NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 28th January 2021, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (9:00am-9:15am)							
1.	**20/21/220**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**20/21/221**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/222**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 17th December 2020.**	**D**	Read minutes
4.	**20/21/223**	**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 – Alder Hey's Response to the Third Wave							
5.	**20/21/224**	**9:25 (55 mins)**	• **Update on 3rd wave.** - **Overarching Plan.** - **Adult ITU Governance Arrangements.** - **Access and Restoration update.** • **Staff/Patient Safety:** - **Covid-19 vaccine update.** - **Staff safety metrics.** - **IPC assurance including nosocomial infections.** - **Safe Waiting List**	J. Grinnell N. Murdock/ N. Askew A. Bateman M. Swindell M. Swindell B. Larru A. Bateman	To provide an update on the 3rd wave of the pandemic. To provide an update on clinical governance arrangements. To provide an update on access and restoration of services. To provide an update on the Covid-19 vaccine for staff. To provide an update on staff absences and testing. To provide the Board with an update on IPC. To provide an update on patients waiting for an	**A** **A** **A** **A** **A** **A** **A**	Read report Read report Read report Presentation Presentation Read report Presentation

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			Management update. • **COVID Risk Register.**	J. Grinnell	appointment more than 52 weeks and management plan going forward To discuss the current key risks.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**20/21/225**	**10:20 (10 mins)**	**CQC Section 31 Response and Action Plan.**	E. Saunders/ N. Askew/ L. Cooper	To provide an update on actions taken in response to the section 31 notice issued by CQC and to discuss the implications of this patient cohort for the wider system	**A**	Read report
7.	**20/21/226**	**10:30 (10 mins)**	**Use of Restrictive Physical Intervention and Clinical Holding Report for 2019/20**	L. Cooper	Provide assurance to Trust Board of activity in relation to the use of restrictive physical intervention and clinical holding across the Trust for the reporting period 1.4.2019-31.3.2020.	**A**	Read report
8.	**20/21/227**	**10:40 (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.	**20/21/228**	**10:50 (10 mins)**	**Cumulative Corporate Report Metrics - Top Line Indicators:** • **Quality.** • **Safety.**	N. Murdock N. Askew	To receive a report of Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
The Best People Doing Their Best Work							
10.	**20/21/229**	**11:00 (5 mins)**	**Cumulative Corporate Report Metrics – Top Line Indicators:** • **People.**	M. Swindell	To receive a report of Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	*Refer to item 9*
Strategic Update							
11.	**20/21/230**	**11:05 (10 mins)**	**Alder Hey in the Park Campus Development update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report

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Strong Foundations (Board Assurance)							
12.	**20/21/231**	**11:15 (10 mins)**	**Financial Update.**	J. Grinnell	To provide an overview of the position for Month 9 and the latest financial guidance.	**A**	Presentation
13.	**20/21/232**	**11:25 (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 plan are being proactively managed.	**A**	Read report
14.	**20/21/233**	**11:35 (15 mins)**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the 21.1.21.** - **Approved minutes from the 19.11.20.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 25.1.21.** - **Approved minutes from the meeting held of the 23.11.20.** • **Safety & Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 20.1.21.** - **Approved minutes from the meeting held on the 18.11.20.**	K. Byrne I Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Items for information							
15.	**20/21/234**	**11:50 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
16.	**20/21/235**	**11:54 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 25th February 2021, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in January 2021:
- **Ref. No: 367 – Lease for land situated off Thomas Lane – Liverpool City Council**

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M9	**J. Grinnell**
Corporate Report	**Executive Leads**
NHSE consultation re ICS future models	**D. Jones**
CQC Action Plan	**E. Saunders**

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 17th December 2020 at 9:00am,** via Microsoft Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Director of Finance/ Deputy Chief Executive	(JG)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. C. Liddy		
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Patient Story	Ms. J. Weights	Assistance Practitioner	(JW)
Apologies:	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. U. Das	Director of Medicine	(UD)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. L. Cooper	Director of Community Services	(LC)
Item 20/21/205	Ms. R. Chhokar	Assistant Chief Operating Office	(RC)
Item 20/21/205	Ms. R. Greer	Associate Chief of Operations	(RG)

Patient Story

The Chair welcomed June Weights, Assistant Practitioner, who agreed to share the story of a family that she helped to make Christmas a little easier for.

June visited the family due to their youngest child having global development delay. The baby was 17 months old, wasn't sitting independently or spending anytime in prone and mum was really struggling therefore it was decided that June would conduct weekly visits. Mum engaged really well with the service and baby started to make progress.

It was during one of these visits that mum very hesitantly asked June if she would be able to contact Alder Hey Charity to see if there was any possibility that they would be able to provide a toy for each of her children for Christmas. June advised the Board that mum has also got six-year-old twins who accessed the Trust's services when they were younger and had received toys from the Charity before. Mum told June that she felt really embarrassed asking for help but advised that the family were really struggling financially and weren't able to afford toys or

Christmas dinner this year. June explained that Dad is a support worker on minimum wage, they have three children and mum attends lots of appointments with baby. June assured mum that she would seek help and contacted a local Round Table charity to see if they could offer any support. The Chair of the Round Table advised that the charity supports community projects rather than individual families but agreed to speak with the Committee to see what could be done. Within a short period of time it was confirmed that the Round Table would help 50 local families. Contact was made with local producers, butchers, greengrocers to see if they could supply the ingredients for Christmas dinner for 50 local families. Contact was also made with local schools to see if they could identify families who were struggling.

Following the conversation with the Chair of the Round Table, June rang mum to tell her that as a result of her finding the courage to highlight her family's struggle she had helped 49 other families experiencing the same difficulties. A couple of days later, June received a further call from the Chair of the Round Table who advised that the charity had had such a good response from local suppliers that they were able to provide Christmas dinner for 60 families and toys for children too.

On behalf of the Board, the Chair thanked June for sharing this family's plight that has deeply moved everyone, and also for finding a way in which to help such a large number of families.

20/21/198 Welcome and Apologies

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

The Chair informed the Board that a large part of the meeting will focus on the restoration of services, quality, wellbeing and the forthcoming changes to Integrated Care Systems (ICSs).

20/21/199 Declarations of Interest

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

20/21/200 Minutes of the previous meetings held on Thursday 26th November 2020
Resolved:
The minutes from the meeting held on the 26.11.20 were approved.

20/21/201 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)* – It was agreed to amend this action and provide a themes and trends analysis of the last three years in order to carry out a comparison with the Trust's peer groups rather than the national system. It was confirmed that this information will be included in the Serious Incident report for Q4 or at the very latest Q1 in 2021/22.
ACTION TO REMAIN OPEN

Action 20/21/177.3: *Covid-19 Assurance Plan Progress Update (Financial Framework Update – During the next regional call, query the detail of incentives if the Trust exceeds its targets)* – It was confirmed that the incentive model is on hold at the moment. This query has been lodged with the regional office and an update will be provided in due course.
ACTION TO REMAIN OPEN

20/21/202 Covid-19 Assurance Plan – Progress Update

Access and Restoration of Services Update

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

- *Outpatient Care:* The Trust has achieved a figure of 94% in November against the 100% national target. It was reported that there has been a great effort despite the current environment and the new PPE that staff are having to use.
- *Day Case and Elective In-patients:* The Trust has achieved a figure of 92% in November against the 90% national target.
- *Diagnostics:* The Trust has achieved a figure of 89% in November against the 90% national target.
- It was reported that the forward look forecast indicates that the Trust will be able to sustain Outpatients and Day Case In-patients during December.
- *Access Times:* Restoration Diagnostics have a target of 90% set against 7 of the 15 diagnostic measures that are used to make up the DM01 target. Good progress has been made against both the DM01 and restoration standard. DM01 has achieved a figure of 97.1% against the 99% standard and Restoration Diagnostics have achieved 89% against the 99% standard. This achievement with restoring the services has reduced the number of children waiting more than six weeks for a scan.
- ED performance for the year continues above 95% despite the challenges of social distancing.
- *Cancer Performance:* The Trust achieved 100% for access times in respect to the timeliness of cancer care in November.
- *Waiting list size and times* – The Trust has been making continuous progress between July 2020 and November 2020 in respect to the increase in patients receiving treatment within 18 weeks.

  The Board was advised of the challenges being experienced in addressing the backlog of patients who have been waiting for treatment for a long time. It was reported that this is quite concentrated in surgical care and some very specialist services. Discussions are taking place to see what support can be given to these services such as ENT, pain and spinal surgery where there remains a number of long wait patients.

  There are some families in this group who have chosen to postpone treatment until the pandemic is over therefore there are 30 families who are choosing to wait over 52 weeks for treatment.

  During January's update the Board will be presented with an outline of additional actions that will help sustain extra capacity, of which, proposals have been received from surgical teams identifying how this can be done. Attention was drawn to the importance of concentrating on high impact actions that will make a difference so that long waiting patients can access the treatment that they need.

The Chair thanked Adam Bateman for the update and commended the work that is taking place to achieve restoration targets.

Safe Waiting List Management Report

A Safe Waiting List programme was implemented in June 2020 due to the effects that the pandemic was having on access to elective care and the pressure it was putting on waiting times. That coupled with a number of issues around data quality it was agreed to establish a strong programme to address these challenges.

Following the identification of a 52-week reporting error in July the Trust commissioned MBI Healthcare Technologies to undertake a review of Alder Hey's approach to inpatient referral to treatment time (RTT) management and reporting. Since then the Trust has completed an elective care assurance review with MBI to understand the issues being experienced.

The conclusion of the review provided a number of findings:

- There were a number of data quality issues identified so it was agreed to validate the respective records prior to the reconstruction of the inpatient RTT waiting list.
- The Trust is ensuring that it is reporting accurately as this links in with the reconstruction of waiting list reports.
- There is a challenge around the extended waiting times and delays to care.
- Stronger arrangements have been implemented for clinical/clinical harm reviews to make sure that patients on the waiting list do not experience harm as a result of an extended wait. Of the thirty reviews that have been undertaken it was reported that no harm has come to any patient as a result of an extended wait and there is a focus on arranging admission for these patients in December/January so that they can receive the treatment they require.

The Chair queried as to whether the Trust is at a stage where the review has been completed. It was reported that this is will be an on-going process from a clinical review perspective so as to keep patients safe whilst on the waiting list.

Fiona Marston asked as to whether the clinical harm reviews take into account mental harm as well as clinical harm. The Board was advised that the Trust classifies harm by referring to the NHS definitions that are used for serious incidents. An additional paragraph has been included in the definitions document to allow consideration of any psychological effects that have been caused due to the delayed access to services.

Fiona Beveridge informed the Board that SQAC will be receiving a regular update on the management of safe waiting lists.

Staff/Patient Safety

IPC Covid-19 Assurance Framework

The Board received the IPC exception report. The following points were raised:

- There has been an increase in infections which are presently being investigated.
- It was reported that 88% of staff members have received a flu vaccination. In order to receive payment for this target the Trust will need to achieve 90% compliance by the end of February 2021 therefore the organisation is making a note of staff members who have been vaccinated via their GP practice. Attention was drawn to the flurry of requests that have been received since the campaign has ceased.

- The Trust is looking to achieve 90% for fit testing by the end of December 2020.
- It was confirmed that track and trace, self-testing and swabbing is on-going. There have been a small number of Covid-19 outbreaks amidst staff, but the Trust has managed them well.
- Attention was drawn to the outbreak of Covid-19 amidst the Domestic Service. The Trust has increased training with this group of staff as it was realised that the organisation was not reaching them with the Covid communication strategies that are in place.

The Chair asked Non-Executive Directors to liaise with Karen Critchley to register the fact that they have had a flu vaccine externally.

20/21/202.1 Action: NEDS

Louise Shepherd queried the figures relating to self-testing. It was reported that the self-testing kits have been rolled out across the organisation and there has been an increase in figures in respect to the amount of staff self-testing. It was agreed to share the most recent figures with the Board.

20/21/202.2 Action: NM

The Chair queried as to whether self-testing kits will be available for staff members to test themselves after the Christmas period. It was confirmed that each person was issued with enough kits to cover a twelve-week period, testing twice a week, which will take them into the new year.

The Board received the IPC Assurance Framework that includes the 10-point plan for the reduction of nosocomial infections. It was reported that the Trust is fully compliant with the plan with the exception of section 8c which relates to the routine testing of inpatients in adult services. The recommendation is that patients are tested upon admission, day 3, day 5 and weekly but there has been a good body of evidence to say that children don't need to be tested as frequently as adults. It was confirmed that the Trust is testing patients upon admission and once a week. This is a slight deviation from the 10-point plan, but it was confirmed that it is in line with paediatric guidance.

Resolved:
The Board received and noted IPC Assurance Framework that includes the 10 point plan for the reduction of nosocomial infections.

Flu Vaccine Status

Staff Safety Metrics

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

- Overall absence – 6.72%
- Covid-19 related sickness – 0.54%. It was pointed out that sickness absence related to Covid-19 is not having a significant impact on the workforce.
- Non Covid-19 related sickness – 5.23%. It was reported that there is going to be a focus on corporate sickness absence.
- 15 staff members of staff are symptomatic or have been confirmed as Covid+.
- 12 staff members of staff are self-isolating.
- 10 members of staff are shielding.

Financial Framework Update

In Month 8 the Trust reported a £0.7m deficit which is £0.3m ahead of plan. The actual YTD performance is a £2m deficit.

The Trust's revised plan for 2020/21 is £5.2m and this has been shared with the Centre and commissioners. Cash in the bank at the end of November 2020 is £110m and the total capital expenditure for November was £3.9m against a plan of £2.1m.

The 2020/21 Forecast Plan is reporting a £5.2m deficit, £2.8m of this figure relates to reduced non-clinical income and annual leave accrual. It was confirmed that the Trust will continue to lobby the non-clinical risk with NHSI. The Board was advised that a lot of work is taking place to address the residual gap of £1.5m.

Capital charges saving achieved £0.9m as a result of improvements that have been made. The risk that relates to the Welsh Contract is £0.9m and the Trust is lobbying against the penalty that will be applied if recovery doesn't achieve 75% of pre Covid levels. The Trust is reporting an improved figure of 78% in November, but it was pointed out that this risk will need to be monitored.

The 2020/21 financial plans are still a challenge across the North West as a result of the new methodology in place. Cheshire and Merseyside have a gap of £122m; £60m due to non-clinical income/annual leave and £62m due to restoration, winter, Covid and other cost pressures. Returns are being completed on a daily basis to justify this position and Alder Hey have assured NHSI that it is doing everything possible to address the situation.

The Board was advised of the possible pressure on capital spend in 2021/22. There is an ask to bring schemes forward to Q4 if funds are available but this may limit access to capital spend for regions and systems in the new financial year. Attention was drawn to the importance of setting time aside to regroup and focus on this issue.

It was reported that the Trust's pre Covid Plan for 2021/22 was a £3.3m deficit assuming £6m CIP delivery. Indicative modelling based on new assumptions is now flagging a £9.5m deficit. The organisation has commenced to develop its Financial Strategy to respond to this issue and there are a whole host of workstreams looking at various areas to help mitigate the risk. Planning guidance will be shared by the Centre mid-January and an update will be provided during February's Board.

Covid-19 Risk Register

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

It was felt that the Trust is starting to see an improvement in terms of Covid-19 risks, and it was pointed out that the themes highlighted in the report are discussed on a regular basis at Board and are heavily referenced in the BAF. It was queried as to whether it is the right time in which to integrate Covid-19 risks with the organisation's normal risk management process. Following discussion, it was agreed to submit the risk register during January's Trust Board and then incorporate it into the normal risk management process.

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

20/21/203 Serious Incident Report

The Serious Incident report was presented to the Board to provide an overview of the current position for incidents reported externally to the Strategic Executive Information System (StEIS), including new incidents reported between the 1.11.20 to the 30.11.20. The following points were highlighted:

- There were no new serious incidents reported during November 2020, and the six investigations that remain open are on track to meet their review dates.
- It was reported that there have been two incidents that were formally reported:
  - *StEIS Reference 2020/13501: Suspension of treatment for patients with Tics, Tourette Syndrome and Paediatric Acute onset Neuropsychiatric Syndrome* - The main learning from this incident falls into two parts 1. The implementation and embedding of the new appraisal system for medics which has increased stability and raises concerns or worries early. 2. Consideration of a Communications Strategy at an early stage of any change to service provision to ensure that the appropriate CCGs are fully sighted on the reasons for the change. The Board was advised that work is taking place with CCG colleagues on the cohort of Tics and Tourette Syndrome patients to agree as to where their care should be provided. It was pointed out that there is a strong feeling that Alder Hey isn't a tertiary service and therefore patients should be managed locally via their GP service.
  - *StEIS Reference 2020/13420: Patient swallowed magnets while an inpatient on ward. Patient in Mental Health crisis in inappropriate care setting* – This incident relates to two adolescents who were admitted onto the General Paediatric Ward at Alder Hey and experienced a deterioration in their mental health during their stay. The outcome of the RCA that was conducted following both incidents focusses on the safety of young people whilst in the care of the Trust in terms of the physical environment and processes in place. It was reported that there are some rapid changes being made to one of the rooms on Ward 4C to ensure it is ligature light and a safer environment, and patients will be reviewed when accessing the Trust via ED and receive an individual care plan where appropriate that will include information on the level of supervision required, and any additional support will be concisely documented. The Board was advised that work is on-going to improve the experience of children and young people who access Alder Hey's services.

The Chair referred to the incident relating to the two young people and queried as to whether the Trust has shared its experience with local District General Hospitals (DGH) as potentially they may have to deal with this cohort of patients moving forward. It was felt that this was an excellent suggestion. The Board was advised that CQC have recognised that this matter is a challenge, especially in a DGH environment and is going to issue guidance shortly on risk assessments and what those environments should be modified to.

Louise Shepherd reported that this incident has been subject to discussions with CQC and a meeting has taken place to provide assurance that all improvements identified in the RCA have been completed. CQC have been furnished with a lot of information during the last week but have requested further clarity on certain

matters. The Board was advised that a full update on the additional CQC work that is taking place will be provided during the private element of the Trust Board.

The Chair thanked Nathan Askew for the work that is taking place to provide the level of detail that has been included in the Serious Incident report.

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

20/21/204 Position Statement for PALS and Complaints, Q2

The Trust Board received the Q2 position statement for PALS and complaints which provided an overview of formal complaints and informal PALS concerns received and completed between 1.7.20 and the 30.9.20. The following points were highlighted:

- *Three-day acknowledgement* - In Q2, 82% of complaints received by the Trust were acknowledged within 3 days. On two occasions the acknowledgement was delayed by more than four days due to the holiday period. The process for acknowledging complaints within the time frame is currently under review and it is expected that performance against this metric will improve. It was reported that November's compliance was 100%.
- *Responses within 25 working days* - It was reported that 52% of complaints were responded to within 25 days during Q2. Whilst the Trust has some really complex complaints that span a number of departments it is felt that this is an area that can be improved upon to ensure the five-week timescale is met. It was reported that the backlog of complaints is currently being addressed and will be completed by the end of 2020. From January 2021, new complaints will be delivered as much as possible within 25 working days.
- *Themes* – The main themes for complaints in Q2 was around clinical treatment and disagreements with outcomes. The main theme for PALS was communication. The Board was advised that the PALS and Complaints service continued to function remotely during the pandemic. A review of working arrangements is going to take place in order to bring the service back on site so that it is more accessible to patients and families.
- There were no referrals to the Parliamentary and Health Service Ombudsman during Q2.
- Attention was drawn to the importance of shared learning between departments and Divisions and it was pointed out that this will be included in the plan for improvement moving forward.

The Chair highlighted how hard and time consuming it is for families to take the time to submit a complaint and felt that it is only right that the Trust be respectful of this and respond to complaints in a timely manner. The Chair advised that there are opportunities to conduct a deep dive into complaints via the Safety and Quality Assurance Committee.

Louise Shepherd expressed her thanks to Nathan Askew for the work that has taken place to date and the improvement plan that is in the process of being compiled to enable the Trust to provide a much slicker service in 2021.

Resolved:
The Board received and noted Position Statement for PALS and Complaints, Q2.

20/21/205 Corporate Report

Corporate Report Divisional Updates:

Medicine

Safe:

- There were zero Never Events, zero clinical incidents resulting in severe, moderate of permanent harm. There were zero grade 3 or 4 pressure ulcers and the cleanliness score is at 96%. It was reported that the metrics reflect a safe Division.
- The Board was advised that there have been some challenges around the Sepsis timeline with 75% of Sepsis patients treated within 60 minutes. It was confirmed that work is on-going to address this issue.

Caring:

- There were 7 complaints and 29 PALS responses. There has been an increase in the numbers of complaints that are linked to the cohort of Tics and Tourette's patients in Neurology awaiting diagnosis.

Effective:

- The Emergency Department continues to meet the national standard at 97.1% whilst responding to the challenges of Covid and continuing to improve its resilience for winter.
- Theatre utilisation has improved.
- There were zero 28-day breaches.
- Was Not Brought (WNB) rate remains high at 11.3% but has improved against the last five months. It was reported that the Trust is contacting families to ensure patient attendance.

Responsive

- RTT compliance continues to improve and is at 81% compliance against the 92% national standard. There has been an intense focus on restoring capacity and access to care.
- It was reported that the Division has worked hard to ensure that there are no patients wating over 52 weeks for treatment.
- There has been a consistent delivery of all national cancer standards, but attention was drawn to the outpatient imaging reporting times. Work is taking place with Radiology to try and address this issue.

Well Led

- The Division remains £153k underspent as a result of a focussed effort to control expenditure through significant reduction in temporary pay spend and also address agreed spends through historically approved business cases.
- Medical appraisals are at 96% and mandatory training is at 69.1%. Mandatory training is a challenge for the Division at the present time along with sickness rates. Finance has been highlighted as a challenge due to the Covid related pressures, for example, short notice sickness which affects run rates.

Louse Shepherd thanked Raman Chhokar for the update and her leadership, drawing attention to the Division's fantastic effort which has produced an exceptional set of results.

Fiona Marston pointed out that the Trust is still behind in respect to achieving its objectives for learning and play and asked for feedback on this matter. It was reported that the Triumvirate are helping with a deep dive into this area of work whilst the Nursing Team are assisting with the metrics to see if they can be improved upon. The Board was advised that learning and play remains a big challenge at the present time due to the restrictions in place owing to the pandemic. The Play Team are doing the best they can in terms of provision on an individual need's basis, and work is taking place to help children and young people become more active within their cubicles. The Physiotherapy Team are piloting the 'Ready, Steady, Go' project which is about getting patients out of bed each morning, getting them dressed into their day wear and keeping them active whilst in hospital.

From an educational perspective, the Board was advised of the positive meeting that took place with the Headmaster of the school that provides the Trust's educational links. It was confirmed that the school are going to try and provide as much learning as possible whilst patients are in hospital, but attention was drawn to the constant challenge of infection control versus providing patients with what they need. It was reported that all of the Divisions are working really hard to see how they can maximise that potential.

Community and Mental Health

Safe:

- There are zero incidents resulting in moderate or severe harm, and there are zero pressure ulcers (*category 3 and above*).
- It was reported that the Tissue Viability post is out to advert.
- Challenges in relation to medication incidents are as a result of delays in receipt of prescriptions via the Royal Mail due to the pandemic and booking of incorrect appointments. The Trust is looking towards implementing a full electronic process for prescriptions from end to end. With regards to the booking of incorrect appointments, the Outpatients Department have developed an improvement action plan for increasing ePPF compliance which will support improvements in correctly pending future appointments.
- The Board was advised of an incident relating to an e-mail that was sent in error. As a result of this incident, process changes have been made and the IG policy summary has been shared with all staff who have been reminded about the importance of checking e-mails.

Caring

- There has been a reduction in PALS (18) compared to October 2020 (33).
- The Division has seen an increase in compliments, with 13 recorded in month.
- It was reported that there has been an increase in formal complaints. This is due to the Division pro-actively converting informal concerns to formal complaints to ensure appropriate investigations/actions are taken so that lessons can be learnt.

Effective:

- The Trust has continued to provide crisis care 24/7.
- There are no children waiting 52 weeks for an appointment and there has been a reduction in patients waiting over 40 weeks.
- Routine referral turnaround time remains a challenge at 18 days. A Task and Finish group are working with the Divisions to address this issue.

Responsive

- Improvement in RTT position.
- There are zero breaches for urgent and routine Eating Disorder waiting time compliance.

Well led

- A ten-year Joint Pathological Demand Avoidance Statement has been agreed with Parent Carer Forums, Education and Social Care partners.
- Medical appraisals are at 100%.
- Flu vaccine compliance in the Division has increased to 64%.

It was queried as to whether the Trust has a formal quality process in place for the work that is being conducted by the external provider to support patient access. It was confirmed that this process was set up as part of the original agreement, therefore all patients referred to the provider by the Trust will go through a triage process of which the outcome is shared with the Trust.

Louise Shepherd praised the Division for the exemplary improvement work that has taken place to turn the service around over the last twelve-months regardless of the pandemic and thanked everyone involved for their hard work in this great feat.

Fiona Beveridge drew attention to the recent approach that the Community Division has taken in respect to converting informal concerns to formal complaints and felt that this a really positive thing to do in order to acquire the learning from each situation. The Chair queried as to whether this process could be commended to other Divisions or used as part of the quality review that is taking place. It was felt that the PALS and Complaints process needs to be fluid for the families of patients to see how they wish to address a situation and the best way to achieve it.

Surgery

Safe:

- There have been no clinical incidents resulting in moderate, semi-permanent harm or severe harm, permanent harm of catastrophic death.
- Sepsis rates have improved and are at 90% for patients treated for Sepsis within sixty minutes.
- It was reported that the Step Programme pilot is virtually complete. This programme is looking to address culture change in theatres, and it was reported that the feedback from staff who have participated in the pilot is very positive. The Board was advised that it has been agreed to roll this programme out in Day Surgery during February. It will be rolled out over a week's period in order to give the programme momentum. A formal update on the programme will be provided in March 2020.

20/21/205.1 **Action: AB**

- Work is taking place to address the challenges relating to an increase in medication errors.

Caring:

- It was reported that the Division is changing its process entirely for dealing with complaints. It was felt that the learning from informal complaints is just as important as the learning from formal ones therefore this approach has been built into the new departmental governance reporting schedules. Each department receives an update on complaints and themes for discussion during their monthly governance meeting that has been established.

Effective

- Theatre utilisation is above 90%. One of the challenges for this area of work relates to anaesthetic provision. The Board was advised that the Trust has appointed three new anaesthetists in November and are looking to appoint a further two to three in January/February 2021. The successful candidates will commence in post over a period of time; with one starting in February and the rest between April through to August.
- Was Not Brought rate remains consistent at 10%.

Responsive:

- There has been an increase in weekend theatre sessions for both inpatients and day cases which has proven to be really efficient . The Division are continually running additional theatre sessions for spinal lists as the main pressures in surgery/long waiters are particularly around spine surgery. It was reported that all patients waiting for spine surgery over 52 weeks are being clinically monitored by the team and it was confirmed that there has been no harm to patients as a result of the delay.
- There has been a slight reduction in patients waiting over 52 weeks to receive treatment, but it was pointed out that this remains a challenge.

Well Led

- There has been an increase in the number of appraisals that have been completed.
- Mandatory training compliance has reduced but there are plans in place to address this. It was pointed out that the majority of surgical consultants have their appraisals in December, and they tend to link their mandatory training with their appraisal.

Kerry Byrne referred to the recruitment of new anaesthetists and asked as to whether there is anything else that the Trust can do to retain staff. It was reported that the Trust has a low turnover of anaesthetists and is proactively recruiting Fellows from the Fellowship Programme that is being run by the Trust for anaesthetists.

Kerry Byrne drew attention to the earlier discussion around learning/play and queried as to whether there is a fundamental challenge that hinders the Trust's relationship with the school. It was reported that a meeting has taken place with the Headmaster who is engaged and has confirmed his intent to work with Alder Hey. It has been suggested that regular meetings take place between the respective teams to enable progress. The Board was advised that there a number of challenges relating to the eligibility of education for some patients which will be addressed over the next few months.

Louise Shepherd thanked Alfie Bass for his leadership, engagement with colleagues and focus on safety since his appointment. The Board was advised of the enthusiasm that was shown during a presentation that was shared with the Exec Team by the Division of Surgery around the Division's improvement work.

The Board noted the summary provided by the Research Division.

Top Line Indicators – Trust level

Quality:

The Board was advised that medication errors are being reported across all of the Divisions with the biggest challenges relating to ten times the dose and prescription

errors. There has been a slight reduction in the last week, but it was felt that there are improvements that can be made across all of the domains i.e. prescribing, dispensing and administering of medication. It was reported that the majority of errors cause no harm or are classed as a near miss and therefore the Trust is able to learn from these incidents, but a step change is required to ensure errors don't occur in the first place.

It was pointed out that a lot of the near miss incidents relate to the prescribing, making and administering of complex medications for children and young people, therefore it is felt that is necessary to have a risk based approach moving forward to challenge and address the highest ranked medication risks. The Board was advised that a Medication Safety Summit is going to take place in the near future to look at medication safety and high-risk medications. One of the quality priorities for 2021 is to have a whole workstream wrapped around this issue.

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

20/21/206 Cumulative Corporate Report Metrics - Top Line Indicator

People

An update was provided under agenda item 20/21/202.

20/21/207 Alder Hey People Plan

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

- The Board was advised that 1,900 members of staff completed the 2020 NHS Staff Survey. This equates to 51% of the Trust's workforce. An overview of the responses to key questions was provided and it was confirmed that the Trust is working on a plan for sharing these results with the outcome of the survey.
- At the end of November 2020, Mandatory Training was at 85.5%. This is due to a lack of face to face training and a focus on the pandemic.
- At the end of November 2020, appraisals were at 82%.

The Chair felt that the results of the Staff Survey were remarkable and thanked all those concerned for the hard work that has taken place to achieve this outcome. Louise Shepherd reiterated the Chair's sentiments.

EDI Task Force Group Interim Report

A number of slides were presented to the Board to provide an update on the progress that has been made by the BAME Inclusion Task Force. Information was provided on the following areas:

- Themes that the Task Force have been focussing on; communications, listening to staff, policy, recruitment, data, employment, training, governance, NHS People Plan challenges and internal EDI expertise.

- Task Force activities to date; listening events, focus on apprenticeships, focus on volunteers, focus on communications, focus on recruitment, approach to anti-racism.
- Employment data and its diversity.
- Launch of Task Force via Black History Month, Daughters of the Windrush screening, weekly blogs, screensavers, content on atrium screens, social media activity, publication of statement on diversity and inclusion.
- Tasks in development; new blog, BAME staff photoshoot, interfaith calendar, BAME colleagues Communications Reference Group, recruitment campaigns, 'Face Like Mine' campaign, targeted recruitment.
- Work to progress; governance, employment, Zero Tolerance Policy, higher education institution agreements.
- It was pointed out that the Trust's Zero Tolerance Policy does not protect BAME staff from overt racism that they face so a group of staff members and an external consultant will be joining forces with the Task Force Group to review the policy to ensure it covers BAME staff.

It was reported that the Task Force will continue to meet monthly until March to continue to develop the action plan and focus on areas of development. A full report will be presented to the Trust Board in April 2020.

Fiona Marston commended Claire Dove for her inspirational leadership on this area of work and pointed out that the whole process has given BAME staff a voice. Fiona Marston did not feel that there was sufficient representation from the BAME community on the Council of Governors and queried as to whether this was being built into the work around BAME representation at Board, committees and Council of Governors. It was reported that the Task Force Group are going to invite Erica Saunders to a meeting to discuss governance and next steps.

Shalni Arora reiterated Fiona Marson's comments with regards to Claire Dove's leadership. Shalni Arora highlighted the need for a change in culture and drew attention to the importance of ensuring that people know that racism is not acceptable at Alder Hey. It was also felt that the Trust needs to empower non BAME staff to be able to stand up to this matter and continue to monitor racism and BAME recruitment going forward.

Claire Dove concluded the update and emphasised the importance of discussing the final report in March to agree a sustainable on-going approach in order to keep up the momentum of this work.

The Chair thanked Claire Dove for her leadership and all those who have supported the Task Force Group. The Chair felt that it is really important as a Board to address the overt racism that BAME staff are experiencing, support forthcoming changes to the Zero Tolerance Policy and empower staff to express concerns and explain that it's not acceptable.

Ian Quinlan queried as to whether there should be a senior person in the organisation that BAME colleagues can go to during the interim to raise concerns knowing that they will be heard. Claire Dove pointed out that the Trust will require good leadership to address this area of work and advised that the Staff Advice Liaison Service (SALS) is a good place to raise informal concerns. It was pointed out that diversity in the SALS team is required.

Nathan Askew advised the Board that BAME staff tend not report incidents and in order to see an increase in reporting felt that a harsh stand needs to be taken by the Board along with a decision on the outcome for behaviours. Claire Dove reported

that the Trust's consultants are taking racism seriously and are supporting zero tolerance fully. Nathan Askew praised Claire Dove and colleagues for the work that has taken place via the Task Force.

Resolved:
The Board noted the BAME Inclusion Task Force update.

20/21/208 Future of ICSs, Commissioning and Provider Collaboratives.

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

- The strategic direction of system working and the consultation on two proposals to put Integrated Care Systems (ICSs) on a statutory footing in the NHS Bill during spring of 2021. It was reported that a response to the proposals is required by the 8.1.21.
- An overview of Alder Hey's response to a number of questions that were asked by NHSI as part of the consultation.
- An overview of the key comments via three Alliances; Federation of Specialist Trusts, Children's Hospital Alliance (CHA) and the Specialist Trust Alliance.
- The financial framework for 2021/22 and beyond.
- The vision, mission and aims of the Cheshire and Merseyside Health Care Partnership Memorandum of Understanding (MoU), along with Alder Hey's response in for support of the MoU.
- An overview of the response recommendations from the Federation of Specialist Hospitals and Specialist Trust Alliance.
- Following the presentation, the Trust Board was asked to:
  - Agree the proposed key points for the 4 NHSE/I consultation questions.
  - Agree the approach/response via the 3 collaboratives.
  - Agree direction for Cheshire and Merseyside MoU and support proposed return comments.
  - Build upon this via a Trust Board strategic session in February 2021.

The Chair felt that the presentation provided a good insight/analysis and captured a large number of points. Board members were asked for their comments.

Fiona Beveridge asked for assurance that the voice of Alder Hey won't be lost as a result of adopting this approach rather than having a Trust response. The Board was advised that a decision had been made to respond as part of the collaborative to demonstrate the membership of the collaboratives and signal a mutual strength in terms of a response. It was also felt that the responses from the three collaboratives covered the key points that Alder Hey wanted to make.

Louise Shepherd pointed out that collaboratives will eventually become the vehicles in which organisations will work in, and to demonstrate that they are already in place and playing a leadership role is really positive. Attention was drawn to the opportunities that will transpire to enable organisations to work at a strategic level across Cheshire and Merseyside as a result of the new legislation. It was also felt that the system approach outlined could provide a strong platform for Alder Hey to play a leadership role in improving the health and care of CYP.

Louise Shepherd advised the Board that the work that has taken place over the last twelve months from a strategic partnership/clinical network perspective has changed the perception of Alder Hey's role to that of being a supportive one and therefore

has placed the Trust in a better position. There is a concern about the architecture of the provider voice in the Healthcare Partnership Board therefore the CEO Collaborative that meets on a fortnightly basis has been tasked to look at how the Provider Collaboration should look going forward. Questions have been raised at the Healthcare Partnership Board from a governance perspective about the reporting process for children and young people but there is a lack of confirmation due to the uncertainty at the present moment.

Fiona Beveridge acknowledged that the service footprint is broader than Cheshire and Merseyside and queried as to whether there are other consultations taking place in parallel that the Trust should be feeding into, for example, Royal Manchester Children's Hospital (RMCH). It was reported that the NHSE/I consultation is a national one and all responses are being fed back to the national group, but it was pointed out that RMCH are part of the Children's Alliance who are working on the collaboration of members' responses to ensure that each organisation is speaking the same language across the regions.

The Chair asked as to whether there is anything that can be included in the Trust's response to say that this is the direction Alder Hey has chosen to take as it demonstrates better outcomes for children and young people.

The Trust Board felt that the case for submitting responses to NHIS via the three collaboratives was appropriate, and following discussion agreed to approve the Alder Hey response to the consultation that is being conducted by NHSE/I.

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

Louise Shepherd advised the Board that the Health Care Partnership Board recognises the Trust as a lead NHS provider and is really supportive of Alder Hey leading on the children and young people agenda, whilst recognising that this will have to be done in consultation with local Government. It was pointed out that there are a number of proposals around obesity, healthy living and respiratory that the organisation is in a position to lead on. This has been shared with the region in the Trust's first response on the outcomes of children.

Resolved:
The Board approved the Alder Hey response to the consultation process that is being led by NHSE/I to determine the future of ICSs.

20/21/209 Alder Hey in the Park Campus Development Update

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

- It was confirmed that the Alder Centre development is now open. Members of the Board who haven't seen the building were offered the opportunity to visit the premises in January 2021.
- The Executive Design group took place on the 15.12.20 where a number of designs that are being developed on the campus were revealed (*Neonates new build, Mental Health schemes and the Green Engineering scheme*) which provided an opportunity for feedback from attendees at the meeting.

