgery and is regularly reviewed within the team and discussed at Divisional Integrated Governance meeting.

Well led

- Mandatory training is 87%, discussion to take place with Ward Managers and Matrons within Surgery to review what steps are being taken to improve these figures.
- Current SIRI and Never Event action log is kept upto date and is discussed through Divisional Governance process and CQSG.
- All RCA's level 1 and any IPC RCA's are regularly revidewed in order to evaluate and ensure any lessons or shared learning has been dissiminated, work is ongoing in this regard.

AM stated it was interesting to hear update in terms of mandatory training performance. SQAC received and noted the Division of Surgery update.
SQAC received and noted the Surgery Divisional update.

AM expressed thanks to all of the Division for comprehensive reports provided.

20/21/47 SQAC Amended 2020/21 Workplan

ES presented the amended 2020/21 SQAC workplan and sought any feedback. ES stated that it had been a struggle at times previously to remove items from the workplan, and that there is huge merit and value in the updates provided within the workplan.

ES requested that the workplan be adopted, and for the committee to keep the workplan under review. ES emphasised the important of SQAC ensuring that they are fulfilling the principles in terms of maintaining high level focus.

SQAC received and accepted the workplan, which would be kept under review.
AM thanked ES for update.

20/21/48 Pregnancy Testing Before Treatment Policy

SQAC received the Pregnancy Testing Before Treatment Policy, which had previously been presented to CQSG.
SQAC ratified the Pregnancy Testing Before Treatment Policy.

20/21/49 Any other business

None

20/21/50 **Review of meeting**

AM stated that the committee had discussed a significant amount of information, and thanked all concerned. AM recognised that SQAC was still in a period of transition, with all learning how to manage the meeting, now that there is a slightly different focus, with increased articilulate accountability in providing assurance to the board.
AM reiterated her thanks to all for contributions made.

20/21/51 **Date and Time of Next meeting**
18th November 2020 at at 9.30 via teams