- It was reported that the Developer, Step Places has submitted the planning application for the North East plot of the land.
- *Park reinstatement* - A session is due to take place to discuss the tendering for Phase 2 and Phase 3 of the park re-instatement to agree the requirements and costings of the next phases of the project.
- *Relocations* - The demolition of all respective buildings has been completed and work is taking place on a long-term Estates Strategy which will include a plan for desk/office supporting accommodation for both clinical and non-clinical staff returning on site in April 2021. There are three actions that must be done as part of the Trust's internal estates planning; 1. Look at a temporary off-site solution for Corporate teams who are working mostly from home. 2. Further work is required to provide assurances prior to implementing clinical office changes. 3. There are a number of practical service changes required, mainly around the Fracture Clinic that will be conducted over the next three months.

  The Board was advised that Phase 1 of the park will not complete in December 2020 due to concerns raised by the public on the proposed siting of the Multi-Use Games Area (MUGA), and inclement weather. As a result of these two issues it was confirmed that the completion date will now be towards the end of March. It was reported that the Trust is currently out to further consultation to agree as to whether the MUGA will be sited directly next to Alder Road or more embedded in the park away from Alder Road residents. The Trust has received a lot of feedback from the community and it was reported that the owner of Step Places has raised concerns about the MUGA being situated next to his development.

  It was queried as to whether the Council will be taking ownership of the park once Phase 1 is complete. It was confirmed that this is the Councils intention. In terms of the Trust's reputation as a result of not meeting the completion deadline, the Board was advised that the Trust has met with a number of Councillors and its local MP who have all been very supportive in terms of understanding the vision and the work that needs to be done. A tour of the campus was undertaken by the local MP and his colleague who felt that it was going to be a fantastic facility for the community once complete.

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

20/21/210 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:

- Kerry Byrne asked as to whether the Board would receive a further update on the EU Exit given that it takes place prior to January's Board meeting. The Board was advised that the Trust is in a good position from a stock level perspective and has done everything possible to prepare for leaving the EU on the 31.1.20. The only issue that may create a problem inn 2021 is logistics and supply, but it was reiterated that stock levels are in a good state. Following discussion, it was agreed that an exception report would be circulated to Board members if anything transpires that could affect the plans that have been implemented.

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

20/21/211 Board Assurance Committees

RABD – It was reported that during the meeting on the 14.12.20 the Committee received a comprehensive update on the Inpatient RTT Assurance Review which provided information on key findings and recommendations. The minutes from the meeting held on the 19.10.20 were submitted to the Board for information and assurance purposes

People and Wellbeing Committee – The Board noted the highlight report from the meeting that took place on the 17.11.20. The minutes from the meeting that took place on the 14.9.20 were submitted to the Board for information and assurance purposes.

Innovation Committee – The minutes from the meeting that took place on the 12.10.20 were submitted to the Board for information and assurance purposes.

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

20/21/212 Any Other Business

Ockendon Report

Resolved:
The Board received and noted the contents of the Ockendon report. It was noted that section 4.98 is not applicable to Alder Hey at the present time but this will need to be reviewed once the new Neonatal Unit is open.

20/21/213 Review of the Meeting

The Chair felt that that a lot of progress has been made and recognised the leadership that Louise Shepherd and the Exec Team have provided to the Trust. The Chair wished everyone an enjoyable time over the Christmas period.

Date and Time of Next Meeting: 28th January 2021 at 9:00am via Teams

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 28th of January 2021							
24.9.20	20/21/122.4	Phase 3 Covid-19 Response	*IPC Covid Assurance Framework* - Discuss the possibility of incorporating the IPC Covid Assurance Framework with the BAF – ES/NM/PB	Nicki Murdock/ Pauline Brown/ Erica Saunders	28.1.21	Closed	**22.10.20** - Discussions are taking place in terms of the shape of the integrated framework. An update will be provided in January following the Safety Summit. **27.1.21** It has been agreed that the IPC Assurance Framework will remain as a seperate document but updates will be cross referenced in the BAF cover report. **ACTION COMPLETE**
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	On Track	**27.1.21** - This action will be addressed during January's finance update. **ACTION CLOSED**
17.12.20	20/21/202.1	IPC Covid-19 Assurance Framework	*Flu Vaccine* - Non-Executive Directors to confirm with Karen Critchley as to whether they have received a flu vaccine via their GP practice.	Non-Executive Directors	28.1.21	Closed	**27.1.21** - This action has been completed. **ACTION CLOSED**
17.12.20	20/21/202.1	IPC Covid-19 Assurance Framework	Provide Board members with the most up to date staff self-testing figures.	Nicki Murdock	28.1.21	Closed	**27.1.21** - This action has been completed. **ACTION CLOSED**
Actions for the 25th of February 2021							
03.03.20	19/20/346	Key Issues/Reflections and items for information	Invite the new Nurse cohort from India to the Trust Board lunch and write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff.	Pauline Brown	25.2.21	On Track	This item has been deferred until further notice due to the Covid-19 crisis.
02.06.20	20/21/60.1	Freedom to Speak Up	Compile a breakdown of the issues that SALS have addressed during the current year.	Kerry Turner	25.2.21	On Track	**23.1.21** - This item has been deferred to February due to the governance light committee approach that has been taken as a result of the 3rd wave of the pandemic.
24.9.20	20/21/123.1	DoS – Governance and Safety Rates	Provide an update a further update on the work that is taking place to address governance in the DoS.	Alfie Bass	25.2..21	On Track	**23.1.21** - This item has been deferred to February due to the governance light committee approach that has been taken as a result of the 3rd wave of the pandemic.

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
26.11.20	20/21/177.3	Covid-19 Assurance Plan – Progress Update	*Financial Framework Update* - During the next regional call, query the detail of the incentives if the Trust exceeds its targets.	Rachel Lea	25.2.21	On Track	**17.12.20** - It was confirmed that the incentive model is on hold at the moment. This query has been lodged with the regional office and an update will be provided in due course. **ACTION TO REMAIN OPEN**
26.11.20	20/21/177.4	Covid-19 Assurance Plan – Progress Update	Arrange for a Board strategy session to place in February.	Karen McKeown	25.2.31	Closed	**27.1.21** - A Board Strategy Session has been scheduled for the 25.2.21.**ACTION CLOSED**
Actions for the 25th of March 2021							
26.11.20	20/21/188.1	Board Assurance Framework	Submit the Risk Management Strategy to the Board for ratification in January.	Erica Saunders	28.1.21	On Track	23.1.21 The Risk Management Strategy is to be submitted for ratification in March 2021.
26.11.20	20/21/188.2	Board Assurance Framework	Submit the risk appetite to the Board in March 2021 for ratification.	Erica Saunders	25.3.21	On Track	
17.12.20	20/21/205.1	Corporate Report Divisional Updates	Division of Surgery - Provide an update on the 'Step Programme' in March 2020.	Alfie Bass		On Track	
Actions for the 29th of April 2021							

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

Alder Hey Children's NHS Foundation Trust

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th of January 2021

Paper Title:	**Covid Wave 3 Response – Overarching Plan**
Report of:	**Executives**
Paper Prepared by:	John Grinnell, Deputy CEO/FD

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Winter Plan Wave 1 and 2 response
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:	Re distribution of clinical capacity

COVID Wave 3 Response

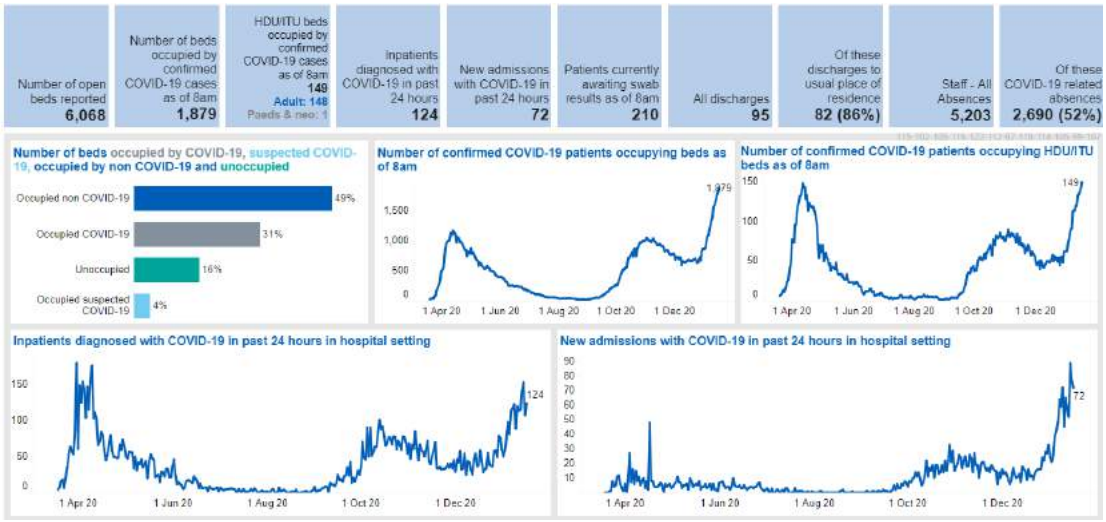
1.0 Introduction

The Board signed off our initial Winter plan in September, however it became clear at the start of January that due to increased infection rates and consequent hospitalisation this needed to be revisited. This plan now updates our clinical and operational response to Wave 3, outlining our role in the system and our continued efforts to maintain access to services for CYP.

2.0 Local context

Cheshire & Merseyside and the wider North West Region triggered the need for collective response to rising hospital admissions, which in some organisations meant half of their bed capacity was being taken by COVID+ patients, and that critical care capacity would be breached by mid-January. This meant all but the most urgent elective cases were to be cancelled and the need for mutual aid was enacted by the hospital cell. For Alder Hey this included the Regional request that we help protect critical care capacity for CYP and also from C & M that we support adult hospitals by re-enacting our plans to care for COVID+ adult ventilated patients. There are key differences between Wave 1 and Wave 3; Wave 3 is taking place during winter pressures, and as much as possible of the elective programme has been sustained (whereas electives shut down in Wave 1). Taking this into account, along with learning from Wave 1 regarding the number of adult ICU beds utilised at Alder Hey, the mutual aid offer for Wave 3 has been agreed as up to 10 adult ICU beds.

The graphic below details the position across C & M as at 17/1 which quite starkly shows the growth in hospital admissions that the system is facing.



This, coupled with high staff absences has put a massive strain on the system. This level of admissions far outweighed the pressure the system faced in wave 1 and has required a corresponding shift in response across the whole service.

Alongside this there has been a need to create capacity to vaccinate our staff and where we can provide support into the wider system.

3.0 Cheshire & Mersey Paediatric Response

Due to the fast-evolving situation that Cheshire and Merseyside (C & M) Hospital Providers are facing due to the COVID-19 pandemic, the C&M Paediatric Network developed an offer of mutual aid to the region to support the increasing pressures on adult critical care services. There is system recognition for a planned and proactive offer, which is possible due to the lower than normal bed occupancy levels within paediatric providers (DGHs ~50%). The offer of support was agreed at C&M Gold Command on 15.1.21 and is based on the following principles:

- Maintain critical care services for CYP
- Where possible, prioritise care closer to home for CYP
- Ensure equity of offers of support across the region
- Recognise while paediatric services can support the region, this will not resolve the adult crisis.

The C&M Paediatric Network prefers a planned approach to mutual aid for adult services across the region, with shared benefit for all Trusts, and shared impact / additional pressures on all of the paediatric units. Any offer of support must also take into consideration co-dependant services including emergency department, paediatric assessment unit, paediatric high dependency patients and neonatal services and therefore closure of DGH paediatric wards should be avoided. The following recommendations were made by the network and form a key plank of Alder Hey's response:

- Maintain all paediatric DGH sites to ensure safe, local and accessible care
- C&M DGHs to reduce capacity by 50% on all sites to release staffing and physical space to support adult services
- Alder Hey to ensure paediatric critical care capacity for the region could open to full capacity if required
- Establish weekly clinical MDT to review patients and facilitate mutual aid
- Alder Hey to establish an adult ICU at Alder Hey (up to 10 patients)
- Alder Hey to develop a contingency plan for 20 inpatient paediatric beds to support C&M paediatric inpatient capacity and non-elective surgery admissions
- Alder Hey to sustain emergency and urgent care, and deliver priority specialist planned care.

4.0 North West Regional Paediatric Response

The North West has two Paediatric Intensive Care (PIC) centres – Alder Hey Children's Hospital and Royal Manchester Children's Hospital.

The Region requires the two services to work in partnership to provide a co-ordinated service for the NW population during the COVID pandemic.

The Region should be able to accommodate children requiring PIC Level care from the NW within our region, or if this is not possible, within the wider North of England PIC Network.

We need to ensure that we retain sufficient capacity for PIC for urgent Trauma admissions, Medical admissions and for P1 and P2 surgical patients, plus patients requiring surgery for which there is a developmental window of opportunity (e.g. Selective Dorsal Rhizotomy).

Current North West Paediatric Intensive Care provision

NHS Trust	PIC Unit	Usual level 3 PIC Beds	Planned Level Paediatric Level 3 beds at OPEL 4	Description of change
Alder Hey Children's Hospital	Alder Hey Children's Hospital	21	24	Commissioned for 21 PICU beds, but have physical space for 24 beds. In HDU, commissioned for 15 HDU beds but have physical space for 19 therefore have the physical space for 27% increase.
Manchester Foundation Trust	Royal Manchester Children's Hospital	15	26	If paediatric critical care OPEL level increases PICU would need to expand into HDU to provide level 3 beds in this footprint. HDU would need to be accommodated in a satellite area.

To date, the planned increase in level 3 beds if at Opel 4 has not been required. COVID-19 is not placing the same demands on Paediatric Services that it is on adult services. We are not seeing COVID-19 related acute respiratory distress cases requiring either PICU or Paediatric ECMO.

Alder Hey are working closely with partners nationally to understand demand relating to PIMS-TS, a paediatric multi-inflammatory syndrome temporarily associated with COVID-19. This is a new condition, and whilst there is currently no RCT evidence, understanding is growing nationally around treatment and spotting early signs to prevent deterioration. Numbers of children affected are currently small in North West region (c. 70-80 children in total across the year) but these are growing slightly in relation to the greater infection rate. A proportion do require PICU and this has further supported the national approach to protect PICU capacity for CYP. NHSE have indicated that should PIMS-TS numbers rise (currently being modelled) PICU sites should be ready to pivot any adult capacity to PICU should beds be needed. Based on current occupancy and relatively small numbers of PIMS-TS requiring PICU at Alder Hey to date, it is expected that our current PICU capacity and surge capacity is adequate to serve. This will be reviewed in line with national modelling from NHSE when it is available.

5.0 Alder Hey Overarching Response

Building on the system requirements and our knowledge of Wave 1 and Wave 2 we wanted to clearly set out the priorities of our response which would guide us through Wave 3 and become a foundation for our decision making.

. Our Priorities in order are:

1) **Ensure paediatric critical care capacity could open to full capacity if required (high priority, but low likelihood)**

2) **Deliver good access to planed care for children and young people**

* theatre schedule to run 67% of pre COVID levels (100 + sessions per week)

* outpatients to sustain full schedule (overall)

3) Establish adult ICU for COVID-19 (up to a maximum of 10 patients)

4) Provide paediatric capacity for Cheshire & Merseyside (up to a maximum of 20 patients in total)

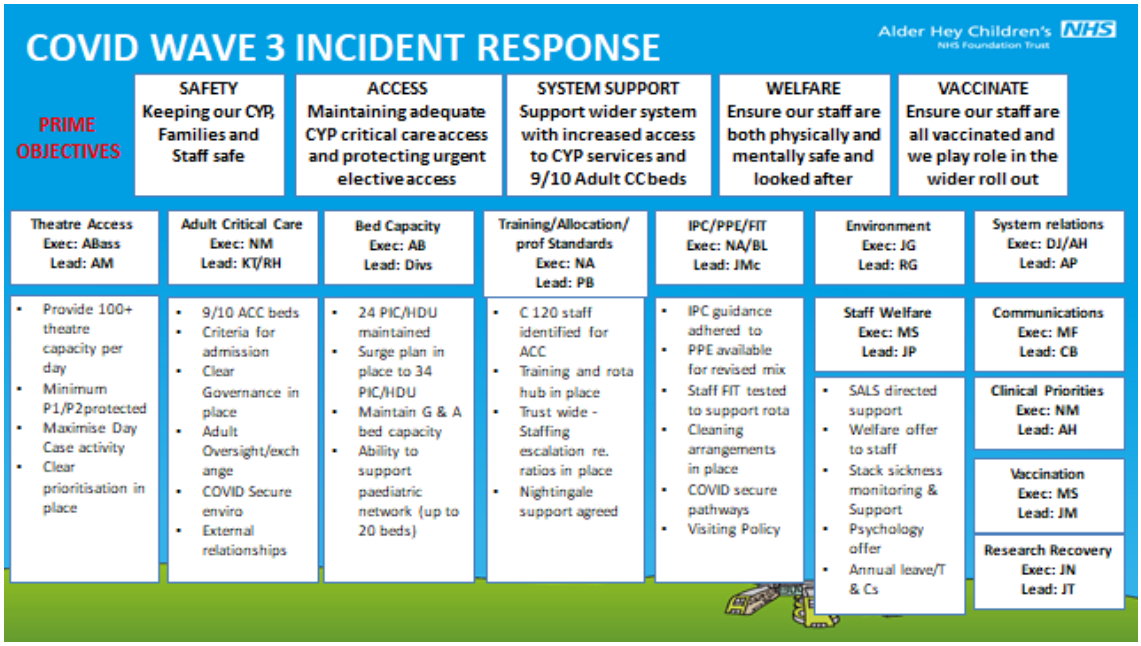
* paediatric inpatients

* inpatients requiring non-elective surgery

5) Some staff volunteers to work at the Nightingale Hospital

6) Vaccinate all of our staff and support the wider system in the vaccination programme

In organising ourselves around these principle we have enacted a full incident response with daily command oversight 7 days a week. We also ensure we are supporting the cell and regional command responses as overseen through Gold command. Our work programme to support this response is summarised below including clear leadership and accountability structures:



This holistic approach has proven critical in ensuring we focus on keeping our staff, CYP and their families safe.

6.0 Key Components of the Plan

6.1 Operational Plan

The Clinical and Operational Teams have re-shaped the capacity of the hospital to maintain access for CYP whilst offering an adult intensive care 9/10 bedded unit, deliver the vaccination programme and where we can offer our teams to those services under pressure in the system. The team have worked tirelessly to ensure we get that balance right in particular that CYP can continue to access services where they need it. This balanced approach has culminated in the following operational plan being put in place:

COVID-19 Capacity Plan

1. **Keep children and young people safe**
2. **Keep staff safe**
3. **Maintain capacity and access to paediatric critical care** for children and young people
4. **Sustain as much theatre capacity as possible**
5. **Sustain outpatient capacity**
6. **Ensue safe staffing of an adult ICU at Alder Hey** (for up to 10 COVID-19 patients) to save lives and support other NHS hospitals and staff in extremis

Priority	Aspect of surge	Capacity
1.	**Accommodate surge from current paediatric critical care capacity to full opening of core capacity**	21 PICU, 15 HDU
2.	**Good access to planed care** for **children** and **young people**	100 theatres (90 elective, 10 emergency)
3.	**Establish adult ICU**	9 – 10 patients Escalation to 10 should not compromise PICU capacity.
4.	**Paediatric G&A capacity for region** a) **Inpatient transfers from a buddy hospital** **b) NEL surgical admissions**	Make available a total of 20 general & acute beds for the region a) 11 medical paediatric G&A beds Note current occupancy at Warrington= 9 paediatric inpatients, and S&0 is 9 inpatients) b) 9 surgical paediatric G&A beds
5.	**Contribute to Nightingale**	Across C&M this will provide + 36 adult beds

Theatre sessions per week

	December	18 January-28 February
Planned & urgent	136	90
Emergency	10	10
Total	146	100

Critical care

	December	18 January-28 February
PICU	21	21
HDU	15	15
Adult ICU	0	10

We recognize this is fast moving situation so require to flex as required and we continue to actively scenario plan as the system pressures emerge.

6.2 Staffing Plan

The Chief Nurse and Clinical Divisions have developed plans to ensure nursing staff, AHPs and Medics are available to support this revised operational model. This in many ways has been more complex than Wave 1 as we are looking to maintain a material level of theatre provision, a full outpatient schedule, operate a 9/10 bedded critical care unit, provide up to 20 beds for the system, run a vaccination programme and where we can support colleagues with staff outreaching to units under pressure.

All revised rotas have been signed off by the relevant professional leads and is within current professional standards. The overarching staffing plan has been signed off by the Medical Director and Chief Nurse.

A separate Board agenda item incorporates the signed off staffing plan for the adult ICU and plans for managing any required surge capacity and or managing higher than anticipated staff absence.

6.3 Clinical Governance Arrangements

We had developed robust arrangements as part of wave 1 and 2 response to ensure we maintain patient safety and had clear governance processes in place. We have developed a robust clinical prioritisation and ethics response to support decision making where access is limited.

The Adult ICU arrangements have been documented and shared with SQAC and is available for reference as **a separate Board agenda item.** This importantly includes our own governance arrangements and the adult oversight and support we are receiving from LUFT and LHCH.

6.4 Vaccination Programme

The team at Alder Hey rapidly implemented a vaccination hub on the hospital site to deliver staff vaccinations. This was a tremendous effort with the first vaccination administered on 6th January. The team here at Alder Hey received three batches of the Pfizer/Biotech vaccine and completed first doses on 20th January. In addition our staffs were offered access to Aintree Hospital and Liverpool Heart & Chests vaccination hub which we are tremendously grateful for. In total as at 21st January 78% of our staff have been vaccinated with their 1st dose and have booked slots for their 2nd dose. A breakdown is below:

No of Staff	3890
First Dose Administered	3037
% Complete	78

Staff Group	Number of Staff	First Dose Administered	% Complete
Add Prof Scientific and Technic	315	237	75
Additional Clinical Services	501	348	69
Administrative	843	657	78
Allied Health Professionals	298	246	83
Estates and Ancillary	232	177	76
Healthcare Scientists	132	115	87
Medical and Dental	335	287	86
Nursing and Midwifery	1234	970	79

	Number of Staff	First Dose Administered	% Complete
BME	290	218	75

Going forward we will continue to have access to the LHCH hub for our staff to get vaccinated using the Pfizer/Biotech vaccine. We are also have arrangements with Clatterbridge Hospital (CCC) who will give our staff access to their hub which is administering the Astra Zeneca/Oxford vaccine. Our vaccination team will be prepared to offer 2nd dose as arranged and support the mutual aid offers from LHCH and CCC.

6.5 Infection Prevention Control

Dr Beatriz Larru and Jo McBride continues to oversee our response to the pandemic in mitigating the risk of SARS-CoV-2 transmission and in providing expert advice and guidance to our staff. A separate IPC Governance paper outlines the actions taken and assurance the Board can take. During this 3rd wave the team have been particularly active in responding to potential nosocomial outbreaks in the hospital, having highly responsive track and trace team and allocating testing in a way that minimises the risk of transmission whilst keeping the hospital operational. At any one time up to 120 staff have been absent from work due to Covid-19 symptoms or self-isolation. This seems to have now stabilised however remains an area of vigilance.

Dr Larru has also worked closely with Public Health England to ensure that Alder Hey takes part in a 'Smart Release' pilot which is running across Fire, police and NHS bodies looking at the safe return to work of staff earlier than the 10 day isolation period using enhanced testing regimes. Should this strategy prove safe and effective, it would mitigate the risk of large staff absence numbers.

6.5.1 PPE Availability

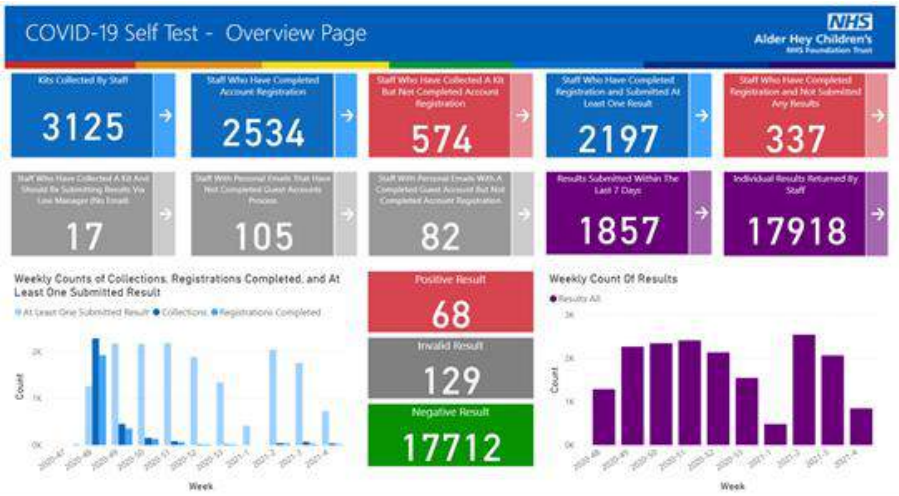
The other key aspect of keeping our staff and patients safe is that we have adequate PPE to respond to the changing care needs of our Wave 3 response. A PPE steering group oversees a forward projection of stock and staff FIT testing which is reported daily through Gold command as shown below:

Department	Assumptions	Surgical Masks	Long Gloves	Short Gloves	Estimate 1860	Estimate 8833	Estimate 1812V	Estimate 3M+ mask	Estimate Mexitin	Estimate fam10 Easy	Solway Mask	Aprons	Non sterile Gowns	Visor	Goggles	Oversleeves
Sub Total Required Per Week		36,755	19,574	130,546	218	117	114	2,597	156	729	1,298	53,924	6,056	5,311	106	0
Contingency	10%	3,676	1957	13055	22	12	11	260	16	1	0	5392	606	531	11	1
Total Required Per Week		40,431	21,531	143,600	240	128	125	2,856	171	780	1,298	59,316	6,661	5,842	117	1
Estimated daily burn rate		5,776	3,076	20,514	34	18	18	408	24	111	185	8,474	952	835	17	0
Stock Count		387,000	73,400	471,300	11,700	11,010	1,520	32,100	12,980	4,760	5,220	192,400	58,260	17,980	1,310	24,000
Offsite stock (ACC location)		116,900											29,700	200		
Total Stock		503,900	73,400	471,300	11,700	11,010	1,520	32,100	12,980	4,760	5,220	192,400	87,960	18,180	1,310	24,000
Number of weeks supply		12.46	3.41	3.28	48.73	85.76	12.15	11.24	75.74	6.10	4.02	3.24	13.20	3.11	11.23	24000.00
Number of days supply		87.24	23.86	22.97	341.08	600.34	85.04	78.67	530.16	42.72	28.14	22.71	92.43	21.78	78.64	168000.00
Forecasted day Remaining and RAG Week Commencing																
wc 18th January		85.44	16.86	20.05	334.08	593.34	78.04	71.67	523.16	36	30.20	15.71	85.43	15	72	167,993
wc 25th January		81.21	19.62	21.16	327.08	586.34	71.04	64.67	516.16	29	32.26	20.51	78.43	15	65	167,986
wc 1st February		76.98	22.37	21.47	320.08	579.34	64.04	57.67	509.16	22	34.32	13.51	71.43	15	58	167,979
wc 8th February		72.75	25.12	21.78	313.08	572.34	57.04	50.67	502.16	15	36.37	18.31	64.43	15	51	167,972
wc 15th February		68.52	27.88	22.10	306.08	565.34	50.04	43.67	495.16	8	38.43	11.31	57.43	15	44	167,965
wc 22nd February		64.29	30.63	22.41	299.08	558.34	43.04	36.67	488.16	1	40.49	16.11	50.43	15	37	167,958
wc 1st March		60.06	33.38	22.72	292.08	551.34	36.04	29.67	481.16	-6	42.55	9.11	43.43	15	30	167,951
wc 8th March		55.83	26.38	23.03	285.08	544.34	29.04	22.67	474.16	-13	44.61	13.91	36.43	15	23	167,944
wc 15th March		51.60	29.14	23.34	278.08	537.34	22.04	23.02	467.16	-20	46.66	18.71	29.43	15	16	167,937
wc 22nd March		47.37	31.89	23.66	271.08	530.34	15.04	23.37	460.16	-27	48.72	23.51	22.43	15	16	167,930
wc 29th March		43.14	34.64	23.97	264.08	523.34	8.04	23.72	453.16	-34	50.78	28.31	15.43	17	16	167,923
wc 5th April		38.91	27.64	24.28	257.08	516.34	1.04	24.08	446.16	-41	52.84	21.31	29.45	17	16	167,916
wc 12th April		34.68	30.40	24.59	250.08	509.34	-5.96	24.43	439.16	-48	54.89	26.11	22.45	17	16	167,909
wc 19th April		30.45	33.15	24.90	243.08	502.34	-12.96	24.78	432.16	-55	56.95	30.92	36.47	17	17	167,902
wc 26th April		26.22	35.90	25.22	236.08	495.34	-19.96	25.13	425.16	-62	59.01	23.92	29.47	17	17	167,895
wc 3rd May		24.41	28.90	25.53	229.08	488.34	-26.96	25.48	418.16	-69	61.07	28.72	22.47	18	17	167,888
wc 10th May		22.61	31.66	25.84	222.08	481.34	-33.96	25.84	411.16	-76	63.12	21.72	15.47	18	17	167,881
wc 17th May		20.80	34.41	26.15	215.08	474.34	-40.96	26.19	404.16	-83	65.18	26.52	8.47	18	17	167,874
wc 24th May		19.00	37.16	26.46	208.08	467.34	-47.96	26.54	397.16	-90	67.24	31.32	1.47	18	18	167,867

Current stock levels remain adequate with plans to flex mask usage where any shortfalls are identified so that alternative stock can be utilised. National 'Push' stock from the centre is flowing well in comparison to the first wave and our risk level in this area has been down-graded.

6.5.2 Staff Testing

The Trust has also participated in the Government scheme to ensure there is weekly NHS staff testing using home Lateral Flow Tests. In December 3125 home test kits were distributed to our staff, each kits included 3 months of supply assuming tests were carried out twice per week. Through a self-developed App staff can log their tests so we can have a central record. The dashboard below summarises the output from the App and details 17,712 tests being registered with 68 positive tests, a 0.38% positive rate. We have ordered a second batch for distribution and will continue to urge staff to complete their tests as a first line defence.



6.6 Staff Welfare

The plans we put in place at the start of the pandemic to support our people have provided a solid platform from which we have been able to respond swiftly to what our staff have needed in Wave Three. Specifically, we have:

- Benefitted from increased psychology resource in the SALS team to support a growing demand for general wellbeing issues from staff across the organisation, and have also developed a bespoke programme of support for colleagues working in ICU, with both adults and children. Working in partnership with the Clinical Health Psychology Team, the SALS team have developed an action plan which addresses both physical and psychological needs of colleagues who are permanently based on ICU, and those who have volunteered to support the ICU effort. Examples of this support range from better access to food and drink and regular breaks, increased direct psychological support, information and guidance and the set-up of a 'wobble room', a safe space for staff to retreat to if things are difficult.
- Ensured all T&C guidance is up to date, including decision making on key areas such as clarification of annual leave, sickness arrangements and pay, support for those having to shield again and local pay arrangements for additional work. We continue to work closely with Trade Union colleagues and meet every fortnight to discuss all COVID related people issues.
- Continued to manage sickness absence, with a focus on those staff on long-term sick (not covid related)

6.7 Environment

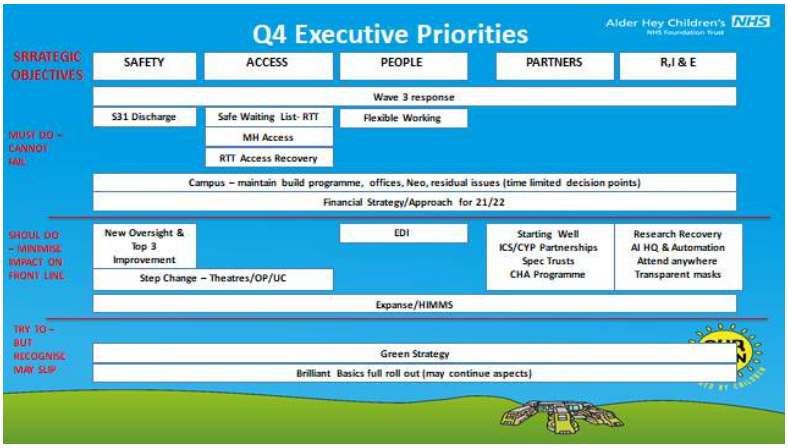
Russel Gates continues to oversee an Environment Group whose main focus is ensuring we are enabling IPC protocols be adhered to. The Group actively monitor flow around the hospital and have been improving staff break out spaces (new Institute café now open), COVID secure reviews and actions in place, adequate storage facilities. Other than regularly reminding individuals of their responsibility to wear appropriate PPE and socially distance there is control over the hospital environment.

6.8 Communication

Whilst we have maintained a high level of communication throughout the pandemic we have further stepped this up during Wave 3. This includes twice weekly live briefings with open Q & A which is recorded, special live events and grand rounds on topics such as vaccination, and all manager briefings on key topics. This is in addition to the communication tools already in place which include the COVID hub which has significant amounts of information and FAQ's and bi-weekly full written COVID briefings to all staff. We will continue to ensure that communicating the latest position and our response is a key pillar of our response and helping our staff feel informed and engaged.

7.0 Governance arrangements and key priorities

As with Wave 1 and in accordance with a reiteration of support from NHS E/I on the 11th January for organisations to minimise activity unrelated to the COVID effort, we have enacted a 'Governance Lite' model that includes us maintaining our Board and sub-committee assurance however with slimmer agendas focussing on key issues and risks. Similarly for internal meeting any non- urgent have been cancelled. To further support this we have done a rapid review of Q4 priorities to ensure we create the focus to support our response and where necessary we continue to drive forward activities that will support our recovery and strategic objectives. This is a fluid position so we will assess regularly however our current approach is outlined in the graphic below:



8.0 Key Risks

The Board will continue to receive a specific Wave 3 COVID response risk register as a substantial agenda item. The key themes however remain:

- Access to care
- Risk of infection to our CYP, Families and staff
- Increased risk to staff welfare
- Uncertain system and financial environment
- Meeting demand for Mental Health Services

9.0 Conclusion and Recommendation

The Board are asked to note and approve the summary plans as part of our Wave 3 response and supporting documentation.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th of January 2021

Paper Title:	**Adult ITU Governance Arrangements**
Report of:	**Nathan Askew, Chief Nurse & Nicki Murdock, Medical Director**
Paper Prepared by:	Nathan Askew, Chief Nurse

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Winter plan and emergency covid response ICU Pandemic Staffing Policy for the management of Deceased Adult Patients COVID19 admission checklist Adult patient arrival flow chart Transport checklist IPC guidance relating to the care of adult patients Prone position in adult critical care guideline Risk management strategy Safeguarding adults' policy Safeguarding children policy
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:	Impact of redeployment of staff and associated reduction in theatre list availability

1. Introduction

Alder Hey has been requested to open a 9 bed adult ITU within the critical care floor to provide additional support to the system in response to the current covid 19 pressures. This paper provides the board with an overview of the governance arrangements and links to several other documents that support the care of adult patients in ITU

The pandemic staffing model and process of redeployment for staff are included specifically which has been based on feedback from staff who were redeployed as part of the wave one response.

The governance arrangement are supported by the Medical Director and Chief Nurse.

2. Background

The NHS moved to response level 5 in relation to the covid 19 pandemic, meaning that the NHS is likely to be overwhelmed within 21 days. The discovery of a new variant of the virus, in combination with reduced public compliance with social distancing measures, has led to a large increase in positive tests and hospital admissions.

The ITU provision in London and the South East is under significant pressure and this has started to be reflected within the Cheshire and Merseyside position. Given the huge increase in pressure on the wider system Alder Hey have been requested to offer mutual support.

The preferred option of support was to open a 9 bedded adult ITU at Alder Hey, with the ability to surge to 10 adult patients if needed

3. Situation

To provide support to the sider system there is a need to ensure that the risks of caring for adult patients in a peadiatric setting are mitigated and that we continue to provide high quality care to the children and young people of Cheshire, Merseyside and beyond.

The attached papers clearly articulate the arrangements for adult patients and ensuring that governance arrangements for this are in place. This model was deployed during wave 1 of the pandemic and the Trust have been able to learn and improve on that response and build the learning into this response.

The Trust have in place a winter and covid 19 emergency plan that covers the mitigations in particular for staffing of the rest of the organisation to ensure that children and young people get access to high quality care.

4. Recommendations

The board are requested to approve the governance arrangements as described and note the improved approach to the redeployment of staff.

Alder Hey Children's NHS
NHS Foundation Trust

Governing Processes for Adult Patients Accessing Alder Hey Paediatric Intensive Care.

The global pandemic of Covid-19 has placed additional pressure across all NHS resources and services. Alder Hey Children's Hospital NHS Trust have committed to support regional increase in demand for acute adult services by supporting the care of adult Covid positive patients requiring intensive care support and facilitating up to 10 intensive care beds (surge model).

Pod 5 will be used to provide care for Adult ICU patients and has been set up appropriately. The standard bed space capacity available is for 9 adult patients with capability to 'surge' to 10 adult patients if critically required. This decision will be made between the Clinical Director for Intensive Care and the Medical Director at the point of requirement and based on impact to other patients, service provision and regional picture of current pressure level.

All documentation relating to the management of Covid patients within PICU can be found on the Critical Care intranet page and folder Covid-19 2021 which can be accessed via this link:

http://intranet/DocumentsPolicies/PICU%20Information/Forms/Front%20Page.aspx?RootFolder=%2FDocumentsPolicies%2FPICU%20Information%2FCOVID%2D19%202021&FolderCTID=0x012000FAA336270A492A44B91CDE714BAA54D5&View={A0A03346-BC5B-4ADB-A531-9B9A3BEB07D2}

This document provides an overview of governance arrangements specifically relating to the care of this patient group.

Clinical Governance

Current arrangements in relation to clinical governance within the Intensive Care Unit will continue in line with trust policy and process.

Dr Nicki Murdock is the executive lead for the adult critical care. Dr Kent Thorburn (Clinical Director ICU) and Alison Fellowes (Ward Manager) will maintain oversight and review of incidents and issues and escalate these in line with divisional process.

The Intensive Care department meet weekly on Wednesdays to discuss current issues and any pertaining to adult patients will be addressed during this.

Incidents relating to the care of adult patients should be reported via the trust incident management system (Ulysees) and investigated through the usual Trust processes.

A risk has been added to the system relating to providing care for adults within a paediatric centre, this is risk number 2343 and will be updated in line with Trust policy and process.

Safeguarding

The risks posed by having adult patients in a paediatric facility are largely mitigated as the patient group for admission will be covid positive, intubated and ventilated, nurses securely in one adult pod and will be repatriated to their local hospital once extubated and clinically stable.

The Alder hey Safeguarding team will ensure that relevant aspects of adult safeguarding (such as identifying patients who are sole carers for other vulnerable adults) and working with external agencies to coordinate responses as required. The Family Liaison team will work with the safeguarding team to ensure that we meet our statutory requirements in relation to this.

Staffing Arrangements

Staffing requirements have been outlined to provide safe and adequate care to up to 10 Adult patients and 21 Paediatric ICU patients.

Nursing staffing is outlined in the 'Intensive Care Pandemic Staffing Model'; this is stored on the intranet under the Critical Care page, Covid-19 2021 folder.

Medical staffing rota for the adult ICU Pod will consist of: (rota's to be held locally)

	Day	Night
Consultant Intensivist	1	1
Anaesthetic Registrar	1	1
ICU Trainee	1	1
Anaesthetic Consultant	1	x

The proning team will support with movement and turns of patients on a planned rota at proning rounds twice per day. This rota is held on MS Teams.

Physiotherapy support is provided on a rota basis to provide:

	Day (0800-2100)	Night
Weekday	3 + proning	1 on call paeds and adult cover
Weekends	3 + proning	1 on call paeds and adult cover

Staff Wellbeing

Psychology support will be available throughout weekday 9-5 working hours. A pastoral support role will be available 24/7.

A wobble room for staff needing some quiet time is being created within PICU. Staff will have access to a range of support services which will either be through self-referral or through discussion and signposting with the SALS service.

Partnership working arrangements:

Our partner organisation in support of the management of patients within Alder Hey ICU at this time is the Royal Liverpool University Hospital Foundation Trust. On commencement of the first patients

arriving to the unit a site visit for support will be undertaken by an adult Intensivist from either Aintree University Hospital or the Royal Liverpool Hospital (both members of RLUHT).

Subsequent supportive visits will be undertaken on an ad-hoc basis, however virtual ward rounds will also take place at 12:00 daily.

Medical and Surgical speciality support is also available 24/7 via the RLUH switchboard and asking for the relevant speciality on call Registrar or Consultant.

Main Switchboard: 0151 706 2000 (Royal Liverpool Hospital).

24/7 support is available from Adult Intensive Care Consultant at Royal Liverpool Hospital contact details are:

Direct Line to ICU: 0151 706 2400 ask for Duty ICU Consultant

Details for direct contact with Adult Cardiology Consultant at Liverpool Heart and Chest are attached as Appendix 1.

Clinical Guidelines and Protocols:

All patients cared for within the unit will be clinically managed in line with all protocols and guidelines currently used within the Royal Liverpool Hospital NHS Trust (RLUHT). These can be located on the Critical Care intranet page and folder Covid-19 2021.

Local checklists have been amended (where appropriate) in line with those at RLUHT and are available on the Critical Care page and folder Covid-19 2021.

Admission route into the unit:

The patients will be transferred via ambulance, into the unit through the helipad entrance and along the corridor to pod 5.

If weather impacts the ability to do this then the route via the ED corridor and through the 'hot lift' will be utilised instead.

This process is outlined fully in the SOP (Appendix 2).

Decision to Admit:

Daily regional network meetings (Gold) will be attended by a Consultant Intensivist on a rota basis, these meetings take place on MS Teams daily at 1130.

Decision to admit will be co-ordinated via this meeting based on the area of greatest needed and undertaken in conjunction with the regional network co-ordinator.

Referring centres will be required to complete a Consultant to Consultant referral prior to transfer.

Repatriation back to local hospital:

A reciprocal agreement is in place with local Trusts to ensure that patients can be repatriated back to the Trust from which they were originally transferred. Repatriation will be coordinated via the regional network meeting, preferably back to the referring trust but within region based upon bed availability.

Transfer back to host trust will be completed the AH transfer team, this SOP is located on the intranet in the Critical Care page and folder Covid-19 2021.

Management and transfer of deceased patients:

Deceased patients will be cared for in line with local guidance which can be located on the intranet in the Critical Care page and folder Covid-19 2021.

All deceased patients will be repatriated to their referring centre.

Emergency Evacuation:

Temporary evacuation action cards outline the process for evacuation of adult patients from Pod 5 should this be required (Appendix 3).

Equipment required will be assessed in accordance with each patient's clinical condition at the time of evacuation.

Pharmacy Support

Staffing

Additional pharmacist staff rota'd to support PICU, releasing experienced staff to support adult ICU

We will be increasing the number of pharmacists providing services on PICU/ ICU across 7 days

All regular Pharmacy staff visiting ICU staff have been fit tested and updated that testing within the last 12 months

Technical staffing support is available across the week to top stocks of medicines up

Medicines

We have re-configured the omnicell cabinet (drug storage unit) for the adult POD to take additional adult drugs, increased stocks of standard drugs and different presentations of drugs – such as pre-filled syringes and higher strengths of drugs

We have sourced some pre-filled syringes where we can to support nursing staff and remove the need for them to prepare syringes

CD storage has been reconfigured and stock holding revised

We have prepared 10 emergency boxes – 1 for each bed specifically for the Covid pod.

We have also advised the commercial medicines unit that our usage patterns for drugs will be different from usual when we take adults and therefore historical allocations of medicines should not be used to inform stock requests. They have acknowledged this.

We have preparations in place to provide the adult clinical Trials for COVID 19

We have increased stock holding of a number of drugs in the Pharmacy dept (antibiotics/sedatives/heparins etc) as well as at ward level

Medical gases

Oxygen – we have advised BOC that usage may increase – both of cylinders and from the VIE. The medical device committee reviewed current oxygen consumption percentage and advised that there is enough available capacity to support additional adult patients.

RRT (renal replacement therapy)

Stocks of Haemosol for Haemofiltration are being monitored centrally each week by return; we have ample stock in hand currently

Infection Prevention and Control

Daily infection control rounds will be undertaken to provide assurance with Trust policies and to ensure that any issues are identified early and resolved swiftly.

All SOP's relating to IPC and checklists for daily walk rounds are located on the intranet in the Critical Care page and folder Covid-19 2021.

Cleaning and Domestic Cover

Cleaning and domestic support has been planned to ensure minimal flow through the unit and to limit exposure of support staff, whilst maintaining an adequate standard for patients and staff.

Day

- AM cleaning before 0900 and bin run
- Midday bin run only
- PM cleaning and bin run.

Night

- Bin run and clean late night/ early morning.

Cleaning will be undertaken in line with national standards. The SOP's and schedule for this are located on the intranet on the critical care page in covid-19 2021 folder.

Procurement and Materials Management

Procurement is providing ICU with a full inventory managed service for PPE, in partnership with the ICU Medical Team and the Inventory Management Team. Appropriate levels of PPE consumables have been determined (Appendix 4).

The Inventory Managed team will visit ICU twice a day to ensure PPE consumables are topped up to the Maximum level.

The Emergency Store can be accessed via Bed Management for any additional out of hours if needed.

Appendix 1

Details to contact Adult Cardiology Consultant at Liverpool Heart and Chest Hospital:

1. Phone calls should be made by the most senior clinician available to ensure the case details are as clear as possible and the advice clearly understood
2. Please phone LHCH switchboard on 0151 600 1616
3. Identify yourself as calling from the intensive care unit from Alder Hey
4. Ask to be put through to the mobile phone of the on call consultant for 'EP and pacing'
5. If they cannot be contacted, ask to be put through to the registrar on call on bleep 2751. Inform them that you need urgent advice from the EP and Pacing consultant and give them a telephone number to which the consultant should return a call. The registrar will locate the consultant and pass on the message.
6. It will be very helpful if you can provide copies of ECG's etc. Our preferred way of doing that is to use our web-based urgent referral system which can be accessed at https://urgentreferrals.lhch.nhs.uk/ (select the 'Heart Rhythm' option for the service required)

   Failing that images could be e-mailed to the consultant concerned or, as a last resort, faxed to 0151 600 1699
7. In the unlikely event that you feel you need us to review the patient in person, please request this through the EP and Pacing consultant. We will identify here the most appropriate clinician to visit Alder Hey.

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Appendix 2

RESPONSE FLOWCHART FOR ADULT PATIENT ARRIVING AT ALDER HEY VIA AMBULANCE

ICU to PICU Consultant
Adult Transfer agreed

↓

PICU Consultant or PICU Coordinator notifies Patient Flow Team
- Adult patient accepted
- Expected time of patient arrival

↓

Patient Flow Team to contact:

- Security (Bleep 346/356) and Interserve (Bleep 800) with ETA
- Interserve will confirm if access via helipad to ICU is available

If helipad route not available, patient should arrive via ED ambulance entrance and access ICU via the hot lift

↓

20 minutes prior to arrival, Patient Flow Team notifies the following of the access plan

- Interserve (Bleep 800) & Security (Bleep 346/356)
- PICU Coordinator
- ED & Radiology if accessing their corridors

↓

Arrival via helipad

Interserve to flag ambulance through the site and shut helipad gates when ambulance entered.

Security to stand by ED entrance in case NWAS miss the route and re-direct ambulance. Then move to meet Interserve/NWAS

ICU staff member greet transfer team at the helipad, escort to pod 5

Arrival via ED entrance

Interserve to stand at ED entrance and prevent ambulance accessing helipad

ICU staff member greet transfer team in the ambulance bay, escort to pod 5

Security to escort transfer team to the hot lift; open doors and call the lift (do not enter lift with patient)

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Appendix 3

TEMPORARY EVACUATION PLAN POD 5 ADULT ICU

ACTION CARD - POD TEAM LEADER

ON BEING ALERTED TO THE INCIDENT

1. Instruct all staff to remain at the patient bedside or within the pod to assist with evacuation if required.
2. Inform senior clinician in the pod.
3. Prior to arrival of Emergency services, the decision to evacuate will be made by the Trust Tactical manager in charge, Senior Doctor and Critical Care Coordinator/s and will depend on type of incident and location of incident.
4. Contact Recovery Coordinator (ext 4866 or Bleep 353 out of hours). Inform them of incident and need to potentially evacuate to theatre recovery.

PREPARE TO EVACUATE

1. Give the order to bed side nurses to prepare to evacuate.
2. Inform theatre recovery you are preparing to evacuate, request any available staff to come and assist with the transfers. (Need to be in airborne PPE)
3. Allocate patients to specific evacuation points (bays 1-9 theatre recovery)
4. Allocate spare staff to each bed to assist with transfer, once staff have left the pod they cannot return.
5. Request doffing staff to retrieve additional oxygen cylinders or equipment required to support the transfer to theatre recovery.
6. Allocate staff to prepare emergency trolleys/resuscitation equipment/spare ventilators/drugs to move with patients on evacuation.
7. Liaise with clinician to determine order of evacuation.

ON EVACUATION

1. Inform theatre recovery you are commencing evacuation.
2. Evacuate patients in immediate danger.
   Emergency evacuation – evacuate most stable patients first
   Controlled evacuation – evacuate unstable patients secondary
3. Roll call of staff and patients at all evacuation points.

TEMPORARY EVACUATION PLAN POD 5 ADULT ICU

ACTION CARD - NURSE AT BEDSIDE & BUDDY

PREPARE TO EVACUATE ORDER GIVEN

1. Attach hand ventilation circuit to portable oxygen cylinder
2. Collect following essential items and place on bed/cot
    - Appropriate size face mask
    - Ambu bag of appropriate size
    - Selection of appropriate size suction catheters/yankuers
    - Mucus trap for emergency suction
    - All patient paperwork/charts/prescription sheets
    - Stethoscope
    - Tracheostomy tray if appropriate
3. Check lines and infusions – have enough white caps/curos to cap off non-essential lines if order to evacuate is given
4. Collect supply of essential drugs that may not be available at evacuation point.
5. If inotropes are running, check adequate volumes in syringe and attach syringe pumps to cot/bed/mobile stacking unit.
6. Ensure patient has adequate level of sedation/paralysis as prescribed.

ORDER TO EVACUATE

1. Await instructions from Pod Team Leader
2. Stop continuous nasogastric feeds and leave NG tube on free drainage.
3. Disconnect and cap off maintenance fluids and non-essential lines.
4. Disconnect monitoring lines from transducer and cap off.
5. Clamp chest drains and place on bed/cot **immediately** before moving.
6. Remove small monitoring module from side of main monitor.
7. Attach patient to hand ventilation set up and switch oxygen cylinder on. Switch main oxygen off.
8. Ensure all essential equipment is transferred with patients.

AT EVACUATION POINT (Theatre Recovery)

1. Remain with your patient/s
2. Attach oxygen/suction to main supply.
3. Connect monitor module to main monitor if available. Small module will provide 2-3 hours battery life.
4. Plug in equipment to main supply
5. Transfer patient on Meditech

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TEMPORARY EVACUATION PLAN POD 5 ADULT ICU

ACTION CARD – SENIOR CLINICIAN

PREPARE TO EVACUATE ORDER GIVEN

1. Review patients to establish evacuation priority – stable patients first.
2. Allocate junior doctors to support preparing unstable patients for transfer.

ORDER TO EVACUATE

1. Patients to be evacuated in order of priority.
2. Junior doctors to escort unstable patients during transfer.

AT EVACUATION POINT (Theatre Recovery)

1. Assess all patients to ensure settled following move.
2. Liaise with bed side nurse to ensure they are happy with patient.

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Appendix 4

Department	Assumptions	Surgical Masks	Long Gloves	Short Gloves	Estimate 1863	Estimate 8833	Estimate 1873V	Estimate 3M+ mask	Estimate Mexein	Estimate fsm18 Easy	Aprons	Non sterile Gowns	Theatre Gowns	Visor	Goggles	Coveralls	Oversleeves
Stock Count		419,450	57,600	663,200	12,800	11,250	1,590	31,920	13,140	690	139,800	50,950	70	20,910	1,310	5,170	24,000
Offsite stock (ACC location)		116,900										38,180		200			
Total Stock		536,350	57,600	663,200	12,800	11,250	1,590	31,920	13,140	690	139,800	89,130	70	21,110	1,310	5,170	24,000
Number of weeks supply		13.27	3.51	4.63	26.06	151.05	9.83	26.44	62.20	6.31	2.73	20.98	6.36	6.71	11.23	5170.00	24000.00
Number of days supply		92.86	24.57	32.39	182.41	1057.36	68.81	31920.00	13140.00	44.19	19.10	146.89	44.55	46.96	78.64	36190.00	168000.00
Forecasted day Remaining and RAG Week Commencing																	
wc 11th January		91.06	17.57	30.27	175.41	1050.36	61.81	30712.92	12928.76	37	12.10	139.89	419.36	40	72	36,183	167,993
wc 18th January		89.25	10.57	30.60	168.41	1043.36	54.81	29505.84	12717.52	30	18.77	132.89	794.18	33	65	36,176	167,986
wc 25th January		82.25	3.57	30.92	161.41	1036.36	47.81	28298.77	12506.28	23	11.77	125.89	1169.00	26	58	36,169	167,979
wc 1st February		80.44	-3.43	31.25	154.41	1029.36	40.81	27091.69	12295.05	16	18.43	118.89	1543.82	19	51	36,162	167,972
wc 8th February		78.64	-10.43	31.58	147.41	1022.36	33.81	25884.61	12083.81	9	11.43	111.89	1918.64	12	44	36,155	167,965
wc 15th February		71.64	-17.43	31.90	140.41	1015.36	26.81	24677.53	11872.57	2	18.09	104.89	2293.45	5	37	36,148	167,958
wc 22nd February		69.83	-24.43	32.23	133.41	1008.36	19.81	23470.45	11661.33	- 5	11.09	97.89	2668.27	- 2	30	36,141	167,951
wc 1st March		68.03	-31.43	32.55	126.41	1001.36	12.81	22263.38	11450.09	- 12	17.76	90.89	3043.09	- 9	23	36,134	167,944
wc 8th March		61.03	-38.43	32.88	119.41	994.36	5.81	21056.30	11238.85	- 19	17.59	83.89	3417.91	- 15	16	36,127	167,937
wc 15th March		59.22	-45.43	33.20	112.41	987.36	-1.19	19849.22	11027.61	- 26	17.42	76.89	3792.73	- 20	9	36,120	167,930
wc 22nd March		57.41	-52.43	33.53	105.41	980.36	-8.19	18642.14	10816.37	- 33	17.25	69.89	4167.55	- 26	2	36,113	167,923
wc 29th March		50.41	-59.43	33.86	98.41	973.36	-15.19	17435.06	10605.14	- 40	17.08	62.89	4542.36	- 32	- 5	36,106	167,916
wc 5th April		48.61	-66.43	34.18	91.41	966.36	-22.19	16227.99	10393.90	- 47	16.91	55.89	4917.18	- 37	- 12	36,099	167,909
wc 12th April		46.80	-73.43	34.51	84.41	959.36	-29.19	15020.91	10182.66	- 54	16.75	48.89	5292.00	- 43	- 19	36,092	167,902
wc 19th April		39.80	-80.43	34.83	77.41	952.36	-36.19	13813.83	9971.42	- 61	16.58	41.89	5666.82	- 49	- 26	36,085	167,895
wc 26th April		38.00	-87.43	35.16	70.41	945.36	-43.19	12606.75	9760.18	- 68	16.41	34.89	6041.64	- 54	- 33	36,078	167,888
wc 3rd May		36.19	-94.43	35.48	63.41	938.36	-50.19	11399.67	9548.94	- 75	16.24	27.89	6416.45	- 60	- 40	36,071	167,881
wc 10th May		34.39	-101.43	35.81	56.41	931.36	-57.19	10192.60	9337.70	- 82	16.07	20.89	6791.27	- 66	- 47	36,064	167,874
wc 17th May		27.39	-108.43	36.14	49.41	924.36	-64.19	8985.52	9126.47	- 89	15.90	13.89	7166.09	- 71	- 54	36,057	167,867

Actions taken to improve position:

- Long Gloves - push stock switched back on and alternative supply options being explored. Discussion wittyh IPC/PICU re mitigation of short gloves and oversleeves as alternative, however expecting supply to be resolved ASAP.
- Masks – increaisngly high burn rate of 220 per day just on Adult PICU if use full disposabkle. Procurement in dialogue with Fit testing and clincial leads re use of reusbale makss and fit testing on makss that are in full supply.
- Aprons – order already placed for 300,000 therefore not expect to be an issue, supply available.
- Visor –push stock switched back on

Further update to be provied at strategic command/execs

Redeployment of staff to ITU during a pandemic

Introduction

Alder Hey Childrens Foundation Trust previously increased ITU capacity as part of the national surge programme during wave one of the COVID-19 pandemic. Since wave one much learning has been incorporated into planning for future instances of surge.

Alder Hey are committed to ensuring the continued provision of high quality safe and effective care for children and young people throughout the ongoing national pandemic. To this end Alder hey will only provide care to adult ITU patients as part of a regional or national instruction to provide care to adults in a PICU setting.

The Trust must be ready to enact a plan based on national guidance and best practice to facilitate the expansion of ITU to provide care to adults, or indeed should the need arise more children and young people. The Trust should also be ready to move to alternative models of providing acute ward based care which may be impacted by the pandemic staffing of ITU capacity.

This document sets out clear expectations and responsibilities to ensure that staff are fully prepared for redeployment during a pandemic incident. It is based on feedback from staff who were redeployed during wave 1 of the COVID 19 pandemic and is supplemental to the information in the Alder Hey winter & covid19 emergency response plan (Appendix 1) and Advice on acute sector workforce models during COVID-19 (appendix 2).

This guidance relates specifically to the AHP and Nursing workforce, including therapy assistants, Health Care Support Workers, Assistant Practitioners and all other groups under the AHP and Nursing workforce.

Prior to redeployment

In times of extreme pressure staff with relevant skills and abilities may be required to be redeployed. There should be clear expectations set out about the role they are being asked to undertake.

There will be a requirement for essential services to be staffed and line mangers are responsible for ensuring the correct staff remain in place to run these services. The Trust has a clear staffing escalation plan which will be invoked at ward and department level to enable the release of staff for redeployment.

The impact in wave 1 of the pandemic required the movement of staff into ITU to increase surge capacity. Prior to redeploying staff PICU should move to the pandemic staffing model (attached as appendix 3). More detail about this model can be found in appendix 2.

This changes the model from 1:1 PICU nurse led care to 1:2 PICU nurse led care, with a registered professional working as a ‘bed buddy’. The Bed buddy should provide basic care such as

- eye / mouth care
- personal care
- the recording of observations
- preventing a patient self-extubating

- calling for assistance when required

Bed buddies **may** provide additional care within their scope of practice and competence, the minimum level care to be expected is described above. The PICU nurse and the bed buddy will **work as a team** to provide total patient care to both patients. The PICU nurse will be professionally accountable for ensuring all aspects of care are delivered to both allocated patients.

Administration of medication, management of infusions, management of ventilation and the management of invasive monitoring remain the responsibility of the ITU trained nurse. The bed buddy may take a role in this if they are competent to do so.

It is essential that PICU staff are aware of the above minimum requirement and the need to move to team based care. The professionals being asked to move into the bed buddy role should be fully aware of the minimum level of competence required.

Some patients (those requiring ECMO or complex patients in multi-organ failure) may not be suitable to move to the new staffing model. Patients to be excluded from this model will be assessed as such by the ITU consultant.

It should also be noted that Adult COVID-19 patients are often complex and challenging to manage, Therefore there may need to be increased ITU staffing in this areas to ensure that the patients receive the correct level of supervision and care. This will be directed by the ITU consultant and Lead nurse for the area.

There are staff within the organisation who have skills and knowledge of looking after adult critical care patients. These staff will be asked to volunteer to support the adult critical care unit and their usual roles backfilled as required.

Prior to any staff moving the following actions should be undertaken:

- Staff moved to PICU will be asked to undertake the role which is reflective of their level of skills. **Category A** nursing staff will be those with recent critical care experience and will work as a critical care nurse, all other nursing staff will work as a **category B** nurse, this will be the bed buddy and may involve other professional groups who are not registered nurses.
- Other professionals may be asked to work within specific teams such as the proning team or provide additional physiotherapy support to respiratory patients. AHP staff may also work in the role of bed buddy if they have the clinical skills and competence to do so.
- All staff should have completed an individual risk assessment. This will need to be reviewed with a line manager in the contact of the new role to ensure that adequate precautions can be put in place to protect staff
- There will be a clear and transparent process for staff selection for redeployment as follows:
    a) Staff will be asked to volunteer to move, this will be supported where possible
    b) Staff in services which have been suspended will be asked to move
    c) Staff may be selected by their line manager to move based on the needs of the service only if enough staff do not volunteer to be redeployed

- The selection of staff will need careful consideration. Newly Qualified staff in their first 6 months of appointment, unless having relevant experience, should remain in their primary work place.
- Staff will be informed by their line manager of the decision to move by telephone call or in person. Lists of staff will not be widely shared to prevent staff finding out 'through the grape vine' which causes additional stress and anxiety to staff. Discussions will be held with each staff member which gives a clear rationale for the decision and explains the role they will undertake the support that will be offered.
- Staff will have undertaken ITU familiarisation training which is relevant to their role
- Staff will have 2 supported supernumery shift in ITU before undertaking their role
- All staff will be orientated to the clinical area including rest areas, emergency equipment and store areas

Whilst on redeployment

Staff will be supported by dedicated pastoral support manager. They should be visited at least once per shift to check on welfare. This role must be available 24/7 and will be over and above the staffing levels required to provide patient care.

Rest and relief staff will be incorporated over and above the intensive care staffing numbers to allow staff to take comfort and hydration breaks more frequently due to the difficulties of working in PPE

Staff will be given a roster that replicates as far as possible their usual working pattern. Shifts may need to change to be 12 hour shifts to allow full support to the unit. Staff may need to work 7 days a week and include night duty. Staff who have reasons why this may not be appropriate should have this discussion initially with their usual line manager.

It should be noted that due to PPE requirements and the intensity of the work staff may need to alter their shift pattern. Staff who usually work 4 nights in a row may need to split these to ensure adequate rest and recovery. Staff will be given a roster that takes into account the additional physical and emotional challenges of working during a pandemic.

Staff will be supported wherever possible to make changes to their roster to optimise the balance between their emotional and physical health. As every staff members need is different the individual staff member is responsible for ensuring that they raise issues with duty in line with their professional responsibility to be fit for work.

Staff will be able to request changes to their roster through a central roster team, reducing the workload required by ITU staff and managers

SALS will be available to support staff whilst on redeployment, details of how to access should be available in ITU areas and rest areas

Pastoral support should continually assess each staff members ability to cope and continue to work in the area. There may be times when staff for personal, emotional and psychological reasons may need to be withdrawn from the area of redeployment. The pastoral support role will be instrumental in assessing this and taking supportive action where required.

At the end of redeployment

Staff should be returned to their primary work area as soon as possible

A clear de-escalation plan should be in place on priority groups of staff to return and the process for informing staff of this. The decision to deescalate will be taken by the Chief Nurse or nominated deputy. The Chief Nurse will be responsible for the development and action of the de-escalation plan.

Staff should have a 121 conversation with their manager when they return to their primary work location to assess the level of support that may be required. Managers should be aware they will need to continue to meet with staff and monitor this regularly as the impact and needs may change.

All staff should be given information regarding the support services offered by the Trust including the role of SALS and how to contact them

Group debriefs and psychological support should be arranged within one month of the end of redeployment

Staffing acute wards

The staffing model for increased pressure on our acute wards and departments is well articulated in the winder and covid19 plan. We will ensure that as much capacity remains open to support the care of children and young people as possible, whilst supporting the care of patients in ITU.

To enable the staffing assessment to be made in line with best practice wards will be required to undertake acuity and dependency audits and not reply on staffing rations alone. The acuity of patients, ratios and professional judgement will become important in presenting a balanced picture at the daily safe staffing meetings. This will allow resources to be balanced across the organisation and minimise risk to all patients.

The covid19 emergency plan clearly articulates the minimum staffing arrangements for each area, and the additional roles which can be utilised to support nursing staff in these areas to provide the level of care required.

In times of extreme pressure, the Chief Nurse or nominated deputy will be responsible for the sign off of staffing levels for each area.

Summary

It is acknowledged that the movement of staff during a pandemic causes high levels of stress and anxiety to that staff member. The Trust is committed to supporting staff through unprecedented times.

Bed Modelling

To co-locate the intensive care and high dependency across a singular floor and maintain the Burns unit within their specialist area the proposal is:

Pod 1 (Yellow Pod)

Has capacity to provide for 8 Paediatric ICU patients, inclusive of capacity for 2 ECMO patients.

Pod 2 (Yellow Pod)

Has capacity to provide for 8 Paediatric ICU patients.

Pod 3 (Green Pod – all cubicles)

Has capacity for 8 bed spaces which will be used as surge flexibility between PICU and HDU as required.

Pod 4 (Green Pod)

Has capacity to provide for 10 HDU patients.

Pod 5 (Orange HDU)

Has capacity to provide 9 individual bed spaces for adult ICU patients with the flexibility to surge to 10 adult ICU patients by 'doubling up' of a singular bed space if required.

Donning of PPE will take place in the Yellow pod and Doffing will take place in the shower rooms of the exit corridor ensuring a one way flow and limiting cross contamination.

Burns (Orange Pod)

Stay in location as specialist burns unit.

Staffing Models

Staffing has been mapped in incremental phases, to be reviewed and assessed in line with patient acuity and staffing capability should numbers of paediatric patients surge requiring capacity up to 21 paediatric patients; whilst caring for 9-10 adult ICU patients.

Adult ICU will staff on a ratio of 1 qualified ICU RN to 1 patient, with the support of a bed buddy working on a 1:2 ratio.

Phase 1 PICU staffing provides normal ratio's for PICU care of 1:1, with 2:1 nursing for up to 2 patients requiring ECMO.

Phase 2 PICU staffing provides care for an additional 8 PICU patients on the model of 1:2 ICU RN nursing with the support of 1:1 care provided by 'bed buddy's' who are registered professionals, non ICU trained, providing care in line with the above framework/ parameters.

Phase 3 PICU staffing provides 1:2 ICU RN nursing care alongside a ‘bed buddy’ who will provide support as outlined in the above framework/parameters.

Staffing has been mapped incrementally to allow flexible modelling to support paediatric patients, based on clinical MDT discussion around the appropriate levels required to ensure safe, effective and consistent standards of care.

Adult ITU Staffing Model

Team 1	Team 2	Team 3	Team 4	Team 5
Bed 1 & Bed 2	Bed 3 & Bed 4	Bed 5 & Bed 6	Bed 7 & Bed 8	Bed 9 & Bed 10
ITU RN & ITU RN	ITU RN & ITU RN	ITU RN & ITU RN	ITU RN & ITU RN	ITU RN & ITU RN
Buddy	Buddy	Buddy	Buddy	Buddy

ITU RN - Runner

Proning Team x 4

Rest and Relief X 1

Pastoral Support & Family Liasison

ITU RN Coordinator

ITU RN - Runner

Physio Team x 2

	D	N	24 Hour	4 Week	WTE	WTE + 20%
ITU RN	13	13	26	728	56.0	67.2
Buddy	6	6	12	336	25.8	31.0
Pastoral	1	1	2	56	4.3	5.2
Proning	5	0	5	140	10.8	12.9
Physio	2	2	4	112	8.6	10.3
Total						**126.6**

Paediatric ITU Staffing Model (Phase 1)

Team 1		Team 2		Team 3		Team 4	
Bed 1	Bed 2	Bed 3	Bed 4	Bed 5	Bed 6	Bed 7	Bed 8
ITU RN	ITU RN	ITU RN	ITU RN	ITU RN	ITU RN	ITU RN	ITU RN

ITU RN - Runner

ECMO Nursing

(based on 2 beds

ITU RN Coordinator

(1 per 8 patients/ pod)

	D	N	24 Hour		4 Week			WTE		WTE + 20%
ITU RN	10	10	20		560			43.1		51.7
ECMO	2	2	4		112			8.6		10.3
Total										**56.9**

Paediatric ITU Staffing Model (Phase 2)

Team 1		Team 2		Team 3		Team 4	
Bed 1	Bed 2	Bed 3	Bed 4	Bed 5	Bed 6	Bed 7	Bed 8
Bed Buddy	Bed Buddy	Bed Buddy	Bed Buddy	Bed Buddy	Bed Buddy	Bed Buddy	Bed Buddy
ITU RN		ITU RN		ITU RN		ITU RN	

ITU RN - Runner

Bed Buddy Rest and Relief

ITU RN Coordinator

	D	N	24 Hour		4 Week			WTE		WTE + 20%
ITU RN	6	6	12		336			25.8		31.0
Bed Buddy	9	9	18		504			38.8		46.5
Total										**56.9**

Paediatric ITU Staffing Model (Phase 3)

Team 1		Team 2		Team 3		Team 4	
Bed 1	Bed 2	Bed 3	Bed 4	Bed 5	Bed 6	Bed 7	Bed 8
ITU RN	Bed Buddy	ITU RN	Bed Buddy	ITU RN	Bed Buddy	ITU RN	Bed Buddy

ITU RN - Runner

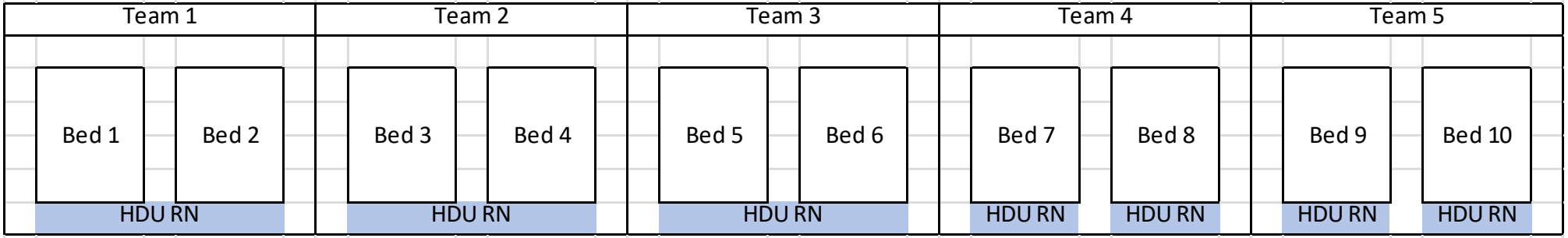
Bed Buddy Rest and Relief

ITU RN - Runner

ITU RN Coordinator

	D	N	24 Hour		4 Week			WTE		WTE + 20%
ITU RN	7	7	14		392			30.2		36.2
Bed Buddy	5	5	10		280			21.5		25.8
Total										**56.9**

HDU Staffing Model



HDU Team Leader

1 HCA per shift

HDU Co-ordinator

	D	N	24 Hour		4 Week			WTE		WTE + 20%
HDU RN	9	9	18		504			38.8		46.5
HCA	1	1	2		56			4.3		5.2
Total										**51.7**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th January 2021

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

Our phase 3 COVID-19 plan has continued to sustain a high-level of planned care to children and young people, as well as maintaining, at all times, urgent, emergency and critical care capacity. This has taken place against a backdrop of increased virus prevalence in the third wave of the pandemic. We remain focused on reducing waiting times by restoring service capacity and improving productivity.

2. Summary of progress in restoring services

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

Service	Standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Outpatients	**100%**	86%	87%	84%	95%	95%
Daycase	**90%**	83%	74%	85%	92%	94%
Elective	**90%**	86%	88%	98%	92%	102%
IP/DC	**90%**	84%	76%	87%	92%	95%

Service	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Outpatients	13,108	16,581	16,656	17,441	14,988
Daycase	1464	1532	1675	1780	1726
Elective	370	378	422	423	400
IP/DC	1,834	1,910	2,097	2,203	2126

In **outpatients** we have maintained a high-level of restoration at 95%. In **elective care**, we have exceeded the restoration target driven by additional weekend working and maintained the increased levels of Day Case activity.

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

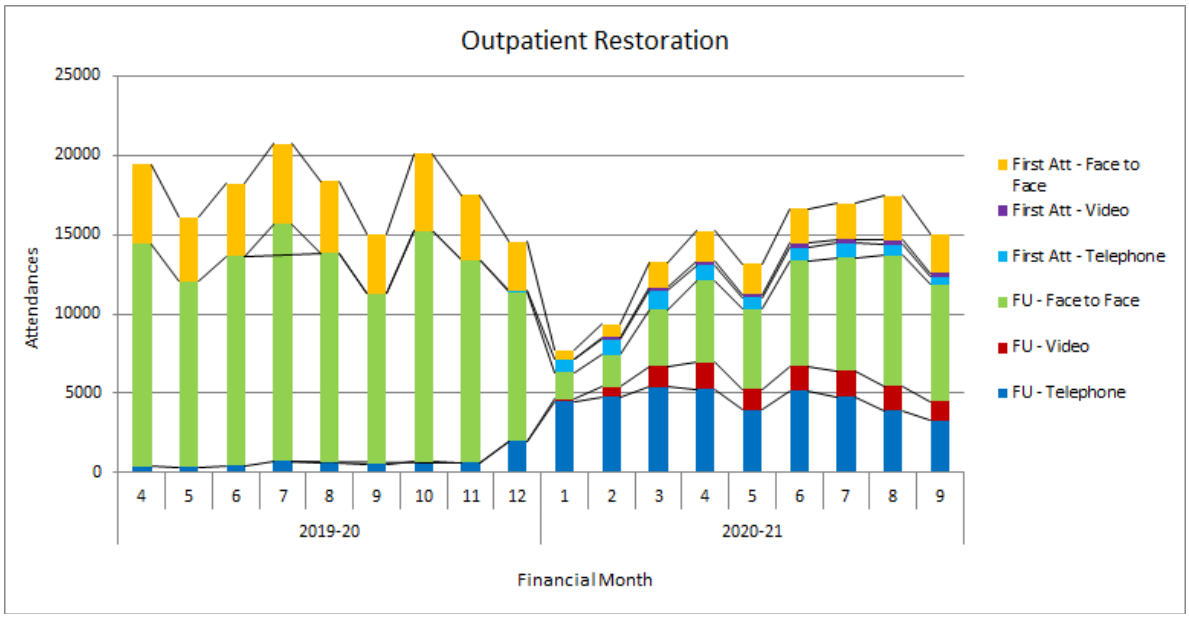
3. Restoration by service area

3.1 Outpatients

Our high-impact interventions continue to improve outpatient restoration. Our performance relative to last year is good, although the volume of patients seen is reduced in-month which is anticipated during the holiday period. 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 patient numbers per clinic with agreed increases in ENT, Cardiology, Paediatric Surgery and Dental.

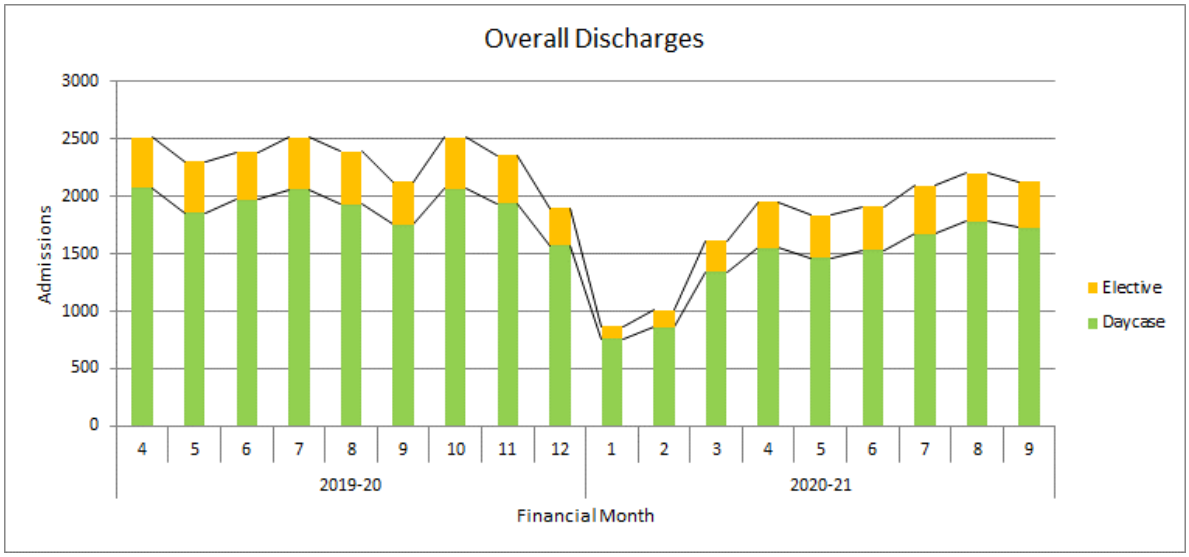
- Review of specialty use of attend anywhere for scope to expand virtual clinics
- Increased Nurse Led & Registrar clinics
- Continuing to revise clinical pathways
- Extended sessions into evenings



3.2 Elective & Day Case Activity

Elective activity restoration has exceeded the national restoration target for two consecutive months. The teams continue to innovate and improve capacity and activity to further improve restoration:

- Focus on maintaining day case surgery improvement programme
- Additional Saturday theatre list commenced
- Pooling of lists
- Review cases per list to maximise utilisation
- Maintain PPE supply



3.3 Diagnostics

The Clinical, Radiology and Day Case Teams continue to work at improving access and work continues to reduce the waiting times. The teams have continued to improve access by refining the suite of initiatives to maintain safety as these interventions are classed as Aerosol Generating and reviewing efficiency within the department. Actions include:

- Decontamination team working patterns changed to reduce turnaround times for scopes
- Operational Track & Trace system within Day Case to improve resilience
- Diagnostic Task & Finish group working to improve diagnostic utilisation within Day Case theatres

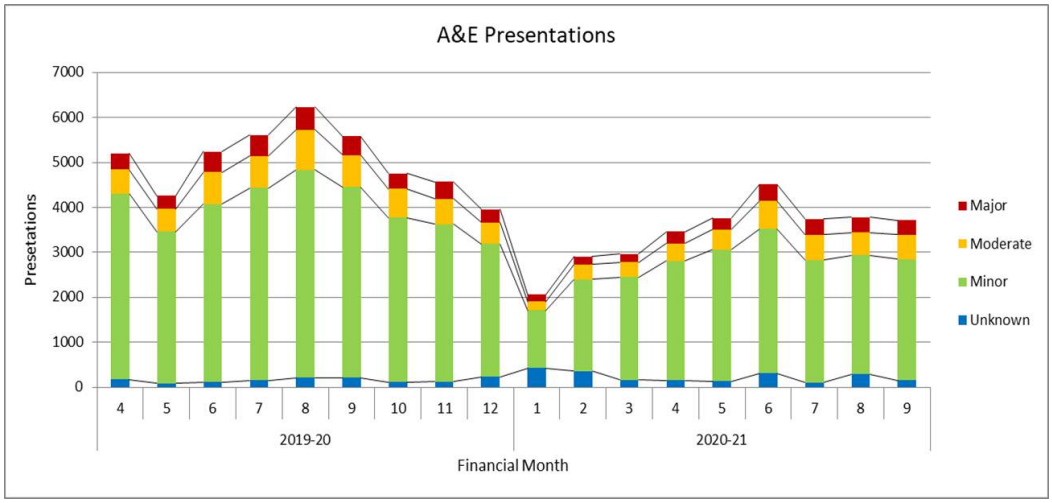
The percentage of diagnostic tests performed within 6 weeks was 92.3% in December. This drop in performance relates to waiting times for MRI scans under general anaesthetic. Staff have worked additional sessions to contain the length of wait for this service.

Diagnostics (DM01) Performance against 99% standard

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

3.4 ED attendances

ED performance for the year has been consistently maintained well above the 95% standard despite the challenges of social distancing. Attendance have remained consistently below per-COVID-109 levels for several months, as demonstrated in the graph below.



In December we were the number 1 ranking Type 1 ED in the country for timeliness of care in the ED.

ED 4hr access standard performance:

Month	Total	Type 1
Apr-20	97.28%	97.28%
May-20	98.14%	98.14%
Jun-20	98.75%	98.75%
Jul-20	97.25%	97.25%
Aug-20	97.79%	97.79%
Sep-20	95.43%	95.43%
Oct-20	96.92%	96.92%
Nov-20	97.51%	97.51%
Dec-20	98.63%	98.63%

3.5 Cancer Performance

Throughout the pandemic we have maintained good access to children's cancer care:

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

4. Planned care

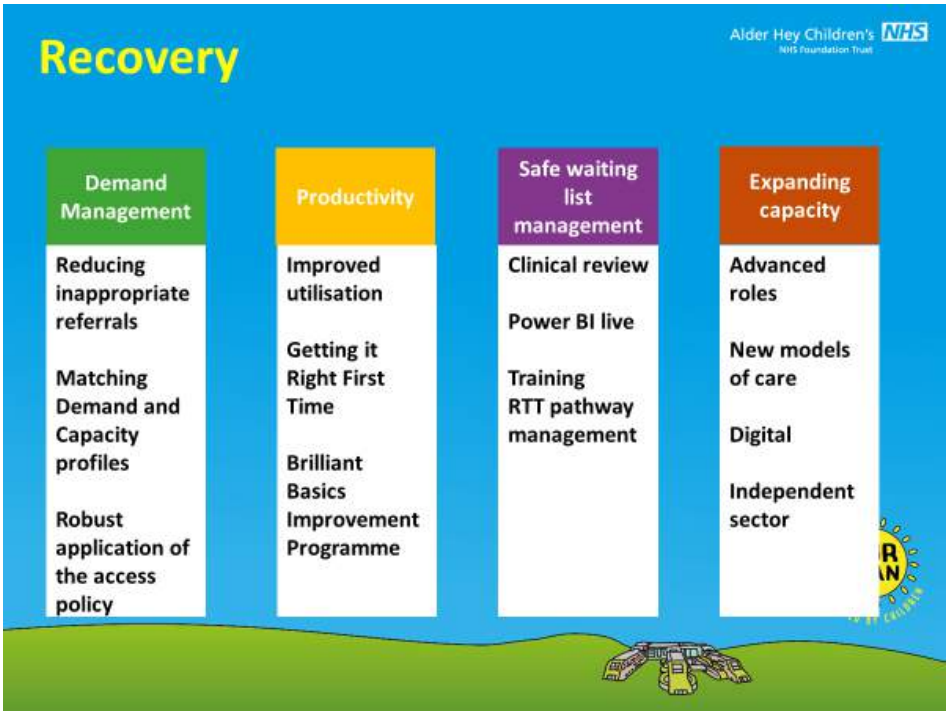
In December our waiting list status is as follows:

Open pathway RTT performance (18 weeks)	60.8%
Total number of patients > 52 weeks	184

We have identified the specialties with the most significant backlog challenge:

	March 2020				Dec 2020					
Spec	<18	>18	Total	% 18Wk	<18	>18	Total	% 18Wk	% Trust backlog	Addition to the backlog since March
ENT	1159	190	1349	86%	778	1005	1783	44%	24%	815
ORTH	1046	143	1189	88%	770	490	1260	61%	12%	347
EYE	702	113	815	86%	500	486	986	51%	12%	373
PAES	572	86	658	87%	428	463	891	48%	11%	377
PDEN	340	68	408	83%	271	344	615	44%	8%	276
COMM	845	389	1234	68%	513	287	800	64%	7%	-102
UROP	365	43	408	89%	208	190	398	52%	5%	147

We will concentrate additional support to these teams and go through the following recovery framework:



We are now seeking to take additional action to improve capacity including an incentive model to support and sustain additional sessions and support from the independent sector.

5. Conclusion

There has been significant progress made with restoring services. As an acute provider we are one of a small number of organisations that has achieved restoration targets which is tribute to the remarkable collective effort of our staff. In January the impact of wave 3 will have an adverse effect on waiting times and levels of restoration as we deliver mutual aid to the region and establish an adult ICU (up to 10 adult patients) on the Alder Hey site. This development has seen a revised theatre schedule be put in place with theatre capacity reduced from 149 theatre sessions per week to 100.

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD OF DIRECTORS

Thursday 28th January 2020

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

Purpose of Paper:	Decision Assurance x Information ☒ Regulation
Background Papers and/or supporting information:	☐ N/A
Action/Decision Required:	To note x To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** x **The best people** doing their best work x Sustainability through **external partnerships** **x** Game-changing **research and innovation** **Strong Foundations** **x** ☐
Resource Impact:	
Associated risk (s)	636, 637, 654, 795, 1919, 2081, 2118, 2119

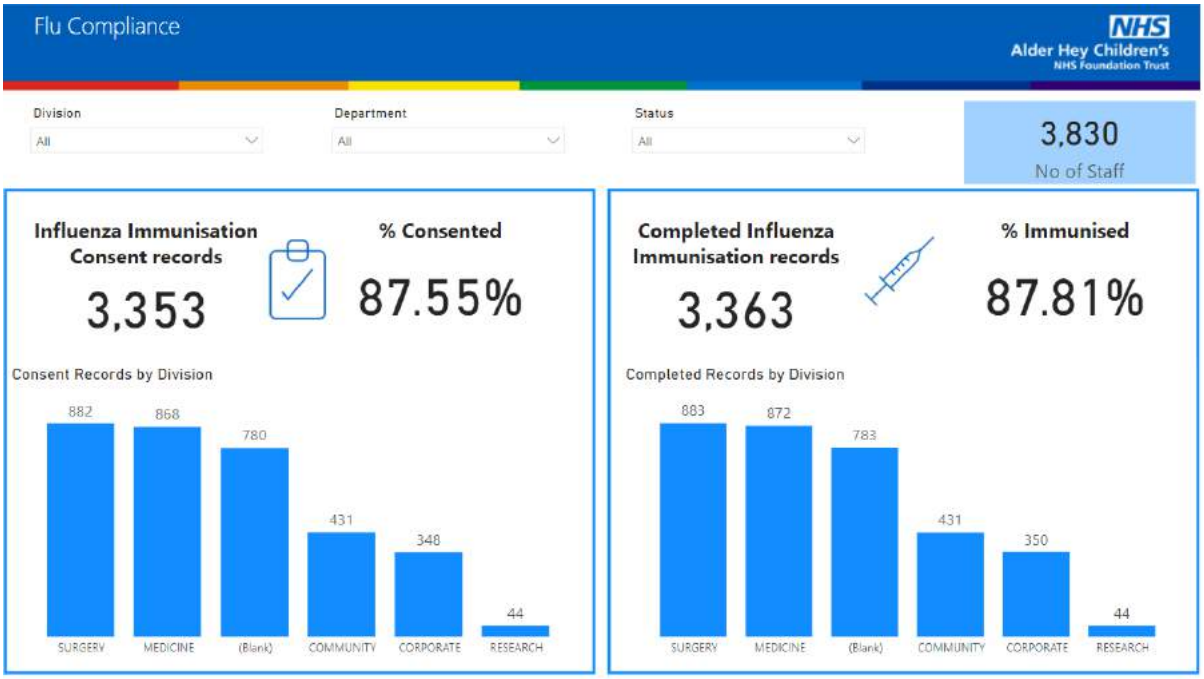
INFECTION PREVENTION & CONTROL EXCEPTION REPORT
2020-21
JANUARY 2021

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

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

Table 1: 2020 -21 Target

Flu compliance can be seen in table 2 for the whole Trust. Please note this is a live system so compliance will change on a daily basis.

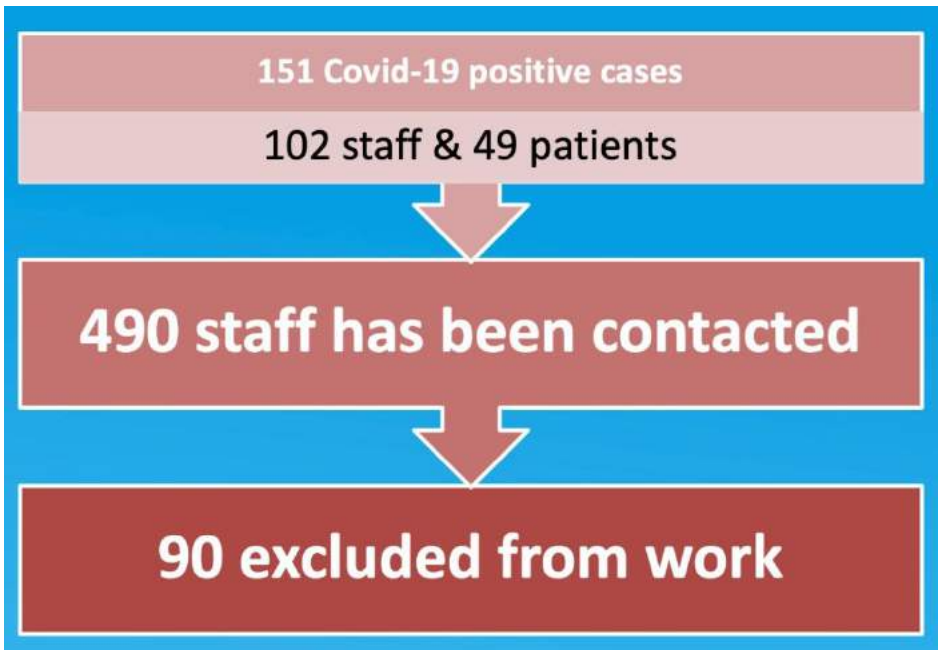


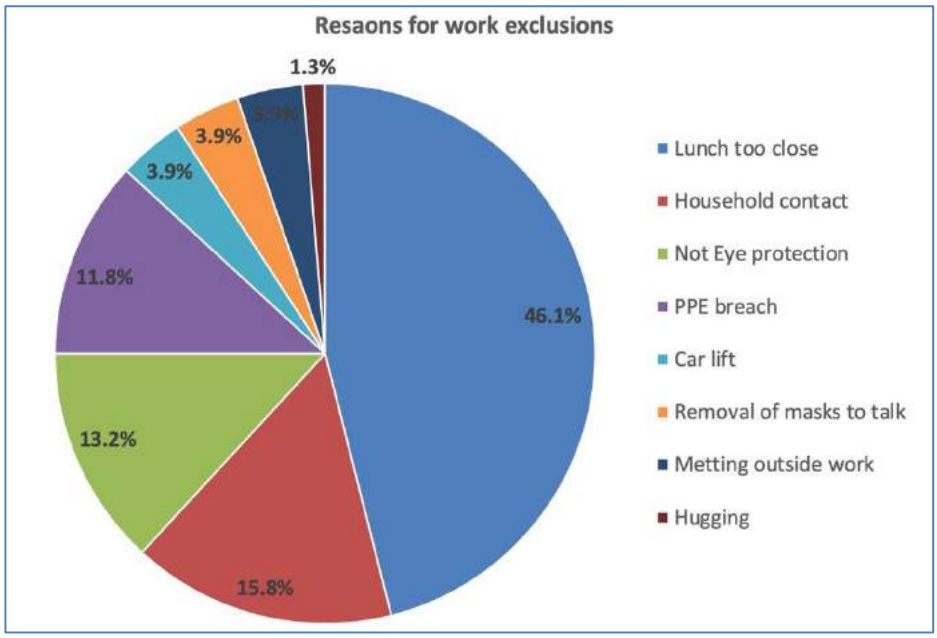
Additional Activity/Achievements/Issues

Track & Trace Service

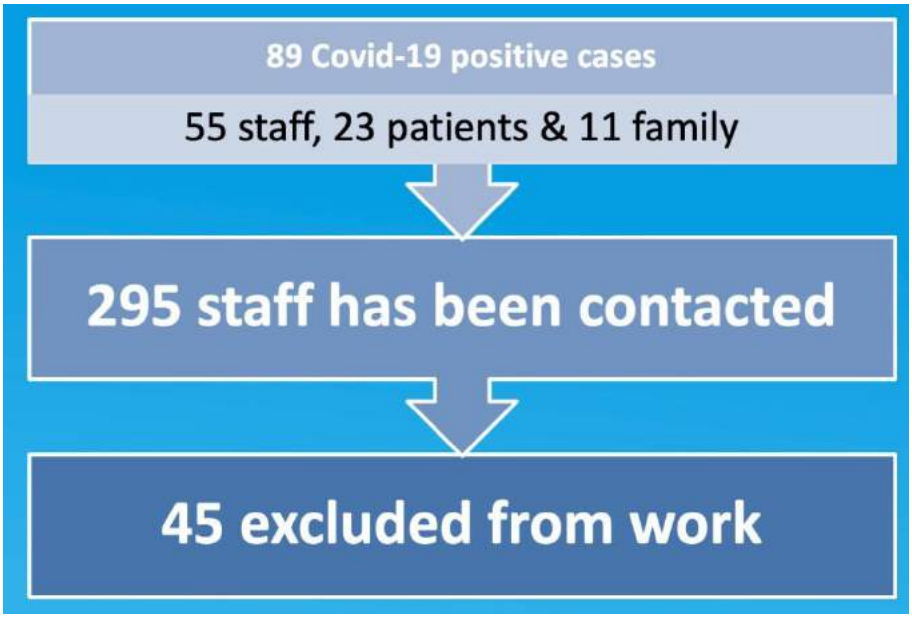
The service has been in place since August 2020. The team comprises of shielding and redeployed staff working remotely, linking with the Trust IPC team onsite.
The service covers 7 days per week 8am-8pm.
The team were rewarded for their achievements in December 2020 with 'Star of The Month'.

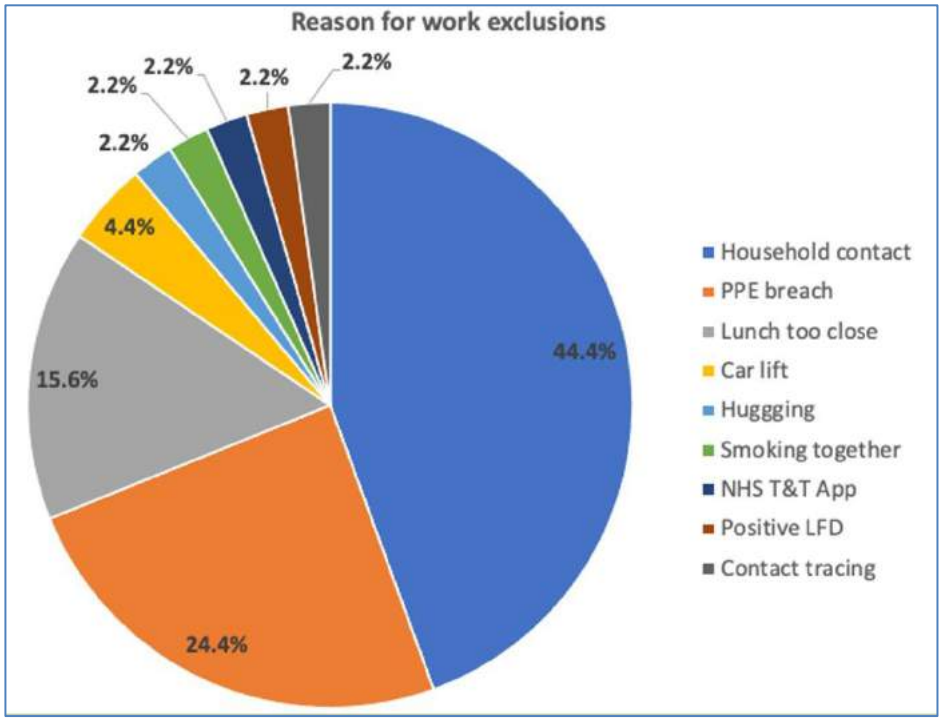
Activity
During the period 1st October-Nov 15th, the activity of the Track & Trace team was:



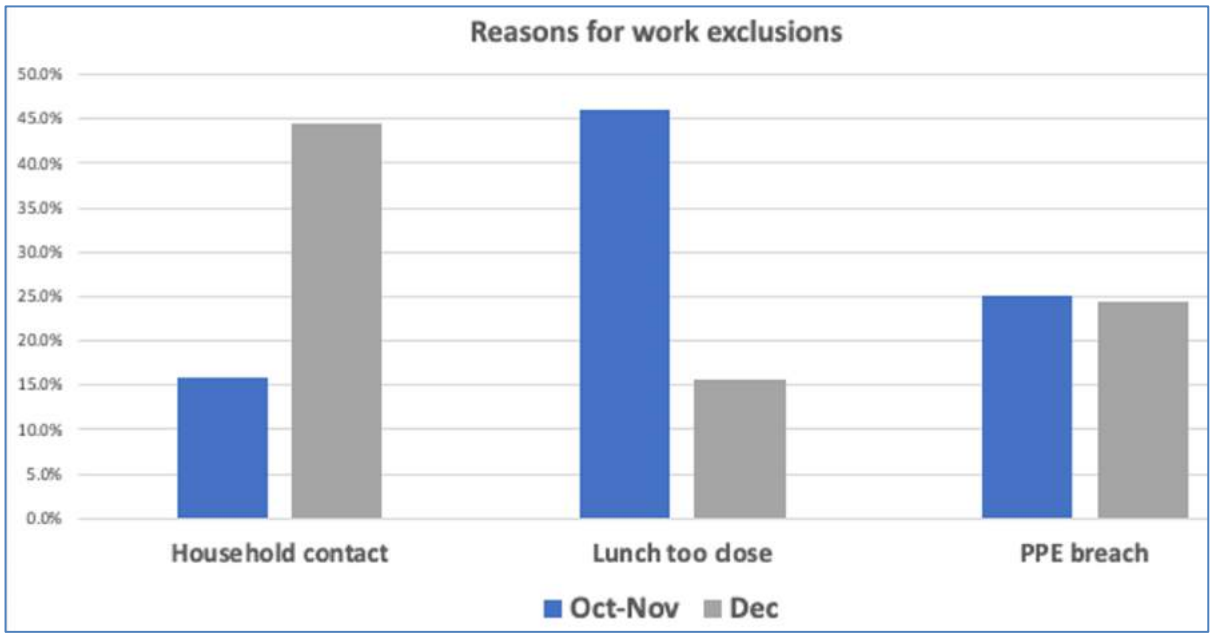


During the month of December, the T&T activity was:





A comparison between the work exclusions between these 2 periods is:



Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th January 2021

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

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

1. Purpose

The purpose of this report is to enable the Trust Board to scrutinise the current COVID 19 risk position and provide assurance that the risks are being managed effectively. In view of the increased risk level identified nationally a deep dive of the risks for the Trust has been completed. The findings are that there is no increased risk level for the Trust, in fact many of the identified risks have reduced since the last reporting period. This reduction reflects the robust planning and actions to mitigate the risks for the Trust, patients, family's staff and the public, which this is reflected in this report.

2. Summary.

There are currently **23** risks identified on the COVID 19 risk register, including **2** high risks (references 2138, 2182). The risk profile is outlined at appendix 1.

Number of closed risks removed from the risk register = **7** (table 2)

Number of new open risks = **1**

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

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

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

Number of open risks with increased risk scores = **1**

Number of open risks with reduced risk scores = **5** (table 3)

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

3. Themes

3.1. Access to services

There is **1** high risk within this theme.

Risk ref 2178: *"Risk of not seeing C&YP who need treatment, the associated risk of late or no presentation and associated potential for harm*.(*When first identified in May 2020 this risk was rated as 4x5 = 20, reduced to 3x3 = 9 in last reporting period, currently rated 2x3 = 6. Late Presentation Ulysses report shows 8 'no harm' incidents with 1 'near miss' relating to late presentation, however only a handful of these relate to parents bringing C&YP in for late presentations (all 'no harm') - the remainder relate to process issues in booking & scheduling & are addressed & managed through usual divisional processes. Controls in place outlined in previous reports remain effective.

Risk ref.2143, 5x1 =5 " *Risk of delay in imaging and subsequent delay in treatment*". At the time of identification in April 2020 the risk rating was 5x3=15, continued to reduce over time and is currently 5x1 = 5, at target, therefore will close on the register. The reduction is due to the contingency plan being enacted and robustly implemented and monitored.

Risk ref: 1560, 3x4 =12 "*Risk of patients breaching 18 weeks referral to treatment target (CHAMS)"* This risk was first identified in 2018 and at that time was rated 3x3=9. It increased significantly at the start of the Pandemic; April 2020, to a rating of 3x5=15, decreased to 3x3=9 in last reporting period, but increased to 3x4 = 12 in this reporting period. There are robust controls

and ongoing actions for example, weekly MDT meetings to monitor waiting times, in addition to single site session therapies. Additional review underway to determine additional mitigations required.

Risk ref. – 2228: 3x3=9 "*Risk of delay in access to Theatre will result in suboptimal outcome for children and Young people*" since first identified in July 2020, although activity continues to near pre-COVID levels. No change in risk position since last reporting period.

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

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

3.2. Resource

There is **1** high risk within this theme.

Risk ref : 2182, 4x5 = 20 One of two highest scoring risks "*Risk of Insufficient financial resource to meet demand".* Trust now operating within the revised financial framework for H2 20/21 with a degree of certainty and clarity over funding for the remainder of this year and the run down to March 2021 delivering a managed financial position acknowledged by NHSI with risk, but these risks are largely mitigated and discussions continue with NHSI in terms of further mitigations to the remaining risks. Significant risk and uncertainty remain around the future position from 21/22 onwards particularly following notification of delays to the contracting and planning arrangements for next financial year, although the existing regime is expected to roll forward for the early part of 21/22. The finance team is currently progressing with internal planning arrangements until national guidance is available, to quantify the risk and mitigate where applicable.

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

Risk ref: 2138 4x4 16 *"Risk that front line nurse availability to work will be significantly compromised during winter 2020 the second COVID peak and that compliance with national nursing standards for safe staffing levels on wards and departments will not be met (RCN / PICS /*

BAPM / QNIC / NQB) and / or the ability to have beds / services will be significantly affected" Risk level remains same as at last reporting period. Although comprehensive plans in place and implemented Staffing ratios set and agreed; signed off by Executive team, associated QIA and EA completed, winter staffing plan presented to CCG at CQRM on 18th December. The Trust agreed to accommodate 10 adult ICU beds to support Trusts across the patch. Pandemic staffing plan devised by Chief Nurse to support the winter staffing plan and meet the additional demands on ITU Divisions have identified staff who can be redeployed as required. Staff were asked to volunteer to be redeployed based on lessons learned from the first phase of redeployment. Exceptional response from staff coming forward to volunteer. Rotas devised, managers releasing staff, training organised, communications via live briefings, updates and written communications. This risk is linked to risk **2343** below.

Risk ref : 2343 5x1 =5 "*Risk that standard of care for adult patients in paediatric hospital might not be equivocal to that received within a district general, adult care focussed environment*". There are significant plans implemented to ensure there is minimal risk to adult patients, which is reflected in the risk rating. The plans include staffing, governance, support etc. At time of reporting Trust accepting adult patients safely, with no new risks identified.

Risk ref – 2181, 3x4 =12 "*Risk of short- and long-term negative effect on staff mental wellbeing"* which when first identified was a high risk 3x5=15 , but as the result of controls in place and progress with additional actions to mitigate, this risk has been reduced, although remains static since last reporting period.. For example, Care first - online Employees Assistance programme, Clinical Health Psychology service support for staff, spiritual care support, Regional resilience hub.

3.4. Infection to CYP, families and our staff.

Risk ref: 2180, 4x2 = 8 "*Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained"* At time of initial risk identification and assessment in April 2020 this risk was rated as 5x3 =15 . This has now reduced considerably. There is reliable national supply in place sufficient to meet Trust needs. In the event any products are not available, the Trust have Robust. contingency measure in place (alternative products or practices) to ensure that it can still operate effectively.

There are **4** risks identified relating to Staff becoming infected with COVID 19 i.e. risks 2164 - 3x3 = 9 , 2268 - 4x2 =8, 2118 – 4x2 =8, 2267 - 4x2. However, all COVID secure risk assessments have been completed and all areas are deemed COVID secure, with action plans to further mitigate risks where relevant.

Appendix 1

1. Risk Register Profile – 21st January 2021 (Total 23)

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**	**2**	**5**	**3**	**6**	**2**	**2**	**0**	**1**	**1**	**0**	**0**
0 (0.00%)			**8 (34.78%)**			**13 (56.52%)**				**2 (8.69%)**				**(0.00%)**

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

Table 2 Closed risks 7

Risk reference	Risk description	Target
2119	Risk of patients acquiring COVID 19 whilst an inpatient at the Trust	5
2128	Failure to comply with Clinical Trial Regulations	3
2129	Failure to comply with National Institute for Health Research reporting metrics	3
2142	Catering staff may become unwell contracting coronavirus, and the potential consequence of this to short- and long-term health	6
2172	Alcohol based hand sanitizer has the potential to cause static electricity when in contact with metal surface	4
2181	Increased risk to staff mental health and emotional well-being	6
2199	Risk to ODN function due to the impact of COVID 19 on providers within the ODN or on the ODN team	8

Table 3 risks with reduced risk scores = 5

Risk reference	Risk description	Current Score	Target score
2160	Risk to accurately report real time staff availability, when the organisation requires it to escalate the staffing model if activity increases.	6	4
2178	Risk of late or no presentation of C&YP who need treatment. (To close)	6	9
2157	Risk of not meeting required staffing levels to support safe and efficient service delivery across clinical and non-clinical departments	6	4
2143	Delay in imaging and subsequent delay in treatment. (to close)	5	5
2180	Risk of not securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained	8	6

END

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th January 2021

Paper Title:	**CQC Section 31 Action Plan**
Report of:	Erica Saunders, Director of Corporate Affairs. Nathan Askew, Chief Nurse Lisa Cooper, Director of Community & Mental Health Division
Paper Prepared by:	Directors / Lead Action Owners

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	To provide an update on actions taken in response to the section 31 notice issued by CQC and to discuss the implications of this patient cohort for the wider system.
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:	

Alder Hey Children's NHS Foundation Trust

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ACTION PLAN

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

CQC Section 31 Action Plan January 2021

No.	Reference column	Dept	Requirement	Action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
Theme A: Immediate Safety Actions											
1		ED	All Children and young people presenting with a mental health issue are appropriately assessed by staff with the relevant qualification, experience, skills and competence	All children and Young People (CYP) attending ED with a mental health need will be immediately referred to the crisis care team for rapid assessment An individual risk assessment will take place resulting in: • Discharge with community based crisis care review • Referral for admission to tier 4 CAMHS service • Admission for further assessment with consideration of legal framework and advice and guidance regarding appropriate on ward medical / mental health management	Chief Nurse	Director of Community and Mental Health	Referral pathway reviewed and in place from September 2020. Wide communication with ED staff about the need to refer Increased referrals into crisis care up from 13 in September to 32 in November		30.09.20	SQAC	Referral numbers and outcomes are be monitored through the monthly mental health report
2		ED 4C	CYP with mental health needs should be cared for in an environment which is safe and reduces risks as indicated by the patient assessment	Where CYP require admission to either tier 4 service / appropriate setting or the acute wards they will have an individual risk assessment which will include a recommendation of the most appropriate space for care. This may be: • A ward based cubicle with environmental risk assessment (4C) • To remain in the anti-ligature 136 room in ED pending transfer to tier 4 service / appropriate setting	Chief Nurse	Associate Director of Nursing – medicine	The crisis care team risk assessment is in place and includes a recommendation of the safest environment to care for CYP. CYP who are extremely distressed and are classed as very high risk pending tier 4 admission may remain in 136 room in ED to ensure their safety until onward transfer is possible The ward risk assessment is used to reduce risk and make any room in the Trust safe for		20.12.20	SQAC	Place of care for admission are monitored through the monthly mental health report

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ACTION PLAN

							CYP until completion of capital work				
3		ED & 4C	CYP who require restraint / clinical holding will have this undertaken by staff with specialist training, qualification, competence and skill	Clear escalation plan in place for additional support where CYP require restraint or clinical holding	Chief Nurse	Director of Community and Health	Immediate response via police. Tier 4 unit staff are trained in restraint / clinical holding and will be released to support admission to 4C Additional external provider available to provide competent staff within 4 – 6 hours for ongoing support		23.12.20	SQAC	Additional staff support monitored through the monthly mental health report
4		Trust	Environmental risk assessment: There should be a standardised checklist which is used prior to admission to assess the risk in a room for any patient with mental health or challenging behaviour requirement, promoting staff to consider all risks and modify the environment as needed	Review current risk assessment identify any improvements required and update accordingly All wards undertake revised risk assessment in line with risk assessment Performa. Risk assessments will be performed and monitored in line with risk assessment policy	Chief Nurse	Associate Chief Nurses	Risk assessment form updated. Circulated to ward managers and ward based nursing staff to have been familiarised with the assessment process if a child or young person is admitted.		21.12.20	SQAC	Risk assessments completed
5			Patient risk assessment: Standardised patient risk assessment which should include triggers and consider the level of supervision required e.g. RMN	Review current risk assessment identify any improvements required and update accordingly. Risk assessments will be performed and monitored in line with Risk Assessment policy	Chief Nurse	Associate Chief Nurses	Risk assessment updated and in use by the Crisis Care Team on admission with clear recommendations to minimise patient risk		01.12.20	SQAC	Revised risk assessments in operation

No	Reference column	Dept	Requirement	Action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
Theme B: Incident reporting											
6		Trust	Enhance incident reporting to ensure that an accurate record is completed for all interventions of restraint	Devise form for reporting restraint on Ulysses to include • Type of restraint used • Duration of restraint • Rapid Tranquilisation (yes/no) • People present during the procedure • Any harm or potential harm	Chief Nurse	Director of Community and Mental Health	Proforma designed and external provider contacted to develop software – form live as of 23.12.20		23.12.20	CQSG SQAC	Monthly Restraint reporting capability will be available on Ulysses Staff will report restraint

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ACTION PLAN

				through the process • Measures taken before restraint used							incidents including lessons learned and actions for improvement in line with policy standards Assurance reports to Board committees will demonstrate compliance with best practice policy standards.
No.	**Reference column**	**Dept**	**Requirement**	**Action**	**Director**	**Lead**	**Progress**	**BRAG**	**Target completion date dd.mm.yy**	**Monitoring Committee**	**Required outcome/output**
Theme C: Annual Report											
7		Trust	The Trust is required to provide annual assurance reports internally and externally	Annual report (2019/20) and annually thereafter to be devised and submitted including: • Trust training plan • Training compliance • Number of incidents, - analysis of any harm / potential harm - risks identified, managed and mitigated - Learning and improvements - restrictive practice - Clear map of ward to board reporting	Chief Nurse	Director of Community & Mental Health	Report on track to report through SQAC and to January Trust Board. To then be published externally on the Trust internet site.		08.01.2021	Trust Board Part 1	Annual report available on Trust internet
Theme D: RCA											
8		MD	Undertake review of original investigation	Review original investigation including	Chief Nurse	Director of Nursing	Investigation will be complete by 31.12.20 and will present to January SQAC		06.01.2021	SQAC	Organisational learning on the management

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ACTION PLAN

				• Investigation process in line with Trust policy and NHS England SI Framework. • Focus of investigation • Investigation outcomes • Lessons learned			Investgation review StEIS 2020 13501 an Action plan re invetigation review St				of RCA's

No	Reference column	Dept	Requirement	Action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
Theme E: Training											
9a		Trust	Develop, implement and monitor specialist mental health training	Develop training for: • Mental Capacity Act & consent	Director of HR&OD	Director of Community & Mental Health OD Manager	Mental capacity act training is included in level 2 & 3 Safeguarding training current compliance is L2 90.6% L3 85.7% (Face to face L3 restarted December 2020 following pandemic)		23.12.20	SQAC & People and Wellbeing Committee	Staff trained
9b		ED & 4C	Develop, implement and monitor specialist mental health training	Develop training for: • Mental Health Act & Legal framework	Director of HR&OD	Director of Community & Mental Health OD Manager	Mental Health Act training compliance (including legal framework): 99% ED 100% Ward 4C		23.12.20	SQAC & People and Wellbeing Committee	Staff Trained
9c		ED & 4C	Develop, implement and monitor specialist mental health training	Develop training for: • Rapid Tranquilisation which secures in a competent practitioner per shift	Director of HR&OD	Director of Community & Mental Health OD Manager	Training package developed and live. Now part of paediatric life support.		ED &4C 31.12.2020	SQAC & People and Wellbeing Committee	Staff trained in line with TNA
9d		Trust wide	Develop, implement and monitor specialist mental health training	Include Rapid Tranquilisation training in paediatric life support training	Director of HR&OD	Director of Community & Mental Health OD Manager	This training has been added to Paediatric Life Support and annual update, this will ensure all clinical staff fully compliant within the annual cycle		20.12.20	SQAC & People and Wellbeing Committee	Monitored against mandatory training
9e		ED, 4C, ACT	Develop, implement and monitor specialist mental health training	Develop training for: • Restraint and clinical holding	Director of HR&OD	Director of Community & Mental Health	Contract with Prometheus (specialist agency) now live. Train the trainer model commencing 25th January		ED, 4C & ACT Team 31.01.21	SQAC & People and Wellbeing Committee	Staff are trained in restraint and available each

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ACTION PLAN

						OD Manager	2021. Process in place to support children & young people currently accessing ED				shift
10		Trust wide	Enhance Trust record system to improve standards of records and record keeping for rapid tranquilisation and restraints	Develop assessment tool in Meditech 6 to require accurate documentation relating to episode of escalating behaviour and actions required	Chief Nurse	Associate Chief Nurses Meditech 6 Lead	New clinical note built and tested in Meditech – now live Communication regarding this will reiterate the expected standards of record keeping for this patient group		31.01.2021	SQAC	New recording note in use

No.	Reference column	Dept	Requirement	Action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
Theme F: Environment and Risk											
11		4C & 3A	Rooms should be available in designated areas within the Trust which are anti-ligature	Current rooms are modified to be anti-ligature	Chief Nurse	Associate Chief Nurses	Work on track for completion 21st January 2021.		31.01.21	SQAC	Anti-ligature room identified

No.	Reference column	Dept	Requirement	Action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
Theme H: National Guidance											
12		Trust	Review Trust policies and procedures and ensure they reflect the relevant NICE and other national guidance	Review NICE guideline NG10; Violence and aggression: short-term management in mental health, health and community settings and determine changes required to Trust systems and processes.	Chief Nurse	Director of Community and Mental Health	Gap analysis completed and will be presented to January SQAC		31.01.2021	SQAC	Policies reviewed, approved and ratified

BOARD OF DIRECTORS

Thursday 28th January 2021

Paper Title:	Use of Restrictive Physical Intervention and Clinical Holding Report 2019/20
Report of:	Lisa Cooper Director Community & Mental Health Division
Paper Prepared by:	Dr Joann Kiernan, Consultant Nurse Learning Disabilities Andrea O'Donnell, Clinical Lead Tier 4 Inpatient Unit Jacqui Pointon, Associate Chief Nurse

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

1. Report Purpose

The purpose of this report is to:

- Provide assurance to Trust Board of activity in relation to the use of restrictive physical intervention and clinical holding across the Trust for the reporting period 01 April 2019 – 31 March 2020.
- Identify areas for improvement and actions for the Trust to take to support children and young people to access care safely.
- Seek approval of the Trust's identified Board lead for restrictive physical interventions and subsequent reduction programme.

2. Background

Children and young people receiving assessment and treatment from Alder Hey either within the Specialist Mental Health Services; acute hospital services (inpatient and outpatient) or wider community, may require the use of restrictive physical intervention or clinical holding. A safe and therapeutic culture should be provided for all children and young people receiving care and treatment including those who may present with behavioural problems whether or not they are detained under the Mental Health Act (1983).

Whilst there is recognised exemplar practice within mental health and learning disability services in Alder Hey, where the use of restrictive physical intervention or clinical holding of a child or young person has historically and culturally been explicit, in other clinical services this can often occur without the child or young person's permission or recorded parental consent.

Alder Hey does have in place robust policy guidance (MH2), which clearly recognises that therapeutic environments are most effective for promoting both physical and emotional wellness; and that the least restrictive physical interventions should only be used where there is a real possibility of harm to the child, young person or to others.

Restrictive physical intervention is increasingly replacing the term 'physical restraint' and is any method which involves some degree of direct force to try and limit or restrict movement (Restraint Reduction Network, 2019). It should be necessary, proportionate and justifiable and only used to prevent serious harm. Any use of planned or unplanned restrictive physical intervention should be carried out using the least restrictive interventions and for the minimum amount of time. The physical restriction or barriers which prevent a child or young person leaving, harming themselves, or causing serious damage to property are also included in the term restrictive physical intervention.

Clinical holding is a form of restrictive physical intervention and is using limited force to hold a child or young person still. It may be a method of helping children or young people, with their permission, to manage a health care procedure quickly or

effectively. Clinical holding has been distinguished from restrictive physical intervention by the degree of force used, the intention of the hold and the agreement of the child (Bray et al., 2014), but should still be considered a restrictive physical intervention.

For those children and young people who are being cared for under the Mental Health Act (1983) there is specific statutory guidance on different forms of restrictive intervention (and considerations for their use) detailed in the Mental Health Act: Code of Practice (2015). In addition, when providing care to young people aged over 16 years, staff should be aware of their professional obligations relating to the Mental Capacity Act (2005).

There are a number of recent publications regarding the use of restrictive interventions and clinical holding with children and young people (NICE guidance; RCN Guidance; DHSC), all of which clearly articulate the need for organisations to have a proactive approach to reducing the use of restrictive interventions but also to ensure that staff are appropriately trained and that there is a positive culture when reporting of the use of restrictive interventions and clinical holding.

2. Data regarding restrictive physical interventions and clinical holding

For the reporting period 01 April 2019 – 31 March 2020, the Trust reported **150** incidents regarding the use of restrictive physical interventions or clinical holding of children and young people accessing services at Alder Hey.

The table below shows the recorded incidents involving restrictive physical interventions or clinical holding reported across the Trust per division:

Division	Total number of incidents involving a level of restrictive physical interventions/clinical holding
Medicine	9
Surgery	3
Community & Mental Health	138
Total	**150**

The table below shows the recorded incidents involving restrictive physical interventions or clinical holding reported across the Trust per service:

Service	Total number of incidents involving a level of restrictive physical interventions/clinical holding
Ward 3C	3
Ward 4B	2
Ward 4C	1
Emergency Department	3
Ward 1C	1
Ward 4A	1

Theatres – Inpatient recovery	1
Community Physiotherapy Liverpool	1
Tier 4 Inpatient Unit	129
Outpatients	8
Total	**150**

As can been seen from the data the reporting of the use of restrictive physical interventions or clinical holding within the Trust's Tier 4 Inpatient Unit is significantly higher than other areas within the Trust. Assurance can be provided regarding the accuracy of the data in relation to the Tier 4 Unit, where the reporting of the use of restrictive physical interventions or clinical holding is fully embedded in clinical practice.

The low reporting of restrictive physical interventions or clinical holding incidents across all other areas of the Trust is potentially due to a number of factors including:

- Staff lack of awareness regarding requirement to report the use of restrictive physical interventions or clinical holding, even when with full agreement of child, young person and/or parent or carer
- Lack of clarity within the Trust's incident reporting system (Ulysses) and number of categories available for staff to use: Physical/verbal abuse; Restrictive intervention; Seclusion; Unacceptable behaviour (clinical) and Unacceptable behaviour (non-clinical)
- Lack of staff training on the use of restrictive physical interventions or clinical holding which may have led to staff feeling unsafe to report for fear of criticism or repercussions

These along with other factors relating to staff confidence, culture and ease of reporting incidents may have led to inaccurate recording and reporting on the use of restrictive physical interventions or clinical holding across the Trust and influence staff decisions to report the use of restrictive physical interventions or clinical holding.

4. Improvement Actions Required

The following areas for improvement in relation to the use and reporting of restrictive physical interventions and clinical holding are identified below.

4.1 Staff Training

Education and training are central to promoting and supporting change. Staff who may be required to use positive behaviour support and restrictive physical interventions or clinical holding must have specialised training (including bank staff), with the focus on training being on alternatives to restrictive physical interventions. There should be a clear and consistently enforced approach to managing challenging behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.

Whilst Alder Hey has provided Positive Behaviour Support (PBS) training for clinical staff since 2015 and formally embedded this into the Trust's Conflict Resolution

training programme since January 2019, this training has not been delivered since March 2020 due to Covid-19 and the requirement for the training to be delivered face to face. In addition, training compliance for Conflict Resolution is not reported to line managers as part of the current reporting arrangements. From January 2021 this training will now be reported on a monthly basis to line managers as part of the mandatory training matrix.

Currently, the Trust's Tier 4 Unit is the only area of the Trust that has specifically accessed formal annual training on positive behaviour support and restrictive physical interventions as part of the unit's staff mandatory training requirements.

Following the success of the Trust in securing two Burdett Trust research grants (May 2020):

- *"Co-production of an evidenced-based child-centred toolkit with children with LD or ASC attending hospital for procedures" (PI Dr Joann Kiernan - delayed start due to COVID January 2021)*
- *"Development of a risk assessment instrument to maximise the safety of patients with learning disabilities in hospital and build trust between parents/carers and staff.' Joint application with Great Ormond Street Hospital (PI-Dr Kate Oulton - delayed start due to COVID January 2021)*

The Trust undertook a procurement exercise to secure an appropriate "Bild compliant training provider" to provide accredited training across the Trust. The provider selected (CALM) is part of the "Bild Association of Certified Training" and have demonstrated their training services comply with the Restraint Reduction Network Training Standards, NHS England Standard Contract and CQC regulations.

The provision of this training as part of a pilot in the Trust's Ward 4C, Emergency Department and Outpatients was approved at the Trust's Safety, Quality & Assurance Committee in October 2020. Training commenced in early December 2020 (Tier 4 unit) and consists of 12 hours of online learning followed by a 2 day face to face physical skills training and skills instructor training. Training is complete for staff on the Tier 4 Unit and has now commenced in the other identified areas. In addition, to this training a "Train the Trainer" approach is being adopted across the Trust to ensure staff continue to receive accredited training on a regular basis.

4.2 Reporting the use of restrictive physical interventions or clinical holding

Further improvements regarding the reporting of restrictive physical interventions and clinical holding need to be made urgently to the Trust's incident reporting system. These should include as a minimum the following:

- Names of staff
- Names of child or young person
- Legal status of the child or young person
- Reason for using restrictive physical interventions or clinical holding e.g. justification for use with reference to the current PBS plan
- Other interventions attempted where suitable
- Type of restrictive physical interventions or clinical holding employed
- Date and duration

- Any Injury/distress caused (child, young person or staff)
- And action taken as a result
- Date/time of review by a Doctor and outcome
- Debrief session with staff involved (date/time/attendees)
- Debrief session with child or young person involved (date/time/attendees)
- Review of the child or young person's care plan following debrief

In addition, a completed body map of the child or young person following each incident should be completed. All incidents should be reported within a maximum of 24 hours.

4.3 Review of policies and procedures

A review is underway of all existing Trust policies that relate, either in part or wholly to restrictive physical intervention or clinical holding. All policies will ensure that they address the needs of the whole Trust and are fully compliant with relevant guidance and legal frameworks.

4.4 Identified Lead for the use of restrictive physical interventions and clinical holding

All provider organisations should ensure they have an identified Executive Director or equivalent who takes a lead responsibility for the Trust's restrictive physical interventions reduction programme. As part of this role they must publish a public, annually updated, accessible report on their increased behaviour support and restrictive physical interventions reduction, which outlines:

- The training strategy
- Techniques used and reasons why
- Whether any significant injuries resulted
- And details of ongoing strategies for bringing about reductions in the use of restrictive physical interventions

This should be included within annual quality accounts (or equivalent publications).

For the reporting period 01 April 2020 – 31 March 2021, the Trust will produce a suitable report which will cover the required information and detail any planned reduction programme. As present there is no planned reduction programme in place due to the inaccuracies identified in reporting the use of restrictive physical intervention or clinical holding in the main acute site. Once accurate reporting is in place an appropriate planned reduction programme will be developed and implemented.

The identified Executive Lead for the Trust is the Chief Nurse who is supported to discharge these duties via the Director of Community and Mental Health Services.

4.5 Information for children, young people and families

For those children and young people who require restrictive physical interventions or clinical holding this must be part of their care plan and include a positive behavior

support plan that specifically identifies the child or young person's needs. These should be dynamic/live tools that are regularly audited, challenged and updated to ensure bespoke implementation and delivery of safe care

Information is currently provided on the use of restrictive physical interventions or clinical holding to children, young people and families accessing the Trust's Tier 4 Unit. This information will be reviewed and shared with all services across the Trust to enable services and areas to adapt for their use.

5. Next Steps

The Trust Board are asked to note the content of this report and approve the Trust's identified Board lead for restrictive physical interventions and subsequent reduction programme.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th January 2021

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

1. Purpose of the report

The purpose of this report is to provide the Trust Board with an overview of open incident investigations reported externally to the Strategic Executive Information System (StEIS), that met the serious Incident criteria, in this reporting period (1st December – 31st December 2020). There were no closed investigations during this reporting period.

2. Summary

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

Section 2 - New open investigations – shows 2 new open investigation in reporting period

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

Moderate Harm incidents reported
There was 1 moderate harm incident (2020/23808) that met the StEIS reporting criteria.

Section 1

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

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

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

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

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

Section 2 New open investigations

StEIS Reference	Incident	Duty of Candour
2020/23828	Waiting list data quality issues	N/A
Lead investigators identified. Investigation has commenced and is expected to be completed within the agreed timeframe		
Expected investigation completion date - 05/03/2021		
StEIS Reference	Incident	Duty of Candour
2020/23808	Grade 3 pressure Uucer under halo jacket.	Completed - Compliant
Lead investigators identified. Investigation has commenced and is expected to be completed within the agreed timeframe		
Expected investigation completion date - 05/03/2021		

Section 3 : Open ongoing investigations

Table 5

StEIS Reference	Date reported	Incident	Agreed date of completion
2020/15939	21/08/ 2020	Removal of Kidney	8/02.2021
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)	30/1/2021
2020/16210	26/08/2020	Patient death following catastrophic and irreversible brain haemorrhage.	30/1/2021
2020/608	07/01/2020	Misdiagnosis of the grading of a tumour in 2011 - Diagnostic incident ,including delay, meeting SI criteria	01/03/2021
2020/18368	04/09/2020	Teeth replanted in incorrect sockets (UR1 &UR2)	30/01/2020
2020/19439	12/10/2020	Inappropriate clearance of C-Spine	20/02/2020

END

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report December 2020

How Did We Do?

Executive Summary **Month: December** **Year: 2020**

Alder Hey Children's NHS

Delivery of Outstanding Care

Safe

- Clinical Incidents reported resulting in near misses and no harm remain high
- Clinical incidents reported resulting in minor harm continue at a steady rate
- Patient Safety meeting continues to provide a focus on Divisional and corporate incidents with associated actions, reflection and ongoing learning

Highlight

- 0 medication incidents resulting in harm for only the 2nd time this year
- 0 clinical incidents resulting in severe harm and above
- 0 never events
- 0 grade 4 pressure ulcers
- 0 hospital acquired MRSA
- 0 hospital acquired MSSA
- 0 hospital acquired C Difficile

Challenges

- 1 clinical incident resulting in moderate harm which was a Grade 3 pressure ulcer relating to a child in an RTA who had a fractured spine and femur and who had a halo jacket fitted. The child subsequently developed a grade 3 pressure sore. Immediate learning included ensuring that any device containing user guidance from the manufacturer needs to accompany the patient.

The Best People Doing their Best Work

Caring

- 92% of people completing the Family and Friends survey would recommend the Trust
- Friends and Family response numbers remain low disproportionately affecting scores

Highlight

- Complaints were reduced back down from 15 to 9 in December, the same number as this time last year
- PALS were also down to 68 a very similar total to December 19
- 100% of those completing the survey from the Community would recommend the Trust
- 100% of those completing the survey who used mental health services would recommend the Trust

Challenges

- Only 90% of families who completed the survey who used Out Patients would recommend the Trust which is the lowest score this year. Work is ongoing to address the areas where improvement has been identified.

Delivery of Outstanding Care

Effective

Performance in the effectiveness domain is strong. In December we treated 98.6% of patients within 4 hours, and were the number one performing Type 1 ED in England.

Unfortunately 3 patients who were cancelled on the day were not re-accommodated within 28 days. Two families were offered dates however were unable to attend over the holiday period.

Highlight

- Timeliness of care in the ED
- Low readmissions to PICU
- Low number of cancellations on the day of treatment

Challenges

- 28 day breaches

Delivery of Outstanding Care

Responsive

The number of patients waiting over 52 weeks has increased to 184 patients. There are two causes. Firstly, there are 21 reportable long patients from our significant validation programme in Safe Waiting List Management. Secondly, additional patients waiting over 52 weeks in ENT. Specialty-based actions are being taken in relation to air filters to increase patient numbers and additional sessions. This will be supplemented by exploration of additional capacity from the independent sector.

Referral to treatment times against the 18-week standard has improved, for the fifth consecutive month, marginally to 60.8%.

The timeliness of access to cancer care.

Generally positive comments and high 90's compliance from those completing the In Patient survey.

An improved position in month in relation to CYP involved in learning as ways of delivering teaching within the COVID restrictions continues to be reviewed and the FFT question set is amended.

Highlight

- Access to cancer care
- High levels of restoration driving improvement in RTT
- 98% of people who completed the In Patient survey received information enabling choices about their care
- 98% of those who completed the In Patient survey said they were treated with respect.

Challenges

- Number of children and young people waiting over 52 weeks for treatment
- The impact of COVID continues to impact on our scores in relation to those involved in Play and Learning, mainly relating to staff availability and COVID restrictions.

The Best People Doing their Best Work

Well Led

In Month 9, the Trust is reporting a £0.3m deficit which is £0.6m ahead of the in month plan. The year to date performance is now a £2.4m deficit which is also £0.6m ahead of the plan. The Trust is currently forecasting a £4m deficit.

December 's elective and daycase activity were 26 spells higher than last year. Outpatient activity was also higher than month 9 last year. (446 attendances) However non elective activity was 398 spells lower than the same time last year.

The mandatory training levels have started to increase and are now 85.03%. It is essential that this improvement continues and they reach the target in future months.

The PDR performance has dropped and is now 74.6%. This will need to improve in future months to hit the target.

Sickness has decreased slightly in the month and is now 5.45%.

Highlight

- Financial performance
- Activity levels

Challenges

- PDR
- Mandatory training

Game Changing Research and Innovation

Research and Development

Month 9 Research Activity:

- 182 patients recruited to research studies (4238 in 20/21).
- 4 new studies opened (34 in 20/21)
- 112 research studies currently open (incl. 6 Urgent Public Health studies)

Divisional Participation:

- Division of Medicine - 93 open studies
- Division of Surgical Care - 18 open studies
- Division of Community & Mental Health - 1 open study

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 95%

Highlight

- Sustained recovery of research activity levels
- Participation in COVID related Urgent Public Health research

Challenges

- Staff released to support adult vaccine studies
- Absence levels due to sickness and self-isolation

Alder Hey Children's NHS
NHS Foundation Trust

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Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis - A&E
0	0	0	0	0	73.68 %
Dec 2020	Dec 2020	Dec 2020	Dec 2020	Dec 2020	Dec 2020

Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
70.83 %
Dec 2020

CARING

Friends & Family: Overall Percentage Recommended Trust
91.49 %
Dec 2020

EFFECTIVE

ED: 95% Treated within 4 Hours
98.57 %
Dec 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 %	92.25 %
Dec 2020	Dec 2020	Dec 2020	Dec 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 %	60.82 %	184	10520
Dec 2020	Dec 2020	Dec 2020	Dec 2020

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
110776	-9001.43	85.03 %	93.63 %	5.45 %
Dec 2020	Dec 2020	Dec 2020	Dec 2020	Dec 2020

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.2%	99.0%	99.8%	100.0%	99.6%	100.0%	100.0%	98.9%	99.1%	100.0%	100.0%	100.0%	99.8%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	43	72	72	48	39	48	60	86	54	50	80	103	78		No Threshold	
Clinical Incidents resulting in No Harm	D	221	342	335	237	138	261	285	380	318	338	320	400	307		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	D	92	88	82	62	48	57	89	92	83	72	70	88	75		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	D	2	4	1	0	1	0	0	6	1	0	0	1	1		No Threshold	
Clinical Incidents resulting in severe, permanent harm	D	0	1	0	0	0	0	0	0	2	0	0	0	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	3	0	2	2	1	5	7	6	2	8	2	11	0		<=3 N/A >3	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	1	0	0	2	0	0	0	0	1		0 N/A >0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Never Events	W	1	0	1	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	76.7%	83.9%	86.5%	83.3%	60.9%	95.5%	96.2%	79.2%	77.3%	85.2%	74.1%	79.2%	73.7%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	87.5%	87.5%	88.2%	88.9%	93.8%	87.5%	90.9%	88.5%	85.2%	86.1%	94.3%	80.8%	70.8%		>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	1	0	0	0	0	1	1	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	0	0	2	0	1	0	0	1	4	1	0	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

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	92.2%	94.3%	94.3%		96.9%	94.2%	94.9%	94.6%	93.8%	90.6%	94.7%	93.7%	91.5%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	80.8%	88.0%	87.6%		96.1%	92.9%	92.3%	90.7%	91.5%	84.4%	92.1%	89.2%	91.5%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	91.9%	92.0%	91.8%		100.0%	100.0%	95.2%	95.2%	92.3%	89.1%	94.7%	98.8%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	95.9%	97.1%	95.7%		94.4%	90.8%	93.3%	97.0%	95.1%	92.4%	94.5%	95.5%	93.4%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	73.1%	90.7%	80.0%		100.0%	90.9%	100.0%	100.0%	82.4%	92.3%	89.7%	91.3%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	95.7%	95.6%	96.1%		97.4%	96.9%	96.6%	96.0%	95.7%	94.1%	95.5%	93.9%	90.4%		>=95 % >=90 % <90 %	✔
Complaints	W	8	10	10	9	8	6	10	5	20	11	20	15	10		No Threshold	
PALS	W	67	124	114	74	45	44	86	105	105	77	98	71	65		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.8%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	85.6%	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%		>=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	36	20	41	36	6	5	3	7	18	17	19	16	10		<=30	N/A	>30	✔
28 Day Breaches	W	7	10	4	7	24	1	2	0	0	8	2	1	3		0	N/A	>0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	96.5%	97.3%	97.8%	96.4%	91.5%	93.2%	94.1%	99.3%	95.9%	95.4%	95.4%	95.7%	97.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	98.5%	98.7%	97.6%	98.1%	100.0%	97.7%	94.1%	98.5%	97.9%	96.0%	98.3%	98.6%	97.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	90.2%	90.5%	89.6%	91.1%	87.3%	95.5%	95.8%	98.5%	93.2%	97.1%	96.7%	97.8%	95.0%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	96.8%	98.0%	97.6%	96.1%	88.7%	90.9%	90.8%	91.1%	99.3%	98.3%	100.0%	99.3%	91.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	91.2%	95.6%	92.5%	94.2%	60.6%	78.4%	64.7%	72.6%	81.5%	82.3%	83.3%	84.9%	76.7%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	85.4%	85.4%	78.0%	79.2%	74.6%	61.4%	84.0%	83.0%	78.1%	75.4%	88.3%	71.9%	81.6%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.3%	92.0%	92.0%	86.7%	66.7%	58.1%	45.9%	39.6%	43.1%	48.2%	54.2%	59.0%	60.8%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,879	12,885	12,895	12,162	11,046	10,909	11,248	11,022	11,402	11,000	10,941	10,826	10,520		<=12899 N/A >12899	✔
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	5	15	52	82	149	127	145	145	148	184		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%		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%	0.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	99.7%	100.0%	100.0%	100.0%	42.8%	67.0%	81.9%	82.9%	78.9%	91.8%	96.4%	97.1%	92.3%		>=99 % N/A <99 %	✔
PFI: PPM%		99.0%	99.0%	95.0%	99.0%	99.0%	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	98.0%	99.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	358	-172	-488	693	0	0	0	0	0	0	-358	332	-9,001		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	624	3,126	3,820	300	1,287	1,792	3,503	936	-483	4,518	187	-1,733	1,610		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	75,657	76,536	76,536	90,030	107,738	111,270	107,221	107,221	107,763	108,756	109,084	110,503	110,776		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	1,479	1,439	30	6,889	3,146	-692	1,342	1,825	1,077	2,492	-792	748	-9,454		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-89	394	-627	-709	-1,433	691	-312	-340	-291	-1,160	20	492	-192		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-1,031	-2,005	110	-5,487	-1,713	1	-1,029	-1,485	-786	-1,333	414	-909	644		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W		1,245	1,181	953	11	0	0	0	0	-349	-398	-456	-402		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W		426	405	318	0	0	-2	0	-1	49	9	11	51		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W		2,060	1,926	1,563	0	2	5	2	2	-62	-183	36	68		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W		23,887	21,027	17,977	160	272	1,024	1,349	1,346	1,067	-1,137	2,228	1,876		>=0	N/A	<0	✔
PDR	W	89.3%	90.1%	90.1%	90.1%	90.1%	1.3%	5.4%	13.4%	20.7%	29.5%	62.6%	72.4%	74.6%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	W	63.8%	82.7%	90.6%	95.1%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.9%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	W	92.1%	94.3%	95.1%	93.2%	92.1%	90.8%	91.0%	90.5%	90.6%	89.3%	88.6%	85.8%	85.0%		>=90 %	>=80 %	<80 %	✔
Sickness	D	6.5%	5.8%	5.7%	6.2%	5.9%	5.3%	5.0%	5.2%	5.0%	5.2%	6.0%	5.4%	5.4%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	2.0%	1.7%	1.7%	2.3%	1.6%	1.0%	0.9%	1.0%	1.1%	1.4%	1.9%	1.2%	1.1%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	4.5%	4.1%	4.0%	4.0%	4.4%	4.3%	4.1%	4.1%	4.0%	3.8%	4.1%	4.2%	4.4%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	833	775	974	1,514	990	740	565	934	946	1,015	1,061	1,365	1,392		<=800	<=960	>960	✔
Staff Turnover	D	10.2%	10.6%	10.7%	10.3%	9.9%	9.9%	10.1%	9.7%	11.2%	11.0%	10.6%	10.4%	10.2%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	91.6%	90.6%	92.8%		92.2%		95.6%	90.3%	91.3%	94.2%	94.2%	94.9%	93.6%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	100.0%	100.0%	97.7%				100.0%	85.6%	97.0%	93.8%	90.0%	87.5%	90.4%		>=85 %	N/A	<85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	172	166	165	146	21	23	43	47	50	61	66	71	76		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	46	46	46	42	21	19	20	25	27	28	34	37	36		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	6	3	1	0	4	3	3	1	3	4	1	4	4		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	3	0	1	0	1	0	0	1	2	0	2	1	0		>=1	N/A	<1	✔
Number of patients recruited	W	1,094	982	917	665	407	537	560	134	508	413	665	832	182		>=100	>=86	<86	✔

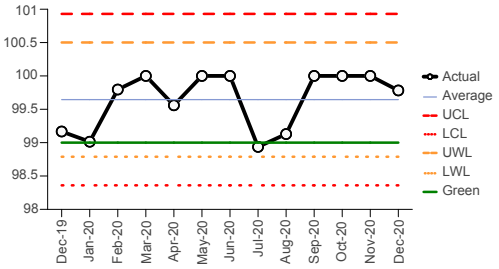
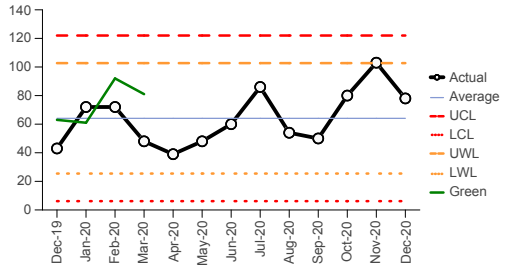
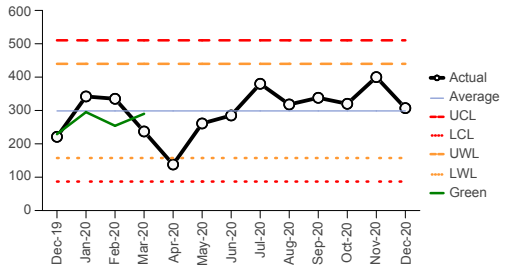
Delivery of Outstanding Care

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	99.78 %	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	78	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	307	No Threshold		

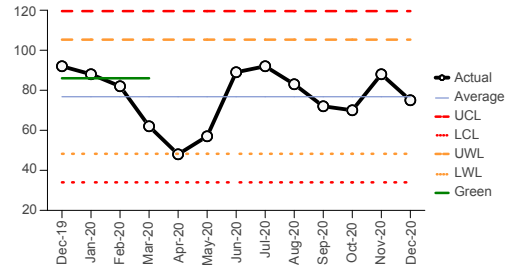
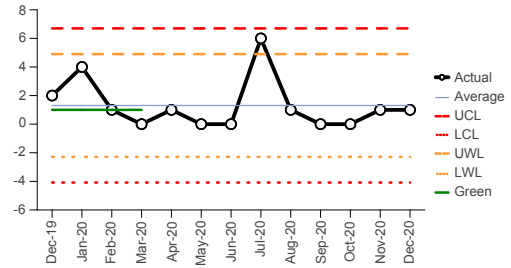
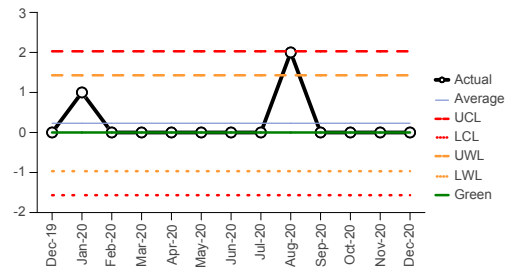
Delivery of Outstanding Care

7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

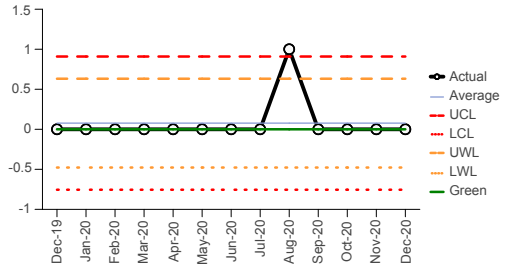
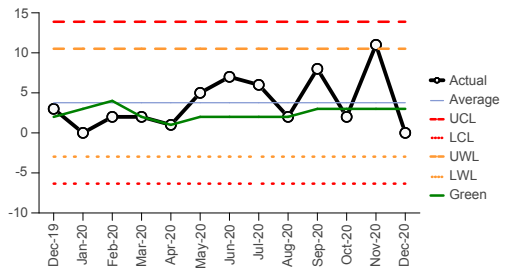
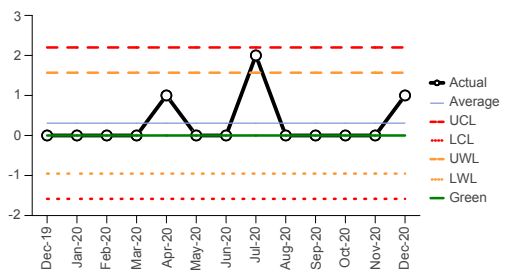
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	75	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

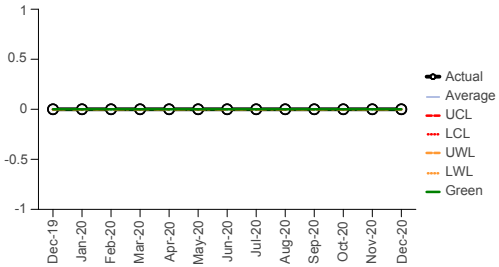
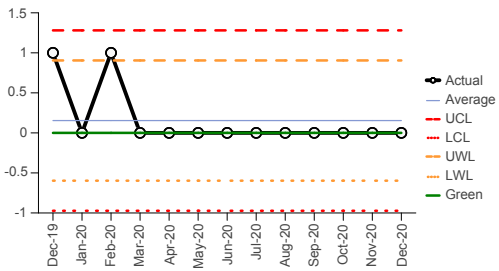
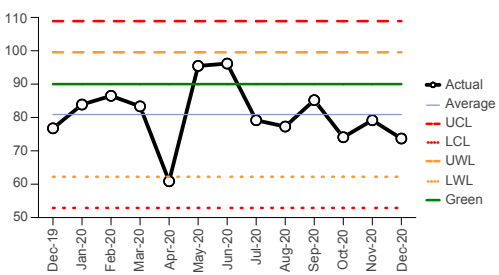
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually. **Exec Lead:** Nicki Murdock **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	0	R >3 A N/A G <=3		No Action Required
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	1	R >0 A N/A G 0		This is a Category 3 Pressure Ulcer under a halo jacket, which was confirmed following a review by Tissue Viability Services on the 09th December 2020. A 72 hour review has been completed and Duty of Candour applied in line with regulatory requirements. An RCA investigation is underway.

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	73.68 %	R <90 % A N/A G >=90 %		Five patients did not receive antibiotics within 60 minutes largely due to difficulty gaining intravenous access including difficulty accessing a Portacath, 3 patients also required multiple lumbar puncture attempts prior to receiving antibiotics.

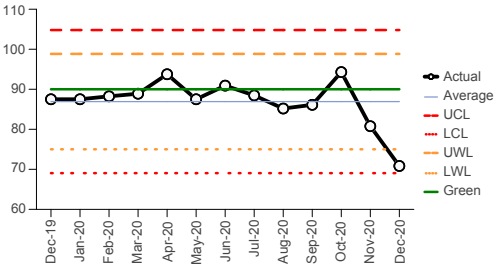
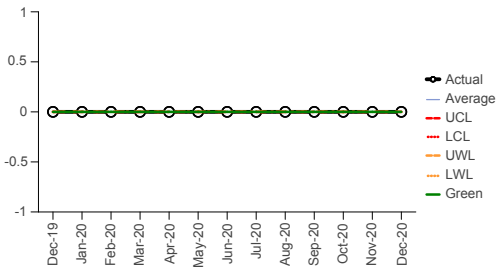
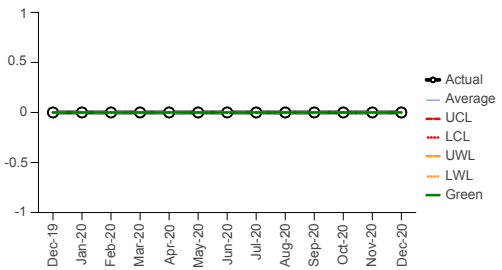
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

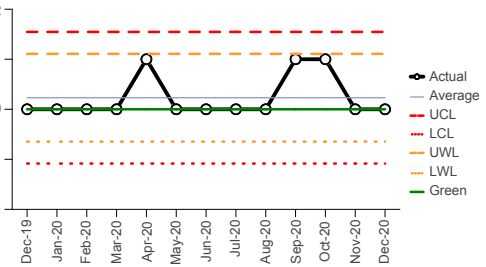
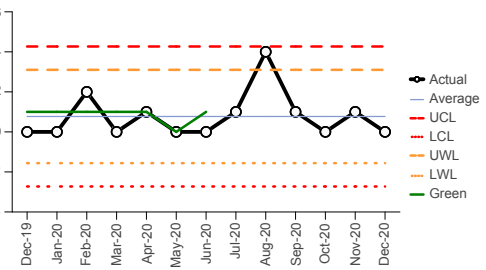
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 20/21 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	70.83 %	R <90 % A N/A G >=90 %		24 patients identified with 7 delays in IVAB >60mins. Noticeably decrease in activity however increase in acuity. 4 of the 7 delays required IV Fluid Bolus due to being hemodynamically unstable IVAB given straight after, 1 infant difficult iv access needed senior support, 2 delays no identified reason-incident reported. Actions: clarification given regarding who is able to check IVAB, data already emailed to all matrons, increase awareness of sepsis data (sharedpoint site for staff), increase visual presence on wards, weekly meetings with Divisional nursing leads. Plans in place for actions.
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 20/21 is zero. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 20/21 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

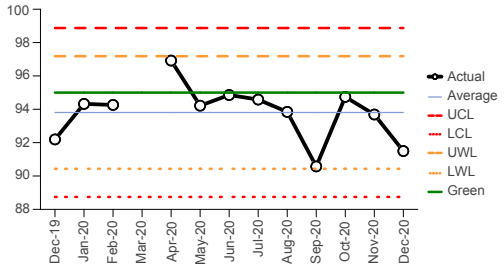
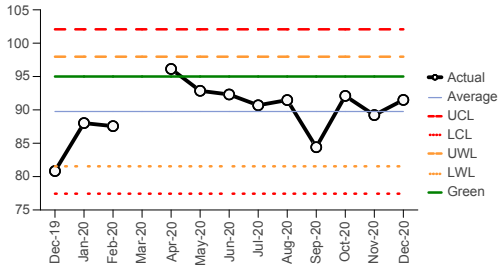
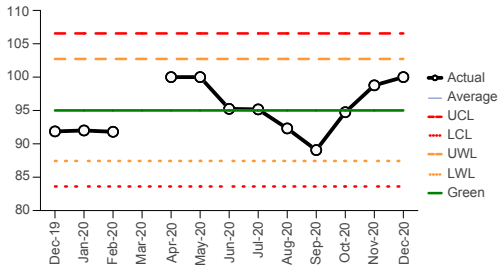
The Best People doing their best Work

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	91.49 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 0.02% from November 2020 to 93.58%. Response channel is predominately made up via SMS (69.2%) and surveys after online consultations (29.3%). In December 2020, Medicine had a total of 575 responses with 24 negative (4.17%), Surgery had a total of 338 responses with 7 negative (2.07%). Community had a total of 118 responses with only 3 negative (2.54%).
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	91.49 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 2.27% from November 2020. There were 235 responses for December 2020, 31 more than November 2020 – 99.6% response via SMS. 14 (5.95%) responses were either poor or very poor. Comment analysis has identified waiting times to be the only key theme in December. Out of 156 comments about how we could improve, 15 (9.62%) mentioned long waiting times as a key problem.
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	100 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 0.5% from November 2020 to 94.92%. There were 118 responses for December 2020, 97 less than November 2020 – 56.8% response via SMS and 39.8% through online surveys after discharge or appointment. There were 3 (2.54%) responses that were either poor or very poor. This was alongside 3 (2.54%) responses that were neither good nor poor. There were no clear themes or trends identified when respondents were asked 'How could we improve?'

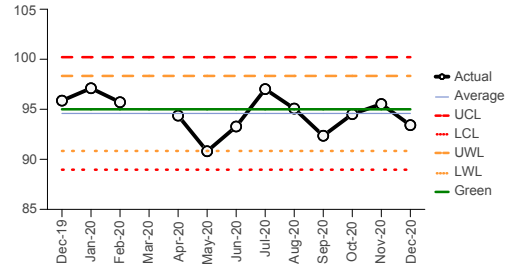
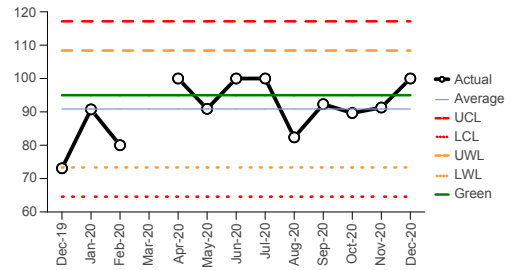
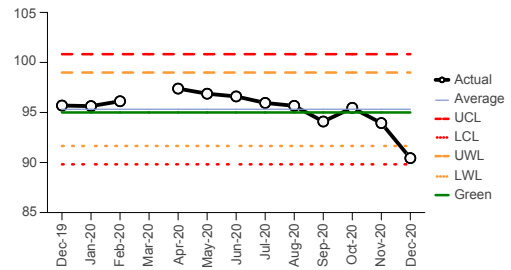
The Best People doing their best Work

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	93.41 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 1.01% from November 2020 to 93.41%. There were 167 responses for December 2020, 33 more than November 2020 – 97.6% response via SMS. Only 3 of these responses (1.8%) were either poor or very poor. Overall percentage was mainly affected by respondents who found their experience neither good nor poor (3.59%). Out of the 94 people who responded to 'How could we improve?' comment analysis identified one recurring theme in regards to keeping families informed during their journey and any changes to their care. This issue was highlighted five times in December.
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	100 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 1.37% since November 2020 to 91.67%. Positive percentage increase is following an upwards trend since August 2020. There were 12 completed surveys, with only 1 very poor response in this area. This one negative response accounts for 8.33% of overall percentage. The one very poor response had no qualitative feedback and further comment analysis has identified no clear trends in this area for December 2020.
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	90.43 %	R <90 % A >=90 % G >=95 %		The percentage has increased by 0.58% since November 2020 to 94.52%. There were 920 completed surveys, with 30 poor or very poor responses in this area. These poor or very poor responses account for 3.26% of overall percentage. Comment analysis highlighted connectivity for video appointments as an area for improvement with 14 out of 156 respondents (8.97%) who had a video appointment commenting on poor video/audio quality. There were seven comments from poor or very poor surveys. Four of those comments related to staff attitude in different departments – there was no trend in one department.

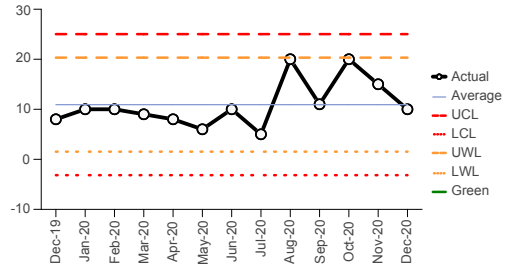
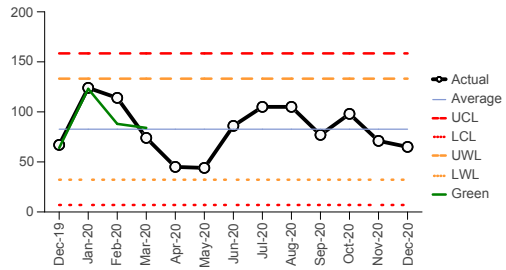
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

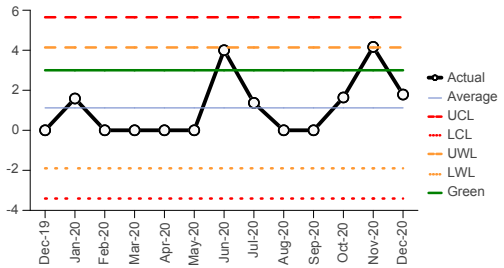
	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	10	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	65	No Threshold		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

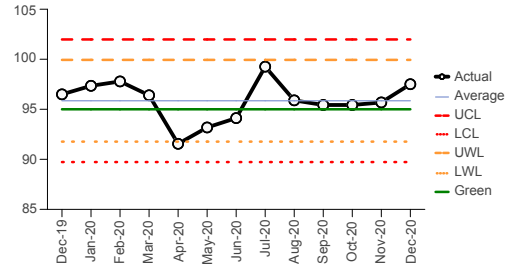
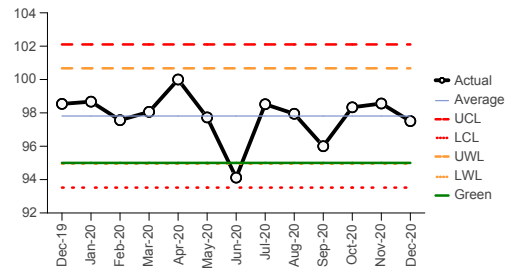
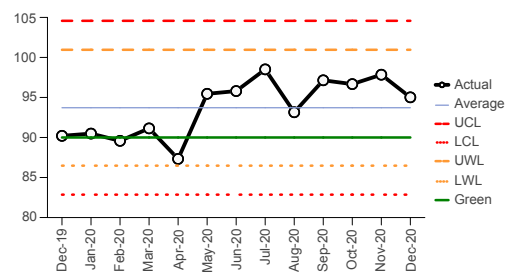
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally 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	1.79 %	R >3 % A N/A G <=3 %		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

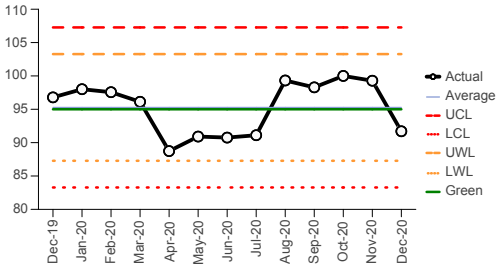
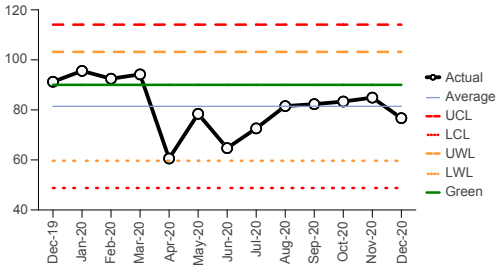
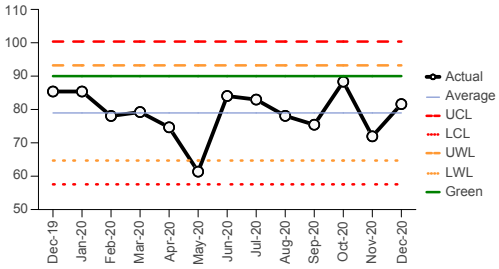
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	97.51 %	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	97.51 %	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	95.02 %	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	91.70 %	R <90 % A >=90 % G >=95 %		Overall percentage of patients that report knowing who is in charge of their care this month was 93.53%, a decrease of 5.77% from November 2020. There is no clear indication as to why overall percentage in this area has dropped. Surgery had 95.77% of respondents who reported that they knew who was in charge of their care. However, Medicine had 82.86% in this area. Out of 35 respondents in Medicine, six reported that they did not know who was in charge of their care.
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	76.69 %	R <85 % A >=85 % G >=90 %		Percentage of patients that report engaging with play this month was 74.70%, a decrease of 10.2%. The decrease in percentage is partly due to focus of the Play team on Christmas preparations on the ward areas. This included the dressing of Christmas trees and ensuring the ward areas are decorated in a Christmas theme. The Play team were heavily involved in the receiving and organisation of the Christmas gift donations to ensure that both inpatients and CYP based in the community are the recipients of a Christmas gift from Alder Hey NHS Foundation Trust.
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	81.61 %	R <85 % A >=85 % G >=90 %		December has shown an increase in the percentage of inpatient children / families reporting involvement in learning/teaching (81.76%) compared to November 2020 (71.9%). Percentage increase is partly due to the rewording of the FFT question in relation to learning so that only patients/families who meet the criteria for learning are asked. There is currently a review of the resumption of group-based teaching within the main classroom which has been prohibited due to infection control since March 2020.

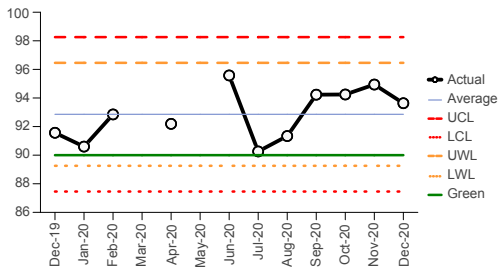
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

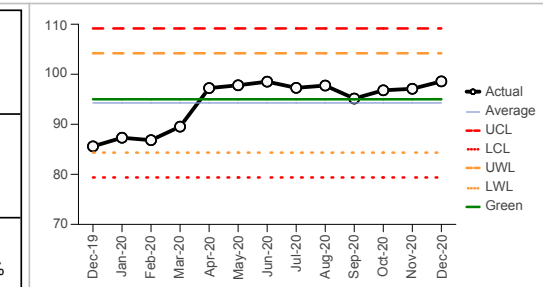
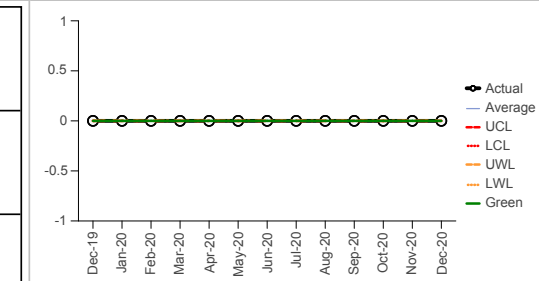
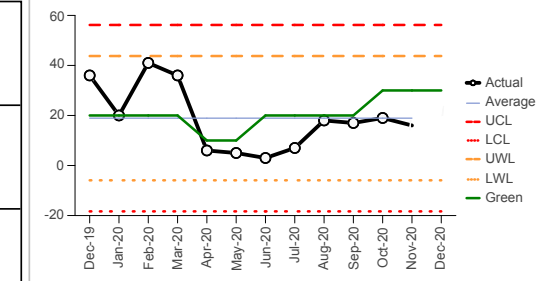
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	93.63 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

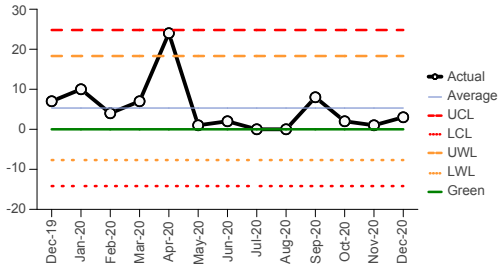
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	98.57 %	R <95 % A N/A G >=95 %		No Action Required
ED 12 Hr Waits	**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	10	R >30 A N/A G <=30		During December we saw a reduction in operations cancelled on the day for a non-clinical reason. Unfortunately a few theatre sessions overran which resulted in cancelations on the day in addition there were discrepancies with starving in instructions which also resulted in cancelations.

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	3	R >0 A N/A G 0		Unfortunately 3 patients who were cancelled on the day were not re-accommodated within 28 days. Two families were offered dates however were unable to attend owing to the Christmas period, however all will be prioritised for theatre lists in January.

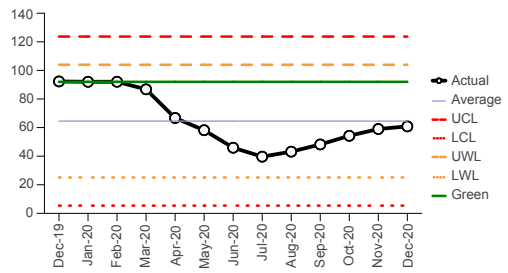
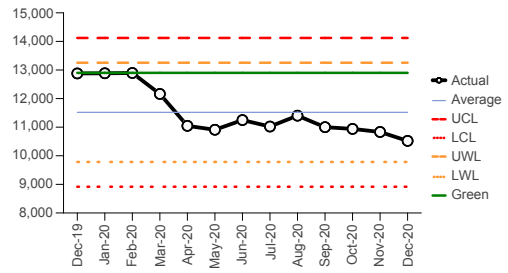
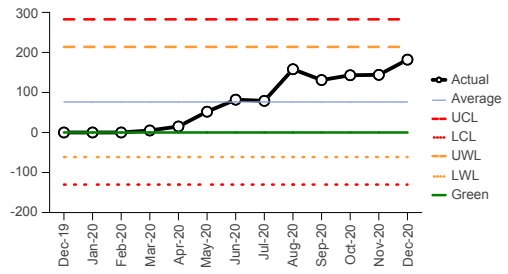
Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

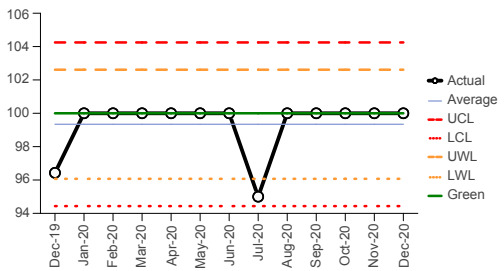
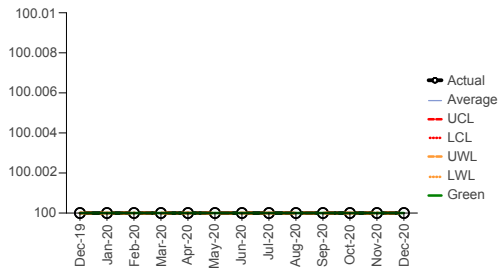
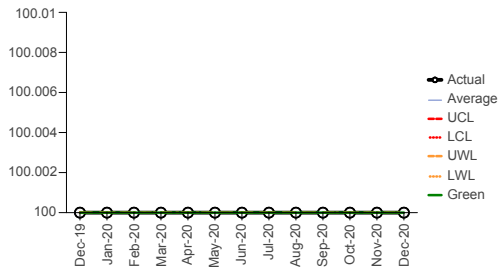
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	60.82 %	R <90 % A >=90 % G >=92 %		Performance continues to improve with notable progress against our restoration targets. 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	10520	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	184	R >0 A N/A G 0		Unfortunately during December there have been an increase in the number of children and young people who have waited over 52 weeks for treatment. The majority of these patients are waiting for surgical treatment. All of which have received a clinical review and continuous plans are in place in attempt to treat these children's as soon as possible. Some of these children have been established via additional validation associated with the Safe Waiting List Programme.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

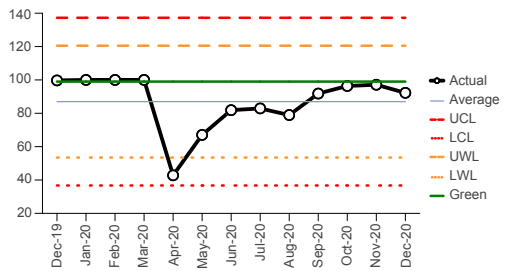
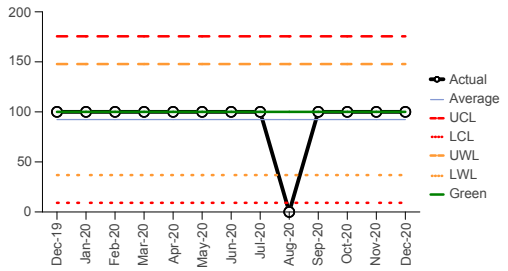
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	92.25 %	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 . Pressures around GA MRI patients have led to some out of month breaches in December, The Team have put on additional sessions in Dec and Jan to minimise the impact. Reduction in anaesthetic cover in January will mean we are likely to see similar performance for that modality in January.
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

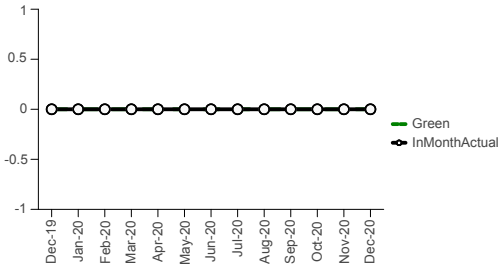
The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

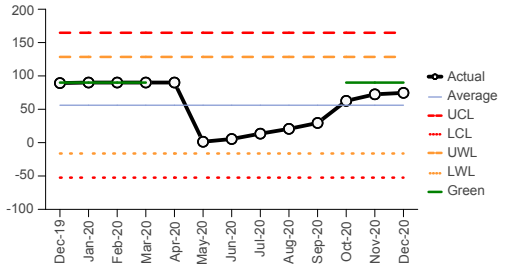
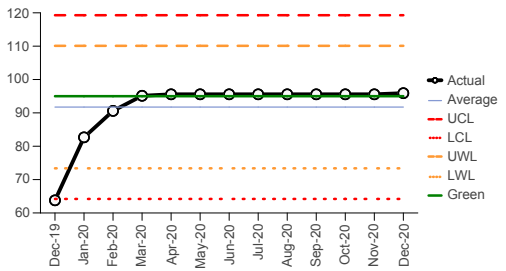
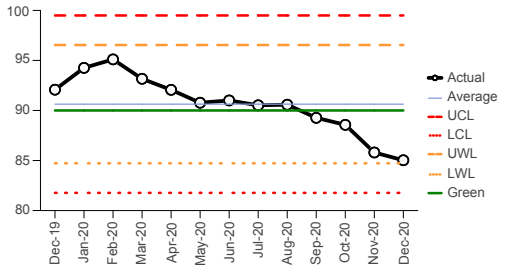
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	74.60 %	R <85 % A >=85 % G >=90 %		PDR compliance has risen 3% to 75% overall but I still 15% below our usual target of 90% across the Trust.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	95.90 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	85.03 %	R <80 % A >=80 % G >=90 %		Mandatory Training is currently 5% below our Trust target of 90%. Topics that have been hit the hardest are the 3 with annual refresher periods that require a face to face session - Basic Life Support, PLS/APLS Update and Moving and Handling Level 2, all are now running again but will require a huge effort to catch back up in terms of compliance. Estates & Ancillary staff have been disproportionately impacted by the changes to Mandatory Training since the pandemic began. We believe this to be due to the lack of access to PCs and therefore the ESR system to complete their e-Learning.

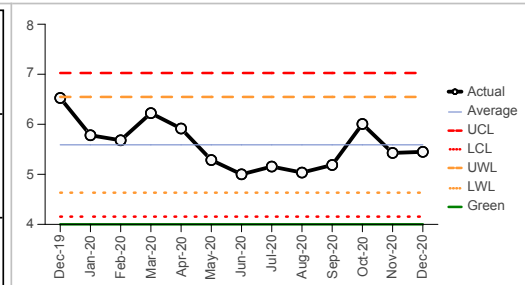
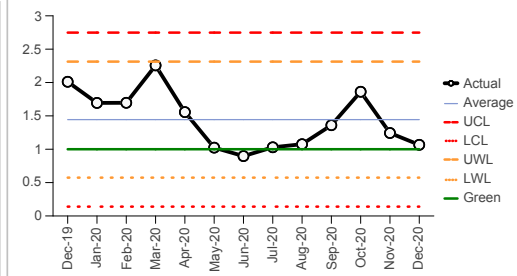
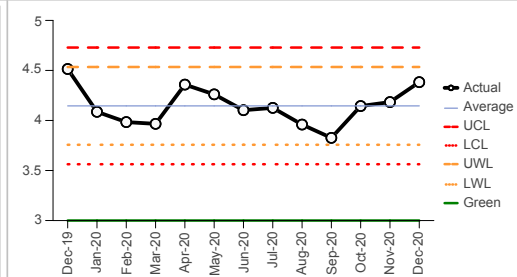
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.45 %	R >4.5 % A <=4.5 % G <=4 %		Sickness has increased slightly from November but still remains above the Trust target of 4%.The HR team are working in collaboration with Divisions to support manager with staff absences in partnership with the SALS Team who are providing support and guidance to managers and employees. The Wellbeing team as of October have been aligned to divisions to further support staff and managers with sickness absence.
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	1.07 %	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	4.38 %	R >3 % A N/A G <=3 %		As above

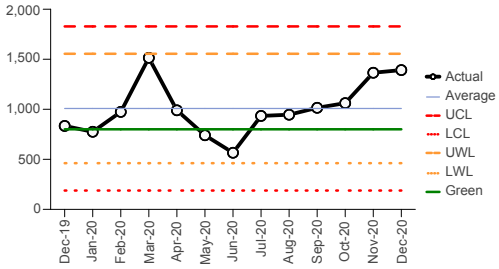
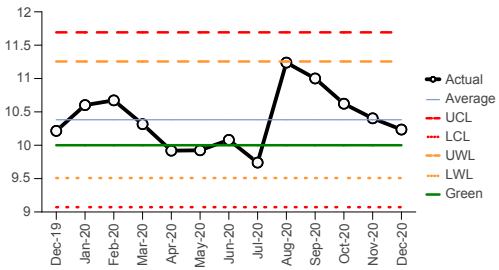
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1391.56	R >960 A <=960 G <=800		Temporary staffing costs have seen an increase following on amendment to rates of pay for NHSP shifts for nursing and health care assistants. This was further to a review of rates of pay across the system to ensure we were equitable. We are are continuing to work with NHSP to ensure we have the right support in place throughout winter.
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.23 %	R >11 % A <=11 % G <=10 %		Turnover has continued to reduce, since a peak in August due to a number of temporary COVID support staff leaving. There were 31 leavers in November; the majority of leavers being in the Community Division (10) The Additional Clinical Services staff group saw the highest number of leavers (11).

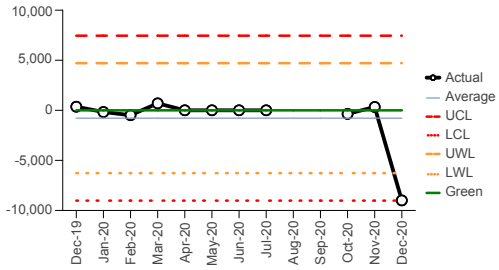
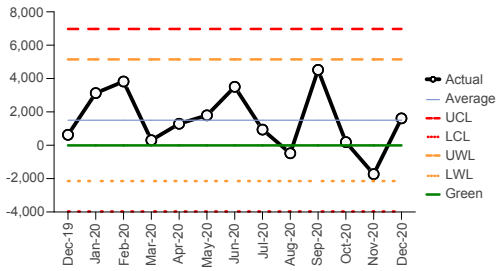
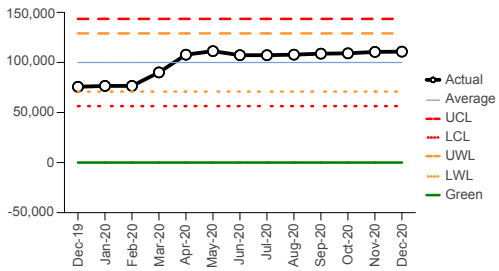
The Best People doing their best Work

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	-9,001	R <-20% A >=-20% G >=-5%		The Trust achieved a deficit in month of £0.3m which was £0.6m ahead of plan. The year to date deficit is now £2.4m which is also £0.6m ahead of plan. The main reasons for the variance to plan are overachievement of income, underspends on non pay and savings on capital charges relating to slippage on the capital plan.
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,610	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	110,776	R <-20% A >=-20% G >=-5%		No Action Required

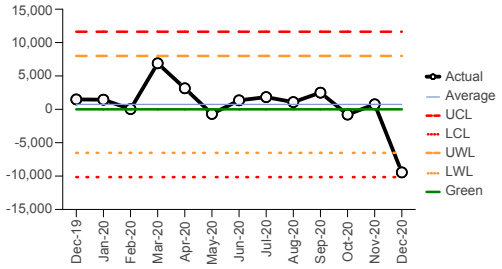
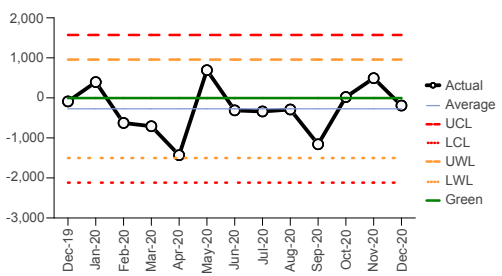
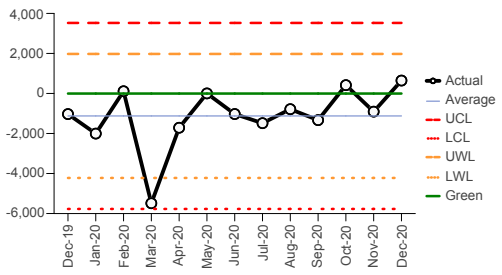
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-9,454	R <-20% A >=-20% G >=-5%		The most significant adverse variances were: Education & training non-HEE £124k Pass-through high cost drugs £123k
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	-192	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	644	R <-20% A >=-20% G >=-5%		No Action Required

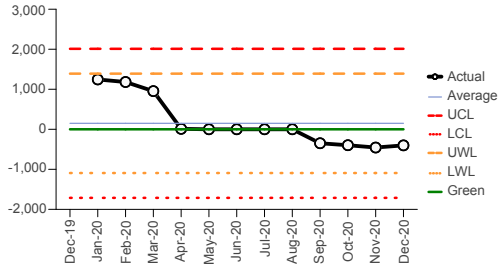
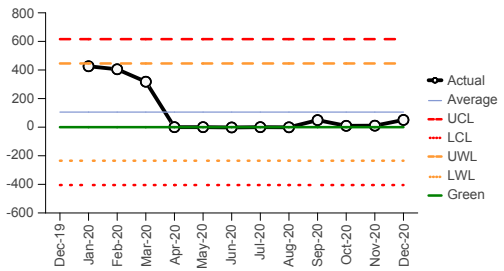
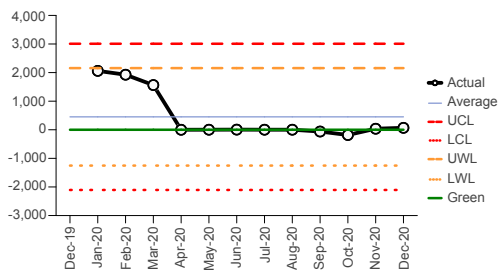
The Best People doing their best Work

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	-402.00	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	50.51	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	67.66	R <0 A N/A G >=0		No Action Required

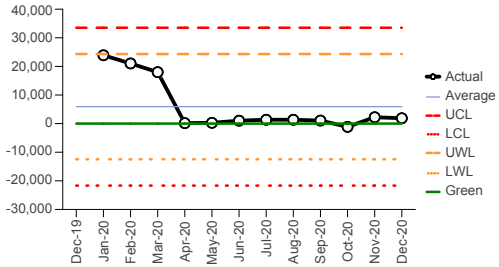
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

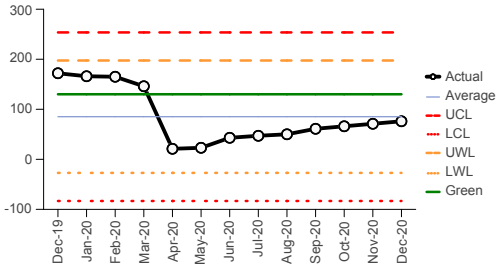
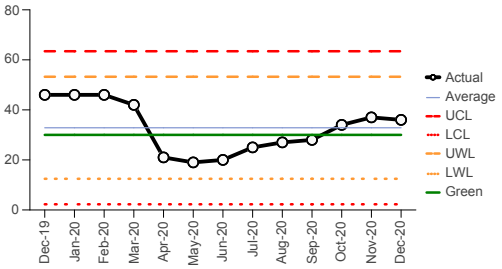
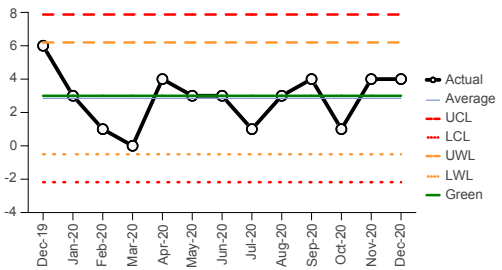
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1875.91	R <0 A N/A G >=0		No Action Required

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

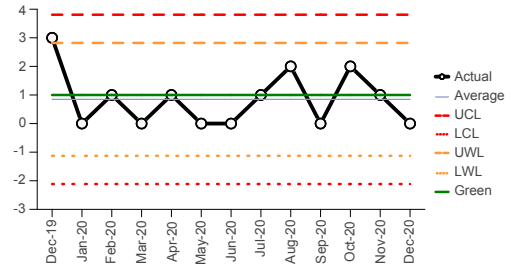
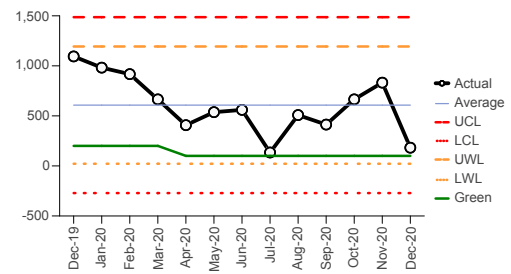
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	76	R <111 A >=111 G >=130		The process of ensuring that 1) the necessary preconditions to safely 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	36	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	4	R <2 A >=2 G >=3		No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

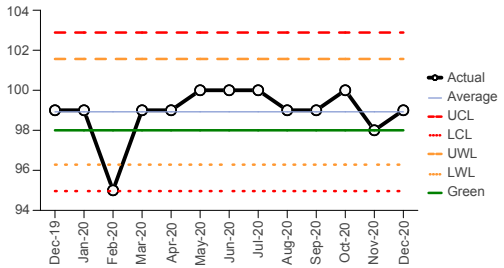
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	0	R <1 A N/A G >=1		Whilst the number of new commercial studies being open is reduced, the overall number of commercial studies open at this time remains positive due to a focus on reactivating commercial research suspended at the start of the outbreak.
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	182	R <86 A >=86 G >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

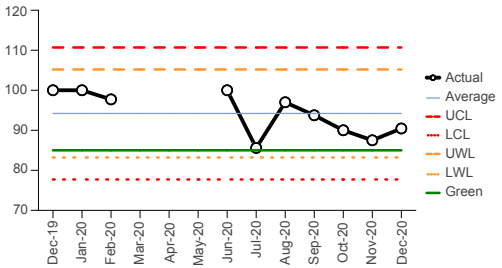
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Nicki Murdock **Committee:** SQAC	90.45 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	16	23	33	No Threshold
Clinical Incidents resulting in No Harm	D	51	96	142	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	9	19	42	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	1	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	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	0	No Threshold
Pressure Ulcers (Category 3)	W	0	0	1	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		90.9%	53.8%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	0	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	2	6	2	No Threshold
PALS	W	15	27	23	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			1.8%	<=3 % / N/A / >3 %
ED: 95% Treated within 4 Hours	D		98.6%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	0	10	No Threshold		
28 Day Breaches	W	0	0	3	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		95.8%	99.2%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		95.8%	99.2%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		91.7%	98.4%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		87.5%	95.9%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		81.2%	72.1%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		81.2%	82.0%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	64.4%	86.1%	54.3%	>=92 %	>=90 %	<90 %
Waiting List Size	W	800	1,785	7,858	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	0	183	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		91.7%	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	45	41	-502	No Threshold
Income In Month Variance (£'000s)	W	75	142	34	No Threshold
Pay In Month Variance (£'000s)	W	12	30	-398	No Threshold
Non Pay In Month Variance (£'000s)	W	-43	-131	-138	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		-355	-47	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	46	4	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		105	-37	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	734	573	-915	>=0	N/A	<0
PDR	W	81.9%	74.6%	67.6%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	100.0%	94.1%	96.8%	>=95 %	>=90 %	<90 %
Mandatory Training	W	88.4%	86.7%	85.6%	>=90 %	>=80 %	<80 %
Sickness	D	4.0%	4.9%	6.2%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	0.9%	1.3%	1.3%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.1%	3.6%	4.9%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	355	213	415	No Threshold		
Staff Turnover	D	8.8%	7.3%	7.7%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	98.6%	93.2%	93.5%	>=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** • Sepsis patients treated with 60 min increased from 75% to 90% **Challenges** • Increase in medication errors recorded
CARING	6 complaints and 27 PALS	**Highlight** • Small reduction in both complaints and PALS **Challenges** • Number of complex complaints still to be resolved related to Tics and tourettes service
EFFECTIVE	ED performance increased again to 98.6% from 97.1% in November. This was 85.6%% at the same time last year and very happy to see this sustained improvement.	**Highlight** • Continued improvement in ED performance. **Challenges** • WNB rate increased to 13.7% • Increase in cancellations < 6 weeks
RESPONSIVE	RTT compliance continues to improve at 85% (against 81% in November) Patients at 40 weeks + reduced from 63 to 24.	**Highlight** ▪ Continued improvement in RTT performance ▪ Material reduction in long waiting patients (40+ weeks) **Challenges** ▪ Capacity challenge in key areas slowly overall RTT improvement. ▪ Reporting times in radiology for outpatients remains challenging. ▪ DM01 performance for EEG and endoscopy
WELL LED	The Division remains underspent. Sickness has continued to improve despite increase in long term sickness.	**Highlight** • Safer staffing rates • PDR rate increased from 69% to 74% • £30k underspent on pay **Challenges** • Sickness rate remains over 4% • Mandatory training – basic life support for medical staff • Non-pay overspend

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Medicine

D Drive W Watch P Programme

SAFE

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	20	34	28	15	13	19	18	29	19	16	29	33	23		No Threshold
Clinical Incidents resulting in No Harm (D)	70	135	93	71	33	64	75	104	75	93	69	123	96		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	23	24	19	7	12	13	19	26	21	16	10	18	19		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	1	0	0	0	0	0	2	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	1	0	0	0	0	0	0	1	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)	2	0	1	0	1	5	3	2	0	4	0	0	0		No Threshold
Medication Errors (Incidents)	22	48	30	15	13	25	29	26	23	18	24	30	36		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	3	5	1	2	1	1	0	0	2	2	0	0	1		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	100.0%	100.0%	100.0%	88.9%	100.0%	83.3%	92.3%	100.0%	84.6%	91.7%	100.0%	75.0%	90.9%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	1	0	0	0	0	0	1	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	1	1	1	0	1	1	1	0	2	0	0	0	2		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Cleanliness Scores	98.3%	97.8%	97.6%				98.5%	97.7%	97.8%	98.0%	98.0%	96.0%	95.1%		>=90 % >=80 % <80 %
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.	100.0%	99.9%	99.8%	99.7%	99.3%	99.3%	99.6%	99.8%	99.8%	99.8%	99.8%				>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	58.5%			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	62.0%	47.0%	53.0%	58.0%	65.0%	65.0%	64.0%	78.5%	84.0%	77.3%	85.0%	85.0%	85.0%		>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	89.0%	84.0%	88.0%	67.0%	67.0%	69.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.0%			>=90 % >=80 % <90 %

CARING

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

EFFECTIVE

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Referrals Received (Total)	1,825	2,014	1,957	1,547	838	994	1,432	1,664	1,566	2,270	2,009	2,073	1,603		No Threshold
ED: 95% Treated within 4 Hours (D)	85.6%	87.3%	86.8%	89.5%	97.2%	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	7.0%	4.0%	3.8%	2.7%	0.2%	0.8%	1.1%	1.5%	0.8%	2.0%	0.8%	1.0%	0.6%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	8.5%	8.3%	8.0%	7.4%	8.2%	8.4%	7.5%	7.8%	8.3%	7.0%	7.9%	7.8%	7.9%		No Threshold

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	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-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	78.9%	80.7%	85.8%	76.2%	73.9%	76.7%	75.4%	82.0%	82.1%	81.0%	83.9%	82.2%	85.7%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	1	2	5	0	1	2	0	0	3	2	1	1	0		No Threshold
28 Day Breaches W	0	0	0	0	0	1	2	0	0	3	2	0	0		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	26	22	41	67	175	1	2	12	55	20	33	20	47		No Threshold
OP Appointments Cancelled by Hospital %	15.1%	12.8%	15.3%	25.8%	46.0%	21.7%	15.5%	13.0%	11.3%	12.1%	11.1%	12.3%	13.5%		<=5 % N/A >10 %
Was Not Brought Rate W P	11.8%	9.1%	10.6%	11.0%	7.6%	9.0%	11.7%	12.1%	12.6%	12.4%	11.8%	10.0%	13.4%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	14.2%	11.3%	14.3%	14.8%	15.9%	13.9%	14.5%	15.3%	13.5%	16.3%	12.6%	12.0%	14.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	11.0%	8.5%	9.6%	10.1%	6.0%	8.1%	11.0%	11.5%	12.4%	11.7%	11.6%	9.5%	13.0%		<=14 % <=16 % >16 %
Coding average comorbidities	4.80	4.77	5.05	5.18	5.54	5.46	5.39	5.33	5.28	5.17	5.31	5.43	5.50		No Threshold

RESPONSIVE

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Convenience and Choice: Slot Availability	82.7%	95.9%	89.6%	66.7%											
IP Survey: % Received information enabling choices about their care W	94.6%	95.5%	97.1%	95.0%	95.0%	100.0%	81.5%	100.0%	95.6%	92.9%	92.9%	96.9%	95.8%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	97.7%	98.9%	97.6%	98.1%	100.0%	100.0%	88.9%	96.8%	97.8%	100.0%	97.2%	100.0%	95.8%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	92.7%	86.4%	83.5%	91.2%	90.0%	97.1%	85.2%	100.0%	93.3%	95.2%	88.9%	100.0%	91.7%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	92.7%	97.7%	97.1%	95.0%	87.5%	97.1%	85.2%	90.3%	100.0%	97.6%	100.0%	100.0%	87.5%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D	90.4%	94.4%	92.9%	93.1%	60.0%	74.3%	63.0%	77.4%	80.0%	88.1%	77.8%	84.4%	81.2%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	81.6%	81.6%	78.2%	76.1%	77.5%	68.6%	77.8%	87.1%	82.2%	76.2%	63.9%	62.5%	81.2%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	94.2%	94.0%	92.2%	88.1%	68.8%	60.1%	46.3%	40.6%	45.0%	55.5%	68.0%	81.0%	86.1%		>=92 % >=90 % <90 %
Waiting List Size W	3,420	3,043	3,495	3,361	3,381	3,266	2,791	2,484	2,420	2,151	1,916	1,778	1,785		
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Waiting Times - 40 weeks and above	1	2	9	14	90	121	127	147	181	137	81	63	24		
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%		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	99.7%	100.0%	100.0%	100.0%	39.1%	64.9%	82.1%	84.6%	77.9%	91.4%	96.2%	97.7%	91.7%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	89.8%	90.2%	91.0%	86.1%	90.3%	90.4%	90.0%	90.4%	92.7%	89.7%	90.0%	90.6%	90.4%		>=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%	99.9%	100.0%	100.0%	100.0%	99.8%	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	82.0%	85.0%	88.0%	95.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%	95.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	81.0%	86.0%	90.0%	86.0%		98.0%	98.0%	97.0%	97.0%	98.0%	93.0%	98.0%	92.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	92.0%	89.0%	95.0%	75.0%	100.0%	98.0%	97.0%	81.0%	69.0%	71.0%	74.0%	72.0%	51.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	82.0%	64.0%	86.0%	84.0%	16.8%	63.6%	62.6%	82.4%	59.1%	98.0%	98.8%	100.0%	94.2%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks					11.6%	17.2%	35.4%	88.2%	77.8%	100.0%	100.0%	100.0%	90.0%		>=99 % N/A <99 %

Medicine

D Drive W Watch P Programme

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-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%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	501	124	-361	-81	-2,544	-1,842	-1,048	278	-1,111	-1,201	-264	153	41		No Threshold
Income In Month Variance (£'000s)	W	869	1,315	80	271	-2,416	-2,220	-1,103	347	-1,170	-622	-647	561	142		No Threshold
Pay In Month Variance (£'000s)	W	-28	15	-67	-297	59	99	92	196	62	-211	-143	338	30		No Threshold
AvP: IP - Non-Elective	W		817	826	610	0	0	-1	0	1	-222	-333	-421	-355		>=0 N/A <0
AvP: IP Elective vs Plan	W		133	107	87	-1	-1	0	0	0	24	7	25	46		>=0 N/A <0
AvP: OP New			1,443.00	1,133.00	855.00	1.00	5.00	2.00	-1.00	10.00	-462.00	-18.00	47.00	-150.05		>=0 N/A <0
AvP: OP FollowUp			4,286.00	3,648.00	3,609.00	1.00	6.00	7.00	15.00	10.00	1,258.00	661.00	825.00	945.29		>=0 N/A <0
AvP: Daycase Activity vs Plan	W		1,202	1,084	980	0	1	2	0	2	15	-5	140	105		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W		7,165	6,073	5,593	2	11	9	17	22	544	162	641	573		>=0 N/A <0
PDR	W	87.8%	87.1%	87.1%	87.1%	87.1%	3.1%	10.7%	12.1%	23.0%	21.8%	60.2%	69.1%	74.6%		>=90 % >=85 % <85 %
Medical Appraisal	W	65.1%	84.1%	91.5%	94.9%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	94.1%		>=95 % >=90 % <90 %
Mandatory Training	W	91.6%	94.1%	94.6%	93.1%	92.3%	91.9%	91.6%	91.3%	91.3%	89.9%	90.2%	88.9%	86.7%		>=90 % >=85 % <80 %
Sickness	D	6.1%	5.8%	6.3%	6.0%	5.6%	4.8%	5.4%	5.6%	5.1%	5.0%	5.8%	4.8%	4.9%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	2.2%	1.9%	2.0%	2.4%	1.6%	0.9%	1.0%	0.9%	1.1%	1.4%	2.2%	1.5%	1.3%		<=1 % N/A >1 %
Long Term Sickness	D	3.9%	3.9%	4.3%	3.6%	4.0%	3.9%	4.4%	4.7%	4.1%	3.6%	3.6%	3.3%	3.6%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	222	250	265	347	201	157	108	167	217	266	235	239	213		No Threshold
Staff Turnover	D	9.5%	9.9%	9.8%	10.0%	9.7%	9.2%	8.3%	7.6%	7.6%	6.7%	6.8%	7.1%	7.3%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	90.7%	91.6%	94.6%		96.5%		97.7%	96.4%	94.9%	94.9%	93.2%	93.6%	93.2%		>=90 % >=85 % <90 %

Surgery Division		
SAFE	• No medication errors occurred that resulting in harm 4>2<11>0 • Reduction in medication errors 37>37<69>43 • Reduction in incidents resulting in near miss 24<32<48>33 • Reduction in clinical incidents resulting in No harm 147 > 140>150<184<141 • Reduction in Clinical Incidents resulting in minor, non-permanent harm 41<50>42 • 1 clinical incident resulting in moderate, semi-permanent harm • No Clinical Incidents resulting in severe, permanent harm or catastrophic death • 1 cat 3 pressure ulcers, no cat 4's • No never events. • No hospital acquired	**Highlight** • Significant reduction in medication errors **Challenges** • Reduction in patients treated for sepsis within 60 mins 75%<86.7%<90%>53.8%
CARING	• Further reduction in formal complaints from 7>2<9>4>2 • Slight increase in PALS from 33>22<29>20 <23	**Highlight** • Continued reduction in formal complaints **Challenges** • Providing access within a timely manner for elective patients
EFFECTIVE	• Reduction in patients readmitted to PICU within 48 hours 0%<1.6%<4.2% >1.8% • Further reduction in referrals received 2992>2908>2231 • WNB rate increased 9.5%<9.5%<11.4% • CCAD cases <30<31>27 • Reduction in cancelled operations on the day 18>15>10 • Increase in patients waiting over 28 days to be rescheduled 0<1<3	**Highlight** • Reduction in readmissions to PICU **Challenges** • WNB rate increased
RESPONSIVE	• Increase % Received information enabling choices about their care96%>95%<99% • Patients who noted that they were treated with respect 94.7%<98.8%<98.1%<99.2% • Patients knew their planned date of discharge 97.7%<100%>97.2%>98.4% • Patients noted that they knew who was in charge of their care 98.5%<100%>99.1%<95.9% • Increase in patients noted they were involved in learning 75.2%>98.8%<74.8%<82%	**Highlight** • Increased weekend theatre sessions both Inpatients and Day Case theatres **Challenges** • Waiting list size 7840>7737<8129<8216>7858 • Patients waiting over 52 weeks for treatment 143>139<183
WELL LED	• Number of PDR's completed 68% • Increase in medical appraisals 97% • Slight increase in mandatory training 87%>84.8%<85.6% • Reduction in staff turnover 9.6% >8.8% >8.3%>7.8% • Increase in both long term and short-term sickness overall sickness rates 6.2%	**Highlight** • Increase in medical appraisals **Challenges** • Management of long-term sickness 4.9%

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	17	28	29	22	18	18	30	42	26	24	32	48	33		No Threshold
Clinical Incidents resulting in No Harm (D)	110	145	166	115	76	96	114	175	147	140	150	184	142		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	47	39	40	38	22	26	48	48	51	40	41	50	42		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	2	3	0	0	1	0	0	4	1	0	0	0	1		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	1	0	0	2	0	0	4	4	1	4	2	11	0		No Threshold
Medication Errors (Incidents)	27	43	38	38	16	22	34	61	36	38	37	69	43		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	1	0	0	2	0	0	0	0	1		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events (W)	1	0	1	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)	60.0%	57.1%	80.0%	88.9%	88.9%	91.7%	88.9%	83.3%	85.7%	75.0%	86.7%	90.0%	53.8%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	1	0	0	2	0	0	0	0	1		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	0	0	2	0	1	0	0	1	4	1	0	1	0		No Threshold
Cleanliness Scores	98.0%	99.1%	96.3%				97.9%	98.4%	96.0%	98.2%	98.0%	96.0%	97.9%		>=90 % >=80 % <80 %

CARING

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Complaints (W)	5	1	2	3	1	2	2	0	7	2	10	4	2		No Threshold
PALS (W)	20	29	30	20	13	7	37	39	33	22	29	20	23		No Threshold

EFFECTIVE

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	0	1	0	0	0	0	2	1	0	0	1	2	1		No Threshold
% Readmissions to PICU within 48 hrs (W)	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.8%		<=3 % N/A >3 %
Referrals Received (Total)	2,837	3,732	3,638	2,816	1,371	1,781	2,256	2,831	2,586	3,164	2,999	2,921	2,710		No Threshold
Theatre Utilisation - % of Session Utilised (W)	83.6%	89.7%	88.5%	86.2%	66.4%	68.1%	86.6%	88.6%	89.1%	88.9%	89.8%	88.8%	84.8%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	35	18	36	36	5	3	3	7	15	15	18	15	10		No Threshold
28 Day Breaches (W)	7	10	4	7	24	0	0	0	0	5	0	1	3		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	11	29	41	140	194	2	0	16	70	52	58	38	45		No Threshold
OP Appointments Cancelled by Hospital %	12.9%	14.0%	13.0%	28.6%	55.9%	30.2%	17.3%	14.9%	11.9%	11.2%	10.9%	11.6%	10.4%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	12.7%	9.4%	9.6%	10.7%	9.7%	10.4%	7.8%	9.2%	10.3%	10.6%	9.4%	9.6%	11.2%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	11.9%	9.3%	10.5%	11.2%	9.9%	11.3%	8.9%	10.9%	11.5%	12.3%	9.8%	10.1%	11.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	13.0%	9.5%	9.3%	10.5%	9.6%	10.1%	7.3%	8.6%	9.8%	10.1%	9.3%	9.4%	10.9%		<=14 % <=16 % >16 %
Coding average comorbidities	4.26	4.16	4.02	4.23	5.20	4.89	4.19	4.06	4.49	4.45	4.39	4.40	4.41		No Threshold
CCAD Cases	26	33	28	36	21	26	24	29	23	30	31	27	26		No Threshold

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Surgery

D Drive W Watch P Programme

RESPONSIVE

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		98.7%	99.0%	89.2%	64.6%													
IP Survey: % Received information enabling choices about their care	W	97.6%	98.5%	98.2%	97.5%	87.1%	88.7%	97.8%	99.0%	96.0%	96.2%	96.2%	95.3%	99.2%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	99.1%	98.5%	97.5%	98.0%	100.0%	96.2%	95.7%	99.0%	98.0%	94.7%	98.8%	98.1%	99.2%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	88.7%	93.1%	93.2%	91.1%	83.9%	94.3%	98.9%	98.1%	93.1%	97.7%	100.0%	97.2%	98.4%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	99.3%	98.2%	97.9%	97.0%	90.3%	86.8%	92.4%	91.3%	99.0%	98.5%	100.0%	99.1%	95.9%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	91.7%	96.4%	92.2%	95.0%	61.3%	81.1%	65.2%	71.2%	82.2%	80.5%	85.7%	85.0%	72.1%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	87.7%	87.7%	77.9%	81.7%	71.0%	56.6%	85.9%	81.7%	76.2%	75.2%	98.8%	74.8%	82.0%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	94.5%	93.5%	94.4%	89.0%	69.0%	59.6%	47.8%	40.3%	43.2%	46.8%	50.9%	53.4%	54.3%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,088	8,651	8,238	7,567	6,655	6,630	7,186	7,431	7,840	7,737	8,127	8,221	7,858				
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	7	31	60	137	121	135	143	147	183		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	66.7%	53.3%	100.0%	100.0%	100.0%	87.5%	100.0%		>=99 %	N/A	<99 %

WELL LED

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	153	-567	-141	-1,187	-4,229	-3,714	-1,773	-1,983	-1,540	-1,990	-487	54	-502		No Threshold		
Income In Month Variance (£'000s)	W	541	-184	367	-502	-4,173	-4,172	-1,908	-1,964	-1,428	-1,460	15	1	34		No Threshold		
Pay In Month Variance (£'000s)	W	-19	60	-342	-241	-133	-111	32	67	35	-457	-68	-67	-398		No Threshold		
AvP: IP - Non-Elective	W		428	355	343	0	0	1	0	-1	-127	-65	-35	-47		>=0	N/A	<0
AvP: IP Elective vs Plan	W		292	298	230	1	1	-2	0	-1	25	3	-16	4		>=0	N/A	<0
AvP: OP New			2,923.00	2,507.00	2,004.00	3.00	3.00	5.00	13.00	12.00	-688.00	-1,258.00	-615.00	-443.19		>=0	N/A	<0
AvP: OP FollowUp			7,884.00	7,137.00	5,625.00	2.00	6.00	10.00	12.00	34.00	-675.00	-1,597.00	-249.00	-264.57		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		856	842	581	0	1	2	1	0	-78	-178	-104	-37		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W		12,521	11,112	8,782	5	9	15	23	47	-1,796	-3,568	-1,276	-915		>=0	N/A	<0
PDR	W	93.3%	94.3%	94.3%	94.3%	94.3%	0.0%	1.1%	17.1%	24.7%	35.5%	57.8%	67.5%	67.6%		>=90 %	>=85 %	<85 %
Medical Appraisal	W	65.2%	84.1%	89.7%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	96.8%		>=95 %	>=90 %	<90 %
Mandatory Training	W	91.1%	93.0%	92.9%	92.1%	90.6%	88.5%	89.6%	89.1%	89.3%	88.0%	87.1%	84.8%	85.6%		>=90 %	>=85 %	<80 %
Sickness	D	7.1%	6.3%	5.8%	6.4%	6.5%	6.8%	5.8%	5.8%	6.0%	6.0%	6.8%	5.8%	6.2%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	2.2%	2.0%	2.0%	2.2%	1.6%	1.5%	1.1%	1.4%	1.4%	1.7%	2.0%	1.2%	1.3%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.9%	4.3%	3.8%	4.2%	4.9%	5.3%	4.8%	4.4%	4.7%	4.4%	4.8%	4.6%	4.9%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	388	343	397	504	457	322	204	310	332	286	446	505	415		No Threshold		
Staff Turnover	D	10.5%	10.7%	11.1%	10.7%	10.4%	9.8%	9.4%	9.6%	9.5%	9.5%	8.7%	8.2%	7.7%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	91.7%	89.4%	91.9%		90.3%		94.4%	86.8%	89.1%	93.6%	94.4%	95.3%	93.5%		>=90 %	>=85 %	<90 %

Community & Mental Health Division

SAFE

- 99 incidents reported in December (75 clinical and 24 non-clinical) Slight reduction in incidents from 127 in November.
- Year on year incident reporting continues to increase in the Community and Mental Health Division:

Year	Total
2017	744
2018	855
2019	1039
2020	1279

- One incident of restricted intervention reported on the Tier 4 Unit. Restraint used to move a child into seclusion (door left open). Child was reviewed by Psychiatrist post incident and PRN was prescribed.

Highlight

- Zero incidents resulting in moderate or severe harm
- Zero incidents resulting in death
- Zero Pressure Ulcers (Category 3 and above)
- Reduction medication errors (16 compared to 33 previous month)

Challenges

- Main incident themes relate to medication (predominantly lost prescriptions) and Access (delay in appointments). Divisional Medication Sub Group met in January and reviewed all medication incidents. In addition to lost prescriptions, there were 3 incidents relating to wrong storage of medication, 2 of these were picked up through medication storage audits. Action plan in place to ensure medication storage audits are completed in all areas that store medication.

CARING

Learning from November complaints:

- SO11180 (ASD/ADHD) - Complaint partially upheld. **Learning** – When a decision is made regarding a child's care ensure the Meditech records are updated as soon as possible.
- SO11547 (ASD/ADHD) - Complaint upheld due to administration errors within the letter to parent. **Learning –** All clinicians need to read clinic letters carefully to check for any errors prior to signing letters off.
- SO11402 (ASD/ADHD) - Complaint upheld due to an oversight in feeding back the diagnosis to parent. **Learning –** ensure outcomes of assessments are communicated to families as soon as possible.

Highlight

- Reduction in PALs from 17 in November to 15 in December
- 18 compliments recorded on Ulysses in December
- 8 Excellence Reports recorded in December
- 100% FFT scores for Community & Mental Health Services

Challenges

- Two formal complaints received in December (a reduction from six in November), both in Sefton Mental Health Services. One is regarding a rejected and referral and one relates to family dissatisfied with a clinical appointment.

EFFECTIVE

Crisis care continue to provide 24/7 service and manage an increasing number of calls. In December 2020, the service received a 278% increase in calls compared to December 2019.

Highlight

- Additional investment agreed to support extension of Intensive Support Team pilot

Challenges

- Booking and Scheduling: The routine referral turnaround time remains a challenge at 16 days outside of the 2 day target. Actions to improve this figure are ongoing, including maximising staff time available to log referrals and re-opening eR-S for some services.

RESPONSIVE	Significant reduction of children and young people waiting over 40 weeks for a new appointment in Community Paediatric. October = 149 to December = 5. Referral to treatment compliance in Community Paediatrics has also improved from 32.3% in July to 64.4% in December	**Highlight** • Eating Disorders waiting time compliance is at 100% for both urgent and routine pathways • Continued reduction in pre April 2020 cohorts for ASD and ADHD **Challenges** • Specialist Mental Health Services locality RTT remains at 69%. However, the service is experiencing significantly higher number of urgent referrals for children and young people with deteriorating mental health. Actions ongoing in Liverpool and Sefton localities including recruitment, additional clinical reviews and virtual support groups.
WELL LED	Launch of COVID support team (mental health) using funding granted from the national lottery. This team will deliver an Online Peer Support Programme for children and young people who are experiencing increased anxiety due to the pandemic. Specialist Mental Health Psychiatry leads appointed in Liverpool and Sefton.	**Highlight** • Continued reduction in staff turnover from 11.6% in June 2020 to 8.8% in December • Medical appraisal rates are 100% **Challenges** • Overall staff sickness remains at Trust target of 4%. Gradual increase in long term sickness. Fortnightly meetings are taking place with line managers and human resources to provide the required support to staff. • PDR rates remain slightly below target at 81.9%

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SAFE

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	2	8	5	5	4	6	6	8	4	8	16	10	16		No Threshold
Clinical Incidents resulting in No Harm	D	30	46	57	42	29	92	84	83	73	88	84	74	51		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	11	6	10	4	4	3	10	6	5	9	11	12	9		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	1	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)		9	1	2	6	6	7	6	11	10	20	33	26	16		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores			100.0%					78.3%	100.0%		98.8%	98.8%				No Threshold
CCNS: Advanced Care Plan for children with life limiting condition		8	8	8	8											No Threshold
CCNS: Supported early discharges from hospital care		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%								No Threshold
CCNS: Prescriptions		32	15	22	17	16	12	15								No Threshold

CARING

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Complaints	W	1	2	3	2	0	2	2	4	2	2	1	4	2		No Threshold
PALS	W	20	44	36	18	19	19	26	29	22	26	33	17	15		No Threshold

EFFECTIVE

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
Referrals Received (Total)		771	919	949	795	433	464	617	873	634	855	975	1,042	827		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		11	18	18	19	17	0	0	4	25	25	18	2	5		No Threshold
OP Appointments Cancelled by Hospital %		12.8%	10.9%	11.3%	18.4%	24.3%	11.8%	6.4%	6.3%	10.5%	10.1%	10.0%	11.3%	8.1%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	11.7%	9.7%	9.5%	9.6%	9.3%	10.2%	11.5%	10.6%	10.3%	6.8%	11.5%	8.9%	30.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	13.4%	11.1%	10.2%	10.8%	13.0%	14.7%	14.2%	15.0%	13.6%	13.8%	13.4%	11.0%	18.6%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		14.1%	12.5%	11.7%	9.1%	9.3%	12.5%	11.7%	8.8%	11.9%	8.9%	14.5%	10.6%	45.2%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		11.3%	9.6%	7.8%	8.2%	13.2%	13.3%	11.0%	14.7%	14.1%	17.5%	15.0%	11.9%	32.1%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		16.5%	9.5%	13.1%	24.9%	26.1%	22.4%	28.3%	25.7%	23.6%	9.0%	12.8%	13.3%	13.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		15.4%	12.4%	11.9%	12.1%	13.6%	15.8%	16.0%	15.8%	13.9%	13.1%	13.3%	11.6%	13.5%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		77.9%	92.6%	76.8%	82.5%	90.5%	91.2%	85.7%	87.6%	75.6%	91.4%	107.8%	91.0%	109.7%		No Threshold
CAMHS: Tier 4 DJU Bed Days		278	340	256	296	322	386	360	380	328	384	470	382	478		No Threshold
Coding average comorbidities			3.00		5.00	3.00	3.00		2.00	6.00		4.50	3.33	3.00		No Threshold
CCNS: Number of commissioned packages		10	10	10	10	9	9	9								No Threshold

RESPONSIVE

		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1	1	1	1	1	1		1	1	1		2	2		No Threshold
CAMHS: Referrals Received		259	354	383	315	110	163	258	262	258	356	348	415	339		No Threshold

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	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
CAMHS: Referrals Accepted By The Service	151	207	230	169	67	93	143	154	147	268	193	231	197		No Threshold
CAMHS: % Referrals Accepted By The Service	58.3%	58.5%	60.1%	53.7%	60.9%	57.1%	55.4%	58.8%	57.0%	75.3%	55.5%	55.7%	58.1%		No Threshold
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%		100.0%									>=96 % N/A <96 %
W RTT: Open Pathway: % Waiting within 18 Weeks	74.3%	76.3%	75.1%	69.3%	44.3%	42.5%	34.0%	32.3%	38.1%	40.1%	48.9%	64.4%	64.4%		>=92 % >=90 % <90 %
W Waiting List Size	1,371	1,191	1,161	1,234	1,010	1,013	1,184	1,032	1,109	1,051	795	756	800		No Threshold
W Waiting Greater than 52 weeks - Incomplete Pathways	0	0	0	5	8	21	22	12	6	10	2	1	1		0 N/A >0
CAMHS: Crisis / Duty Call Activity					288	422	413	550	494	516	596	718	697		No Threshold
W CAMHS: RTT (First Partnership) % waiting within 18 weeks	49.0%	58.3%	59.6%	58.6%	53.0%	53.6%	49.3%	44.0%	53.2%	59.1%	68.8%	70.0%	69.9%		>=92 % >=90 % <88 %
ASD: Completed Pathways	68	68	61	54	24	25	81	111	127	80	95	62	26		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	67.6%	80.9%	75.4%	68.5%	83.3%	72.0%	54.3%	63.1%	73.2%	70.0%	94.7%	87.1%	88.5%		>=92 % >=90 % <90 %
P EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)			100.0%	90.9%	69.2%	90.0%	87.5%	100.0%	100.0%	100.0%	94.4%	94.4%	100.0%		No Threshold
P EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)			100.0%		66.7%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		>=95 % >=92 % <92 %
W CCNS: Number of Referrals	107	109	102	131	107	134	149	188	122	144	146	151	127		No Threshold
D CCNS: Number of Contacts	863	821	830	986	748	859	812	1,083	803	1,035	1,038	877	844		No Threshold

WELL LED

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Last 12 Months	RAG
W Control Total In Month Variance (£'000s)	-9	-58	-65	165	-92	-27	175	-26	0	-70	369	270	45		No Threshold
W Income In Month Variance (£'000s)	26	104	91	330	-30	-64	139	-49	-44	96	397	155	75		No Threshold
W Pay In Month Variance (£'000s)	-30	-90	-87	412	18	131	-29	-64	-98	-31	-81	30	12		No Threshold
AvP: OP New		552.00	531.00	454.00	0.00	1.00	3.00	1.00	0.00	180.00	123.00	181.00	-61.57		>=0 N/A <0
AvP: OP FollowUp		3,079.00	2,766.00	2,759.00	1.00	9.00	5.00	1.00	9.00	666.00	647.00	895.00	797.48		>=0 N/A <0
W AvP: Outpatient Activity vs Plan		3,631	3,298	3,213	1	10	8	2	9	836	766	1,075	734		>=0 N/A <0
W PDR	90.1%	91.3%	91.3%	91.3%	91.3%	2.1%	9.8%	16.6%	23.1%	41.3%	73.4%	81.9%	81.9%		>=90 % >=85 % <85 %
W Medical Appraisal	51.5%	69.7%	91.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %
W Mandatory Training	94.1%	96.7%	95.9%	94.7%	93.8%	93.0%	92.8%	92.1%	92.0%	91.4%	91.7%	89.2%	88.4%		>=90 % >=85 % <80 %
D Sickness	6.5%	4.9%	4.7%	6.3%	4.0%	3.5%	2.7%	2.5%	2.7%	3.8%	3.9%	4.0%	4.0%		<=4 % <=4.5 % >4.5 %
D Short Term Sickness	2.0%	1.2%	1.1%	2.8%	1.4%	0.8%	0.5%	0.7%	0.9%	1.3%	1.5%	1.2%	0.9%		<=1 % N/A >1 %
D Long Term Sickness	4.5%	3.7%	3.5%	3.5%	2.6%	2.7%	2.2%	1.8%	1.9%	2.5%	2.4%	2.9%	3.1%		<=3 % N/A >3 %
D Temporary Spend ('000s)	120	135	148	183	122	47	21	189	194	169	173	212	355		No Threshold
D Staff Turnover	11.1%	11.8%	11.8%	10.8%	10.2%	11.5%	11.6%	10.8%	10.7%	10.5%	9.8%	9.1%	8.8%		<=10 % <=11 % >11 %
W Safer Staffing (Shift Fill Rate)	96.7%	101.0%	94.1%				96.2%	99.5%	99.8%	99.8%	100.1%	98.5%	98.6%		>=90 % >=85 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF ICP (compliant) • All patients screened for potential COVID 19 prior to hospital visit using telephone triage • CRF ward compliant with all standards on Trust Dashboard • Good uptake from Staff for Flu vaccine • All Areas have been certified Covid Secure • Increase in incident reporting under data security, action plan re training to be arranged.	**Highlight** • Mandatory Training > 98% • GCP training 97% • ANTT compliance 92%-CRF Ward –additional training places for CRD nurses secured **Challenges** • All Covid RAs complete for CRD some amber actions to complete • Keeping ward a Covid risk free area with Oxford F/U's and flu vaccine sessions • ANTT compliance score is incorrect and should be 98% • X3 incidents reported under data breaches
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience	**Highlight** • X 0 Complaints • New Children's PRES developed for 20/21 • Positive results from last survey reported **Challenges** • More work to do on local patient internal audits • Collation of survey questionnaires from patients
EFFECTIVE	• Studies selected based on best possible outcomes for children and young people. • No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients. • Clinicians encourage children and young people to make informed decisions about participating in studies.	**Highlight** • Project restart on track current portfolio at 53% • Overall Recruitment figures for UPH studies second highest • X 12 UPH studies open within Trust • Successful completion of Pilot of Lateral Flow Testing (LAVA study) **Challenges** • CRF housekeeping • Project restart to meet NIHR ambition of 80% • Reduced clinical space on CRF ward due to social distancing measures affects patient activity • Staffing for LAVA study • Releasing delivery workforce capacity to allow the opening of new studies
RESPONSIVE	• All Staff Risk Assessments completed as required • New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local providers to offer joint training programmes.	**Highlight** • COVID secure certificates received • Agile working implemented to reduce footfall • A.H supporting the wider system with Covid UPH activity • HCW study recruitment target achieved • Partnership working with external partners **Challenges** • Staff working offsite to support adult vaccine studies • Last minute requests for external support • Effective clinical space to deliver HCW study clinics

WELL LED	• PDR compliance increased to 86.36% • 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** • Long Term Shielding Staff have returned. • Division supporting staff with Flexible working **Challenges** • Sickness levels higher this month. • Increased numbers of staff having to self-isolate with local increased infection rates • Late requests for help can be challenging

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Board of Directors

Thursday 28th January 2021

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

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Campus Development report on the Programme for Delivery January 2021

1. Introduction

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

As of Month 1 in Quarter 4 of 2020/21 the programme Delivery Timetable rag rates projects against planned commencement date. Please note due to most of the construction work closing down for the Christmas holidays some projects may have minimal movement within the month, however remain on programme.

2. Programme Delivery Timetable

A new row has been added to the programme plan for monitoring of relocations from retained estate.Table1. Sets out the planned programme for the years 2019-2023 (financial years).

Table 1.	19/20	20/21				21/22				22/23
Scheme	**Qtr. 4**	**Qtr.1**	**Qtr.2**	**Qtr.3**	**Qtr.4**	**Qtr.1**	**Qtr.2**	**Qtr.3**	**Qtr.4**	**Year**
Initial Park Reinstatement (Phase 1)										
Alder Centre occupation **COMPLETE**										
Acquired buildings occupation Future use under review										
Police station (Lower Floor) occupation										
Commence relocations from retained estate.* 2020 relocations **COMPLETE**							*		Final phase	
Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks)										Final phase
Main Park Reinstatement (Phase 2/90%)										
NEW Mini Master plan (Eaton Rd Frontage) 2 phases to plan										
Infrastructure works & commissioning										
Clinical Hub Construction										
Clinical Hub Occupation										
Dewi Jones Construction										
Dewi Jones Occupation										
Demolition Phase 4 (Final)										
Final Park Reinstatement (Phase 3)										
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										

- Although buildings have been vacated this has been achievable due to staff mainly working from home due to COVID19, there is the requirement to agree on the future office accommodation which

is likely to consist of some off site premises and currently the subject of executive level discussions. An additional target has been added to the table to complete this by the beginning of Qtr. 2.

An Executive design review group has been set up with the first meeting taking place in December 2020; this will entail a quarterly review of the whole campus development to ensure executive contribution and agreement.

3. Capital Cost

The development team fully appreciate the relevance of projects costs extending beyond available budget and how this could impact the overall capital monies available to the Trust. The current financial status of projects is as follows:

Table 2.

Estates Savings Target	Revised Budget	Best Case	Most Likely	Worst Case	Dec Comments
The Park	1,750	3,234	3,454	3,634	Based on estimates following quotes for Phase 1. Quotes for phase 2 expected shortly
Attenuation	600	600	750	800	Work underway to firm up estimates
Alder Centre	2,184	2,416	2,426	2,426	The charity have now underwritten the funding shortfall @ £204k. £242k overspend includes external works in relation to paths.
C Cluster Hub & Dewi	19,822	19,822	20,017	20,017	As agreed by Trust Board - £195k overspend
Infrastructure - Utilities	1,428	1,428	1,700	1,870	Budget increase £228k via Critical Infrastructure Risk PDC funding. Estimates indicate an overspend of circa £500k
Landscaping	481	481	481	577	Relates to the mini master plan which is being developed currently
Infrastructure - Roads (inc s278)	950	950	950	1,122	
Demolition and decomm	2,593	2,796	3,076	3,384	Budget increased by £237k via Critical Infrastructure Risk PDC funding for Boilerhouse demolition acceleration. Costs include estimated £680k to remove Asbestos Dump from site which was not in original budget
Relocations	1,227	1,100	1,227	1,227	Budget expected to be fully utilised
Neonatal	16,800	16,500	16,800	18,600	The Trust has agreed up to £16.8m. This does not include fitting the ground floor. The estimated cost for that are £1.8m included in the worse scenario
Development team	1,100	1,135	1,135	1,135	Slightly over budget
Institute re-works	360	120	200	360	Includes new catering facility
Office Requirement	3,000	2,570	2,570	3,050	East Prescott Road is now available again and consideration is being given to the purchase. It is possible that we will secure funding to facilitate this
Staff removals	250	250	250	250	Fully spent and relates to Medical Records
Car Park	100	100	140	140	Inc £40k for Temp car park barriers
ED Enhancements (UEC)	741	741	741	1,441	PDC funded scheme - part costs reflected in Neonatal line
Isolation Pods (Covid)	1,800	1,400	1,500	1,800	PDC funded scheme
	55,186	**55,643**	**57,417**	**61,832**	
Revised Budget	55,186	55,186	55,186	55,186	
Under/(Over) Budget	**0**	**-457**	**-2,231**	**-6,646**	

*** There are plans to sell Alder Park in 2022. The sale is expected to be between £0.5m - £1.5m
*** There is an option to buy back land circa 1.5 acres. The cost of this would be between £1m-£2m

Capital programme to the 20/01/2021

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

- Neonatal potential overspend against the revised budget of £16.5m, this has remained static over the last month and is currently £0.3m over the target budget set by RABD at £16.5m Value engineering changes and work continues to reduce it further but will also take into account any additional funding required for the lower floor where currently a number of options are being explored including a Paediatric Assessment Unit (PAU)

- Reinstatement of Springfield Park over budget; £1.5m - £1.9m

- Land buy back £1.0 – 2.0m – there is no budget currently allocated

4. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Horticon have been completing works on phase one parks, due to inclement weather and more specifically rain the site is water logged and the conditions are therefore not conducive to sowing the grass seed, this will now be delayed for 3 months and competed in March/April. The formation of the Multi-Use Games Area (MUGA) is now delayed following a recent consultation (this was a requirement of the Liverpool City Council planners) and ongoing discussions with Step Places and also LCC on the exact location. The materials which have been purchased are currently in storage for when a decision is reached. Work continues by Capacity Lab and the local community in discussing the setting up of a charitable benefit Organisation	Location Multi-Use Games Area (MUGA) Public perception that the park phase one is not being delivered.	Continued meetings with planners and LCC parks officers to resolve the location. Capacity lab continues to engage with groundworks on a regular basis and involve stakeholders.

Acquired Buildings Occupation (neighbouring sites)

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

		any opportunities which present.

Police Station (lower floor) occupation

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

Relocations

Current status	Risks/issues	Actions
All planned moves for September to November have been completed, these were only possible due to many staff working from home, a longer term plan is now required for 2021. Senior Management, the Development team and executives are currently exploring a number of options for offsite accommodation. It is clear that the Trust will require approx. 2,000 m2 based on staff continuing to work from home enabling a 50% level of flexible working to be achieved. A recent survey of staff working from home currently suggest this would be well received , with future office spaces allowing for more flexible areas such as co-collaboration space, quiet working areas, private places for phone calls and meeting rooms. Realistic Target Date of end of June/beginning of July set, taking into account	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	The Director of HR and OD along with the development director will be taking some time to work through a long term estates strategy, this will include a plan for desk/office supporting accommodation for both clinical and non-clinical staff. A paper outlining the potential options and plans is die to go to execs for approval week commencing

purchase/lease of buildings		

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

Current status	Risks/issues	Actions
Works are now progressing on temporary services and diversions to enable demolition, although more planning is required to co-ordinate these activities. Oncology, genetics and management blocks have all now been vacated and should be fully decommissioned by 27th January, this is however slightly behind plan by 1 month. Extensive asbestos surveys were required.	Asbestos removal cost/time (£630k above budget).	Complete required works to make the land safe. Work with Finance colleagues to find the additional financial commitment and reduce the financial risk.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Cost v budget remains a concern and work is ongoing to explore what limited options are available to reduce potential cost. It's expected that by the end of January we will have some costing completed which will go to the Resource and Development Group for review. The base park is to be funded by Alder Hey in line with the land exchange agreement with LCC. The plan is to go to tender by the end of Qtr. 4, this has been impacted by the 1 month delay to demolition and the requirement for more extensive asbestos works. Capacity Lab have agreed the setting up of a community driven organisation, with the local community and have now written to the Democratic Services at Liverpool City Council with the proposal for approval. This will be a Community	Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 16) Budget for Phases 2 & 3 is inadequate.	Working with landscape designer to reduce costs within the parameters of the Land Exchange Agreement. Monthly review of the programme and progress with Capacity Lab, with weekly presence on site. Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress.

Benefits Society. Capacity Lab have two major parties interested is supporting funding as part of enhancement to the main park through provision of a café/changing area. They are currently looking at how a modular design could make this an affordable option and will be looking at an initial design with the local stakeholder over the next 6 weeks and have it costed. The following step will then be to share the design and costs with interested parties in view they could agree to fund the development.	As we develop phase 2 there will be some unfinished areas due to the future demolition of the Catkin building as this takes up some of the required landscape.	

NEW Mini Master Plan for Eaton Rd frontage

Current status	Risks/issues	Actions
Engaged Turkington Martin, developed the initial design which will take in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). A review and report has been commissioned and to be completed by Curtin's (Traffic management consultants) Initial Budgets have been costed; a design review meeting with executive colleagues occurred in December 2020 when it was decided that we undertake a review of the potential traffic control options for the entrance both now and when future developments are completed. This will provide options on works and costs. The favoured option would require Liverpool City Council Highways approval.	If not planned appropriately is could cause traffic congestion in the future. Insufficient finding in the budget.	Add to risk register. Continue design work and receive report on advised traffic management from Curtin's Confirm total costs and identify any gaps in the allocated budget.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
Masterplan of Infrastructure works is currently being prepared. Roads and landscaping – the Trust is currently working with Turkington Martin landscape designers to shape the East/Eaton Road end of the new campus (as per Mini masterplan section). This is likely to be taken forward in a number of phases as the new builds develop. It will also include the Blue Light access to the Children's Health Park Planning for the new infrastructure is progressing in line with the overall delivery programme for the campus developments. Electricity new supplies; • As of last week Scottish Power (SPN) recently changed their guidance whereby they reduced the limit on their LV MVA supply capacity from 2 MVA to 1 MVA. • Our connection was to be 1.6 MVA so they were unwilling to complete an offer letter • As an alternative they offered us individual connections to each of the buildings as each building connection fell below 1 MVA • This was non preferred from a Trust perspective for various reasons and we had no capacity for future buildings • SPN have now said that they have surplus capacity in their HV network and can offer us a HV connection without us having to pay any offsite reinforcement costs (previously estimated at circa £1m which would have presented a financial risk for the trust) • This is a preferable solution to the Trust so once the offer of the HV supply is confirmed and provided it is on the terms given verbally we will accept the offer.	Early indication is that to complete all of the work, further capital may be required if a truly world class frontage to the site is to be achieved.	Ensure timely process /programme is adhered to.

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Hub and Dewi Jones Construction

Current status	Risks/issues	Actions
Contract with Galliford Try remains on programme with good visible progress with nil to report. Development to date as per image. 	Ongoing design development potentially could raise issues of quality leading to increases on cost.	Continue with weekly meetings with Galliford Try and challenge design where necessary.

Demolition Phase 4 (Final)

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

Neonatal Development

Current status	Risks/issues	Actions
RABD approval for £16.5M , this required some value engineering to bring the estimated costs down before going to the market for construction. The costs have not changed since last month's report with cost at current time of £16.8 with a target to get back to the revised budget of £16.5m. Further delay for a period of 8-12 week has been agreed whilst further design work on emergency care facilities are planned with the Emergency department teams for the capacity on the ground floor of the planned build (shell and core area). Revised plan reflected in section 2 of the report and also set out below .	Costs of new unit exceed current financial envelope. Project Co engagement extending the programme and increasing costs; Planning and any unknown Section.106 or section S.278 costs	Work with the design team and team to further reduce costs through the Stage 3 design. Continue working with Project Co to mitigate impact. Work with LCC planners to minimise impact

Activity	Stage 3 V2		
	Start	End	Weeks
Stage 3	02/11/2020	21/05/2021	29
Planning Submission	18/12/2020	18/12/2020	0
Combine Stage 3 EDU/UTC and Neo	25/03/2021	09/04/2021	2
Stage 3 Approved	21/05/2021	21/05/2021	0
Tender Period	24/05/2021	16/07/2021	8
Appoint Contractor	13/08/2021	13/08/2021	0
Stage 4 - Contractor Design	**16/08/2021**	**24/09/2021**	6
Mobilisation	27/09/2021	08/10/2021	2
Stage 5 - Construction	**11/10/2021**	**05/05/2023**	82
Stage 6 - Handover	**05/05/2023**	**05/05/2023**	0
Commissioning	08/05/2023	30/06/2023	8
Stage 7 - Occupation	**03/07/2023**	**03/07/2023**	0

On the Neonatal element of the project the design is currently at stage 3 and will ready to tender at conclusion of the stage, continued work will then progress to stage 4. Following expressions of interest for construction, 10 organisations expressed an interest, however only two parties registered interest (Interserve and Galliford Try) following further dialogue with one of the parties Morgan Sindell is also be interested. .	Lack of interested from the construction market competitors. Impact of Covid-19 on construction costs. Planning permission fails to be achieved within the timescale of the overall programme delivery.	Monitor the market for construction cost inflation and robustness of supply chain. Maintain open communication with the LCC planning departments.

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
Discussions with StepPlaces continue regarding the opportunities for a new Nursery, this included a change of provider. Future report will include updates on those discussions. **StepPlaces,** the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support Several work streams are taking place to review potential service enhancements. These include Rehabilitation, Patient/Family Hotel, independent living accommodation for complex needs CYP and outpatient rehabilitation. Business cases for each of the work streams will be brought forward over the next 4 to 6 months.	Change process with Staff will present some challenges Local community resistance to Trust non-development aspects and planning submission. Cost of providing the developments do not match income from commissioners	Ensure Colleagues from HR are involved in any proposed changes along with all stakeholders. Maximise our offering/ support /negotiation on development content and opportunities. Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability. Produce robust business cases to highlight any issues/risks.

Communications

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

Car Parking

Current status	Risks/Issues	Actions/next steps
The Catkin cark has now closed to allow for Demolition work to commence of old and decommissioned buildings. Patient parking has been reallocated within the current Temporary car park. Patient information has been sent to all patients attending on site appointments regarding the changed parking facility. The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday. The criteria for allocating spaces to staff has been agreed the communication on this has been rolled out, an appeals process has also been developed and staff will submit a form for review should they believe they fit the criteria. A number of appeals have been submitted and to date 64 staff have been allocated to this car park, early indication is that currently around 20-25 staff per day are parking there. This may be due to staff working from home for part of their working week during COVID restrictions and following Government advice.	Staff resistance to change. Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	Review car parking requirements in view of the home working currently in play due to COVID 19 and what the future requirements might look like. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan.

5. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 20th January 2021.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th January 2021

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

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

Board Assurance Framework 2020/21

1. Purpose

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

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

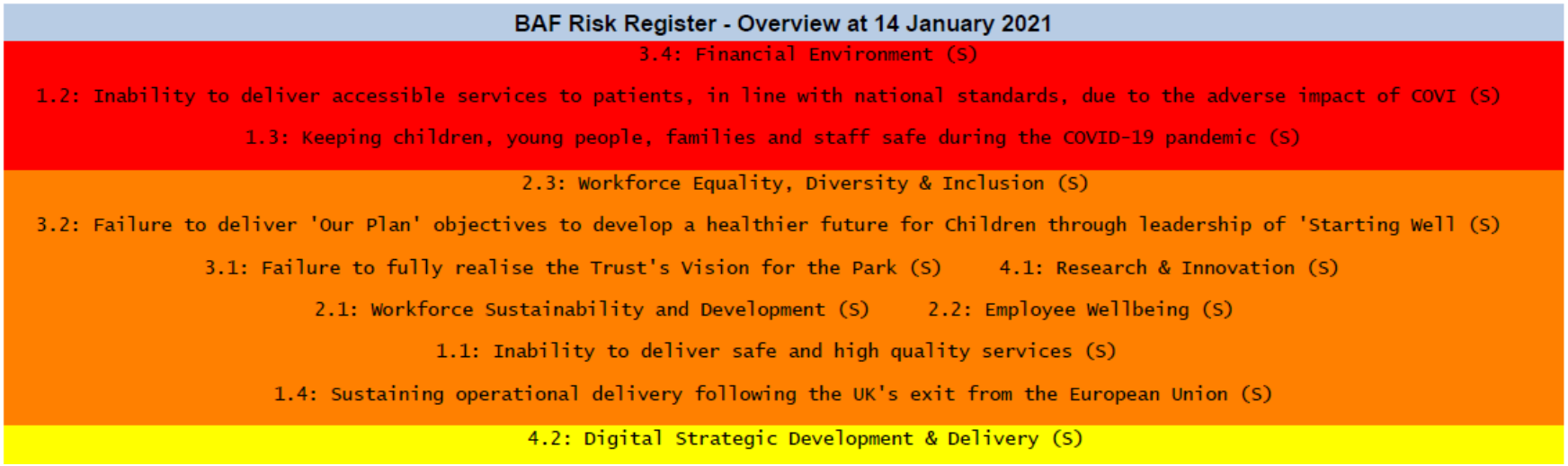
2. Review of the BAF

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

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

3. Overview at 14th January 2021

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



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

Report generated by Ulysses

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

4. Summary of BAF - at 14th January 2021

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

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

5. Summary of December 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; progress with system working supporting delivery of Our Plan during Dec includes progression of AH led C&M CYP programme - however Wave 3 of Covid impacting currently so likelihood of some system delays top progress. Rating remains static but under monthly review.

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

  Actions reviewed and progressing against plan.

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

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

Internal risks:

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

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

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

  Gold Command continues to oversee Covid response and recovery. Recovery progressing well and vaccination programme launched for all staff in priority order. Increased risk of transmission through wave 3. Focus on staff availability, recovery, our role in supporting the wider system and completing the vaccination roll-out.

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

  The risk has been reviewed in the context of the increasing national pandemic. Increase in COVID transmission has led to an increase in short term sickness and isolation due to exposure. The Trust are utilising the covid emergency response plan to mitigate this. This risk will review a full review as we end this wave of the pandemic.

- ***Financial Environment (JG)***
  The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction. An updated revised forecast plan has been submitted showing an improvement. The ongoing pressure from the pandemic will be tracked and any changes to this plan will be raised. The framework beyond this year is not yet confirmed and remains uncertain. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.

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

- ***Digital Strategic Development and Delivery (KW)***
  BAF reviewed and re-set in line with current position

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

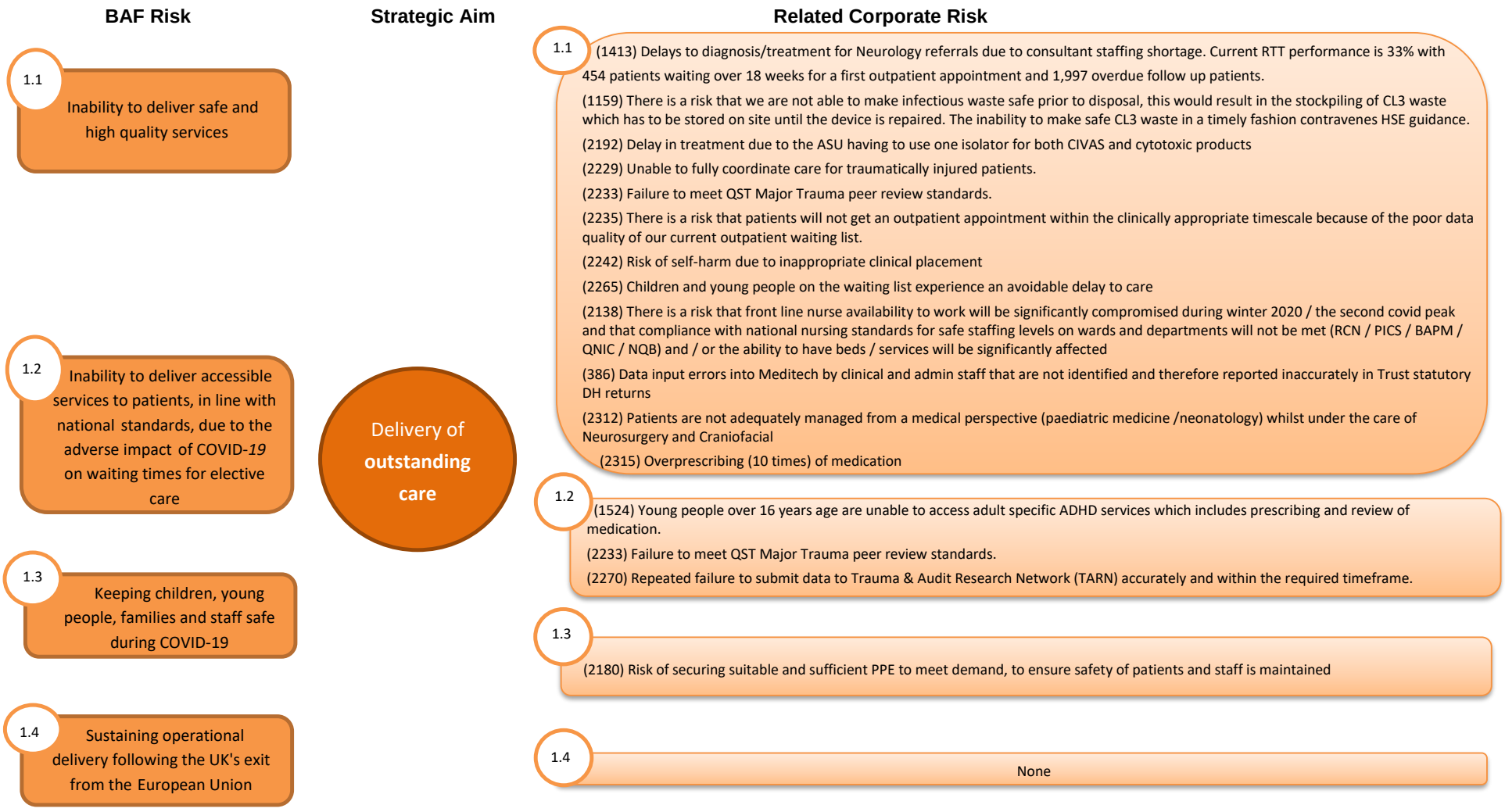
- ***Employee Wellbeing (MS)***
  Risk reviewed - no change to score in-month. Thorough review of risk undertaken to amalgamate risk 2181 in order to manage all actions relating to staff wellbeing at Executive Level.

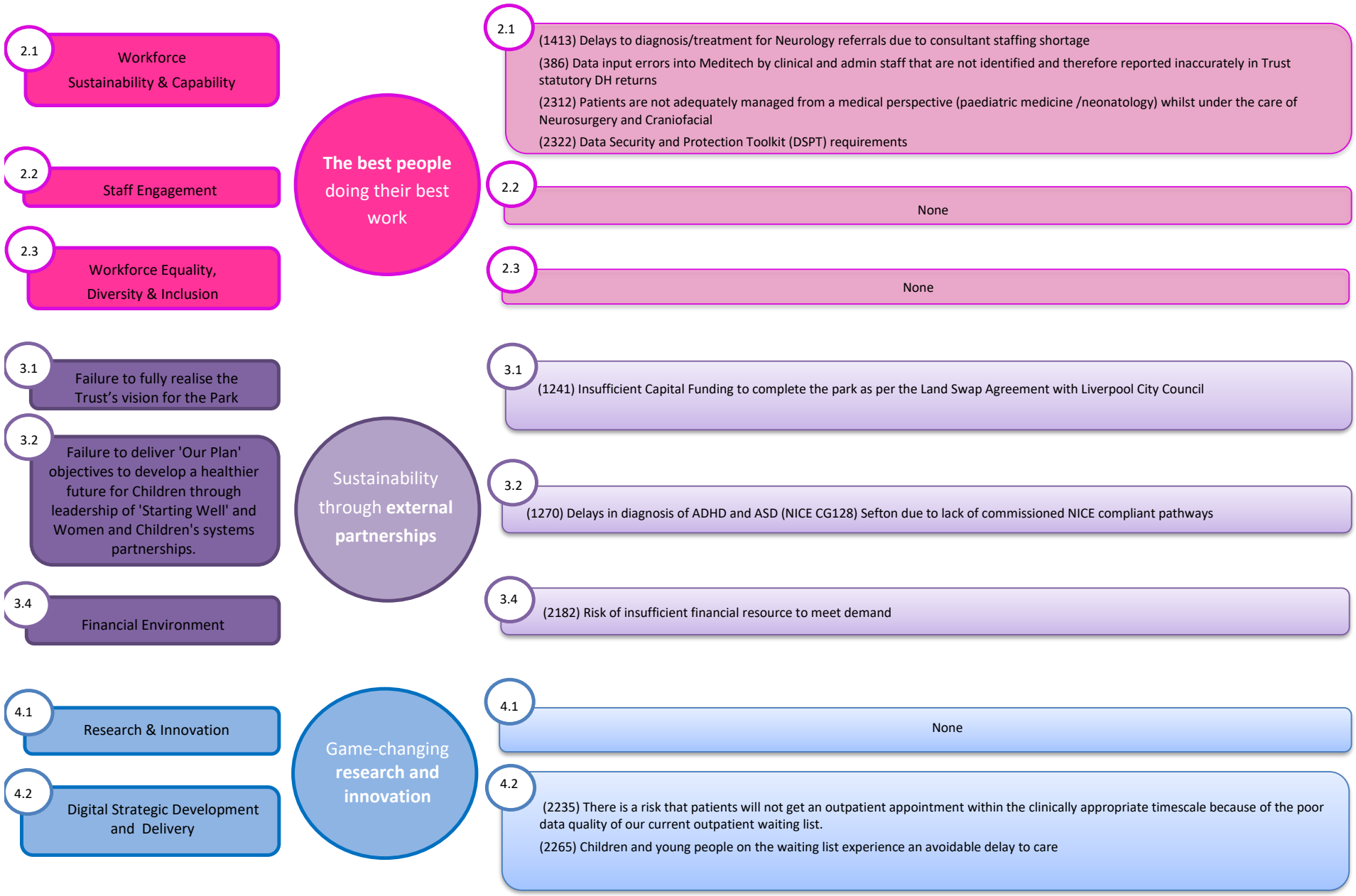
- ***Research & Innovation (CL)***
  No change to risk. Minimal change to status, progress against commercial research noted.

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 4th January 2021




2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
2.1
(1413) Delays to diagnosis/treatment for Neurology referrals due to consultant staffing shortage
(386) Data input errors into Meditech by clinical and admin staff that are not identified and therefore reported inaccurately in Trust statutory DH returns
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
(2322) Data Security and Protection Toolkit (DSPT) requirements
2.2
None
2.3
None
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.
3.4
Financial Environment
Sustainability through external partnerships
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
(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 Delivery
Game-changing research and innovation
4.1
None
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2235, 2242, 2265, 2233, 386, 2312, 1413, 2192, 2315, 1159		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

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

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

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

Executive Leads Assessment

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

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

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

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

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

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

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

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

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

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

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

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

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

Gaps in Controls / Assurance

Staff availability to meet capacity plans through the winter

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

Vaccine roll-out	30/04/2021	Vaccination Programme launched 6th January 2021 with a three week roll-out for all staff including support from LHCH and Aintree Hospital

Executive Leads Assessment

January 2021 - John Grinnell
Gold Command continues to oversee Covid response and recovery. Recovery progressing well and vaccination programme launched for all staff in priority order. Increased risk of transmission through wave 3. Focus on staff availability, recovery, our role in supporting the wider system and completing the vaccination roll-out.

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

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.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

Risk of disruption to the provision of products to the NHS. We continue to monitor supply of products with a view to rapid intervention and escalation as and when a shortage presents itself.

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
Weekly EU Exit meetings to monitor any developing issues	Minutes from meetings K drive On Call managers management pack

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alder Hey Brexit group formally recommenced and will now review Road Map and Operational Plans. Meeting weekly.	31/01/2021	Supplier list received from NHSE which will confirm central/local supplier review Walkabouts to be recommenced SME review and feedback or risk assessments
each lead aware of the above requirement To feedback formally to the group To develop plans where required	31/01/2021	SME teams have been reviewing local/national guidance and updating their respective risk assessments and business continuity plans Procurement team have completed their local reviews and are now liaising with departments to support stock management. SME's are finalising Roadmap detailed up to and beyond EU exit. All documents are located on the K Drive / EU Exit

Executive Leads Assessment

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

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

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.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 386, 2312, 1413, 2322		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

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

Executive Leads Assessment
January 2021 - Sharon Owen Actions reviewed and on track against plan
December 2020 - Melissa Swindell Risk reviewed in month, current score decreased and actions reviewed.
November 2020 - Melissa Swindell actions updated and progress monitored through the PAW Committee

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
SALS Offer: ensure psychology post is permanent and full time given increase in demand for SALS over the past few months.	31/01/2021	business case has been submitted and is awaiting agreement from HRD and Finance (pending) - target end Jan
Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to determine future service development and delivery that meets demand and is integrated with internal and external counselling provision.	31/03/2021	
Liaise with Regional Resilience Hub as it develops and ensure Alder Hey staff can access the screening tools and	01/04/2021	

support can be offered		
Third Wave action plan for staff support	31/03/2021	Third Wave action plan in development and being monitored daily by staff support group comprising ICU Psychology, Clinical Health Psychology leads and SALS (reported to Chief Nurse and HRD)

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	31/12/2020	action closed as all actions being refreshed in line with new taskforce and approach to EDI
1. Work with Community Engagement expert to develop actions to work with local community	31/12/2020	action closed to be replaced by revised set of actions as a result of the taskforce and new approach to EDI
BAME Taskforce established, Claire Dove NED is leading. Taskforce is working to identify the main areas of focus for us to increase representation, improve experience, remove racism	31/03/2021	BAME taskforce have now met three times. action plan and ideas progressing/ Board update to be ready for December 2020
Specialist Trusts discussion to explore implementing an EDI team across all four Trusts.	31/01/2021	discussions nearly complete. three trusts are in agreement. just needs final sign off by respective CEO's.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

Executive Leads Assessment
January 2021 - Sharon Owen Actions reviewed and progressing against plan.
December 2020 - Melissa Swindell Risk reviewed in month. All actions updated
November 2020 - Melissa Swindell Actions reviewed and updated. Good progress being made in the BAME Taskforce

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Establish Executive Design Group	31/12/2020	
Executive Leads Assessment		
January 2021 - David Powell Prior to January Board		
December 2020 - David Powell Prior to Dec Board		
November 2020 - David Powell Incorporation of Eaton Road Masterplan		

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

Board Assurance Framework 2020-21

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. RABD to oversee productivity and waste reduction programme	31/03/2021	
5. Childrens Complexity tariff changes	31/03/2021	Work concluded and joint agreement on the underlying issue with peadiatric funding. Continuted dialogue with NHSI regional and strategic finance team on an interim solution for 21/22.
1. Revised financial plan pending updated guidance from NHSI	28/02/2021	Progess made on securing additonal funding and reducing the residual gap in 20/21 and a revised plamn submitted early Jan. Awaiting confirmaion of national discussions on residual shortfall.
4. Long Term Financial Plan	31/03/2021	21/22 framework and guidance not yet released, Work is ongoing to update AH underlying positon and will be completed subject to updated planning guidance. Plan to take update to February RABD meeting.
2. Five Year capital plan	31/03/2021	5 year capital programme continiously monitored and tracked through finance reports and top 5 risks reported at RABD.

Executive Leads Assessment

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

The framework beyond this year is not yet confirmed and remains uncertain. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.
December 2020 - Rachel Lea The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction. The framework beyond this year remains uncertain, expected guidance is due to be released mid December. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk.
November 2020 - Rachel Lea Financial regime in NHS remains uncertain due to the ongoing pandemic. The position for 20/21 is more known and mitigations are in place to ensure financial balance is achieved; however the longer term next 5 years is still a significant risk.
September 2020 - Rachel Lea Extension of current framework and arrangements for COVID reimbursement and top up has been confirmed to end of September. Awaiting guidance from NHSI on Phase 3 expected September.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Innovation Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
RABD review of commercial contracts per SFI. Trust Board oversight of shareholding and equity investments.	Reports to RABD / Trust Board and associated minutes
Establishment of Research Management Board	Research Management Board papers.
Establish Innovation Board Committee	Committee oversight of Innovation strategy with NED expertise
Innovation team re-organised and funded to ensure adequate capability. Establish role of Managing Director of Research and Innovation to provide unified vision.	
Alder Hey Innovation LTD governance manual established	
Plans for joint research & innovation clinical leadership being explored	
Research - recovery plan operational.	Trust Board papers
Research - monthly focus on research at Care Delivery Board to support strategy deliver.	Care Delivery Board papers
Research - appointment of associate divisional research directors to provide leadership and support to the research community	Research activity is captured by speciality and division. Latest extract of participation attached.

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Development and deployment of the 2030 Innovation Strategy	31/03/2021	1. Innovation 10 year strategy co-produced with LCR stakeholders and advisors 2. AH positioned as part of LCR LEP Project Boom R&D Growth
Approval of the research commercial case (core)	31/03/2021	1. Business case and plan under-development, target date end of March 2021
Research recovery plan operational	31/03/2021	Participating in 7 Urgent Public Health (UPH) Studies. Reactivated 38.9% of Suspended CRN studies. 19 New Studies opened - 13 Academic & 6 Commercial.

Executive Leads Assessment

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

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

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

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

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

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

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

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

Executive Leads Assessment
January 2021 - Kate Warriner BAF reviewed and re-set in line with current position
December 2020 - Kate Warriner BAF reviewed, risk score at target, future actions on track against plan
November 2020 - Kate Warriner BAF reviewed, good progress against plans.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 28th January 2021

Paper Title:	**Audit and Risk Committee – Chair's Highlight Report**
Date of meeting:	21st January, 2021
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 21st January 2021, along with the approved minutes from the Audit Committee meeting that was held on the 19th November 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

- CQC Action Plan (for actions overseen by ARC)
- Board Assurance Framework
- Corporate Risk Register
- Analysis of the Trust Risk Register
- Update on the preparation of the 21/22 Internal Audit Plan
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Update on the preparation of the 21/22 Anti-Fraud Plan
- Anti-Fraud Progress Report
- Update on the preparation of the 21/22 External Audit Plan
- Update on the actions from the ARC Self-Assessment

As a result of the ongoing pandemic and resulting operational pressures within the Trust, the focus of the Committee's discussion was weighted towards risk management. A number of items were deferred to the April meeting including:

- Update from Clinical Audit
- Non Clinical Claims Annual Report
- Presentation on risk management processes within the Surgical Division
- Risk Management Strategy & Policy

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

None

4. Positive highlights of note

The Committee recognised that risks are changing more rapidly than during normal times and received an explanation from the Executive as to how risks are being managed real time.

The Committee noted the reduction in long-standing risks on the Corporate Risk Register across the last 6 months and understood the reasons for those currently remaining.

The Committee asked the Executive to consider whether any risks relating to the creation of the Cheshire & Merseyside Integrated Care System from 1st April 2021 should be added to the risk registers.

Following a recommendation from the Anti-Fraud Specialist the Trust has nominated a Fraud Champion who has undertaken to present to a future meeting on how they plan to discharge this role.

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 was pleased to note that the Internal Auditors are able to provide their annual opinion on internal controls to the normal timing.

Good outcomes from the audits of Clinical Audit Processes and Data Quality Processes (A&E targets) both of which received substantial assurance.

The Committee requested a presentation from the Data Quality Team to their April meeting where the strategy and remit of the team will be presented.

5. Issues for other committees

ARC requested an update from the People & Wellbeing Committee on the development and delivery of a standard methodology for workforce planning.

6. Recommendations

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

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Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 19th November 2020**
Via Microsoft Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. F. Marston	Non-Executive Director	(FM)
In Attendance:	Mr. G. Baines	Assistant Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms. U. Das	Director of Medicine	(UD)
	Mr. J. Grinnell	Director of Finance	(JG)
	Ms. R. Hanger	Theatre Services Manager (*representing Alfie Bass)*	(RH)
	Mr. K. Jones	Associate Finance Director	(KJ)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	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)
Item 20/21/51	Mr. I. Atkinson	Director, KPMG	(IA)
Item 20/21/51	Ms. C. Davidson	KPMG	(CD)
Apologies:	Mr. A. Bass	Director of Surgery	(ABAS)
	Ms. L. Cooper	Director of Community Services	(LC)
	Mrs R Lea	Assoc. Director of Finance	(RL)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Mrs. V. Martin	Counter Fraud Specialist, MIAA	(VM)
	Mr R Tyler	E&Y Accounts Manager	(RT)

20/21/48 Welcome and Introductions

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

20/21/49 Minutes from the Meeting held on the 17th September 2020
Resolved:
The minutes from the meeting that took place on the 17.9.20 were agreed as an accurate record of the meeting.

Fraud Risk Matrix

The Committee received the Fraud Risk Matrix which has been updated to account for new/enhanced Covid-19 related risks. The following points were highlighted:

- Fiona Marston drew attention to the recent media coverage around the supply of PPE and queried as to whether the Trust is at risk in terms of dubious suppliers of PPE. It was reported that during the early part of the pandemic there was a great

demand for PPE and therefore a lot of organisations were exposed, paying in excess of pre-Covid prices. NHSE has since taken control of this matter and stock is being purchased and allocated Centrally hence the risk is more of a national issue than a local one now.

The Committee was advised that a lot of the "out of push" stocks purchased by the Trust was done on a whole Cheshire and Mersey footprint and signed off by the Health Care Partnership and the Cell Chief Executives. Given the circumstances, strong governance and sign-off arrangements were implemented. In response to Fiona Marston's query, it was felt that the issue for the Trust would be from a value for money perspective rather than a fraudulent one.

- The Chair queried as to whether it would be beneficial to sample a small number of localised purchasing to review the Trust's decision making/governance process and conduct a benchmarking exercise from a value for money perspective. Ken Jones reported that Deloitte are conducting an audit of all trusts in order to review the value for money of Covid-19 purchasing and the approach that trusts took, and it was felt that it might be better to focus on this piece of work rather than conducting an independent one. The Chair pointed out that work needs to take place on this matter from a cost benefit perspective and requested that an update be provided following the Deloitte audit.

20/21/49.1 **Action: KJ**

- Gary Baines felt that the Risk Fraud Matrix is a comprehensive document and will provide evidence/demonstrate compliance against the assessment of standards going forward.
- Hassan Rohimun advised that if the Trust is able identify the PPE shortfalls that it was facing this will provide consideration on cost benefit analysis when conducting a sample of cases of the governance/procurement processes that were applied during the earlier stage of the pandemic.
- The Chair asked as to whether the information included in the matrix is going to be uploaded onto Ulysses. It was reported that there is a covering risk on Ulysses and the matrix is attached as a supporting document.

Resolved:
The Audit and Risk Committee received and noted the Risk Fraud Matrix.

20/21/50 **Matters Arising and Action Log**

Action 19/20/07: *Draft Counter Fraud Annual Report 2019/20 (Submit the Risk Fraud Matrix to the Committee in November upon completion, and provide a more thorough update)* – This item has been included on November's agenda. **ACTION CLOSED.**

Action 19/20/50.6: *MIAA Progress Report (Suggest a mechanism to review the effectiveness of External Audit for 2019/20 accounts)* – Work is ongoing internally to acquire information from professional bodies about the products that other organisations are using to agree the best option for the Trust. The Trust is also making use of the interim audit from a lessons learned perspective. **ACTION TO REMAIN OPEN**

Action 20/21/50.4: *Final Internal Audit Plan - 2020/21 (Audit Committee to be involved in the scoping discussions for the Risk Management audit, DMO audit and the Clinical audit*

review) – Scoping discussions have taken place for the Risk Management audit and the Clinical audit review therefore it was agreed to close this action. MIAA are aware that the DMO scoping discussion is still outstanding. **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 Innovation colleagues. Submit a report to the Audit Committee in September)* – Assurance was provided on the process in place for Innovation colleagues who make declarations (see item 20/21/63). **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)* – The Director of Finance confirmed his agreement of the overall external audit fee for 2019/20 due to the way of operating as a result of the pandemic. **ACTION CLOSED**

Action 20/21/29.1: *Presentation on Risk Management Process (Circulate the key Risk Management Strategy document to Anita Marsland, Fiona Marston and other NEDs who will find this information beneficial)* – The Risk Management Strategy was incorporated in the documentation for November's Audit and Risk Committee meeting. **ACTION CLOSED**

Action 20/21/30.1: *Board Assurance Framework (BAF) (Further clarity is required in respect to the risk responsibility of each Assurance Committee in order to avoid duplication - This matter will be discussed during a forthcoming meeting with the Chairs of the Assurance Committees).* This action will be addressed during the BAF update which is on the agenda. **ACTION CLOSED**

Action 20/21/31.1: *Corporate Risk Register (include information in future reports on the risks that are difficult to address and the risks that may need to be escalated to Board level. Amber risks are to 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)* – This information is being incorporated in the key issues report. **ACTION CLOSED**

Action 20/21/31.2: *Corporate Risk Register (Develop a mechanism for keeping partially mitigated risks on the radar to enable them to be fully mitigated)* – Work is ongoing to ensure that all actions being taken are smart. This process is being driven across the Divisions/corporate functions to ensure incremental improvement. It was agreed to address identified examples as they arise. **ACTION CLOSED**

Action 20/21/32.1: *Trust Risk Register (Divisional Governance Audit Follow-up Report – Divisions to provide an update on the outstanding actions in the Divisional Governance Audit Follow-up Report*) – It was confirmed that all recommendations have been implemented. **ACTION CLOSED**

Action 20/21/33.2: *Self-Assessment of the Integrated Governance Committee (Action Log - Care Delivery Board to follow up action 19/20/83, and the action relating to the summary report that covers Corporate Services)* – These actions are being addressed by the Care Delivery Board. **ACTION CLOSED**

Action 20/21/37.2: *Follow up Audit Report (CIP/QIA/Sickness and Absence - Contact the respective owners to request an update on the outstanding recommendations in the*

Follow-up Report relating to CIP, QIA and Sickness and Absence) – These actions have been followed up by MIAA and it was confirmed that all recommendations have been implemented. **ACTION CLOSED**

Action 20/21/38.1: *Anti-Fraud Progress Report, Q2 (Counter Fraud Functional Standard - Provide an update on the outcome of the NHSCFA proposal to the Cabinet Office requesting that the new standard be implemented via a similar process that is being used presently by NHSCF standards)* - The Head of Anti-Fraud has confirmed that there is no additional information to date. The Counter Fraud Authority are still working to their timescales of issuing the new standards by late January 2021 and have provided assurances that there will be no significant changes to standards. In the event there are any changes, it was confirmed that organisations won't be penalised in the first year if they are unable to embed any of the new requirements.
ACTION CLOSED

Action 20/21/38.2: *Anti-Fraud Progress Report, Q2 (Consider the nomination of a Fraud Champion at Alder Hey to help raise awareness of this area of work. Advise Virginia Martin of the nominee's name)* – John Grinnell agreed to liaise with Virginia Martin regarding this matter. **ACTION TO REMAIN OPEN**

Action 20/21/39.1: *Data Analytic Report (Discussion to take place re the sharing of exceptions with the Finance Team for information purposes)* – This item will be picked up going forward as part of a proactive piece of work. **ACTION CLOSED**

Action 20/21/40.1: *Audit and Risk Committee Terms of Reference and Work Plan (Additional meeting to take place each July to solely discuss risk)* – This action is in the process of being addressed. **ACTION TO REMAIN OPEN**

Action 20/21/46.1: *Any Other Business ELFS - 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)* – An update will be provided during January's meeting. **ACTION TO REMAIN OPEN**

20/21/51 Brilliant Basics Programme

The Committee was advised that a lot of work has taken place over the last two years to strengthen systems, processes and reporting in order to manage risk across the organisation. It was reported that Alder Hey is in the process of implementing a continuous improvement model with empowerment at the core of it. A decision has been made to explore the possibility of integrating risk management into the model therefore work is taking place in association with KPMG to address this matter.

The Committee welcomed Ian Atkinson and Chaellene Davidson from KPMG who submitted a presentation on the Brilliant Basics Programme that they are supporting the Trust with. Information was provided on the following areas:

- Programme Workstreams; leadership behaviours, Centre of Excellence/IQ Faculty, strategy development, Brilliant Basics Improvement System and step change projects.
- Aims of the programme:
  - Dedicated time for proactive planning and people development.
  - A structure for performance management and a forum for daily continuous improvement.
  - Practices to support sustaining improvement.
  - A Ward to Board management system that will build in daily continuous improvement, sustainability and an explicit connection to a set of focused Trust goals.
- Alignment of improvement programmes with risk.
- Alignment of standard tools/methodology with a safety and risk focus.
- Operational Excellence tools.

It was reported that the Brilliant Basics Programme is going to be piloted on Ward 4A and Day Case Surgery in December 2020. The Chair asked as to whether the pilot will be reviewed before it's rolled out to other teams. The Committee was advised that engagement will take place during the first phase of the programme to gain an overview of positive outcomes in order to progress the next phase without halting the programme. It will take a team three to four months to complete a wave of training and, if successful, there is an aspiration to roll it out further in the Spring of 2021.

The Chair queried the number of services that the programme will be rolled out to at any one time once the pilot is complete. The Committee was informed that a possible six to eight units will be added to each wave of training. KPMG advised that they are keen to manage the pace of the programme and ensure the capability build runs alongside it to enable a designated group of staff members to continue the roll out of this work.

Fiona Marston queried the Trust's process for ensuring feedback to all staff on the outcomes/improvements that are being made. It was reported that KPMG has committed to an Engagement Plan to highlight good news stories, benefits and lessons learned. As a result of this, work is taking place with the Communications Team to create a profile of the teams participating in the programme to enable lessons learned to be adapted prior to the next wave of training and allow existing teams to commence on improvement areas.

The Trust is also looking to integrate a closed loop model with the improvement methodology to enable risks to be tracked by teams right through to conclusion. This will provide detail on the outcomes/successes of the actions taken and ensure that staff feel engaged and listened to.

The Chair highlighted the benefits of the work that is due to commence and felt that it would be beneficial to receive an update on the outcome of the pilot, in January.

20/21/51.1 Action: JG

Attention was drawn to the importance of making sure that the programme links in with the Trust's risks management processes. KPMG agreed to liaise with Cathy Umbers outside of the meeting to address this matter, during the early stage of the process.

20/21/51.2 Action: KPMG

20/21/52 Trust Risk Register – Analysis Update Report

The Committee received the Trust's Risk Register Analysis Report for the period from the 1.9.20 to the 31.10.20 to enable members to understand the trends and indications of the organisation's risks. A discussion took place around the content of the report and the following points were raised:

- The Chair indicated that the graph in the report that is supposed to pinpoint an increase/decrease in risks is dwarfed by high to moderate risks and therefore does not show the trend of the risk/s.
- Fiona Marston pointed out that the report doesn't provide information on the Divisions/departments who are contributing to a substantial increase/ decrease trend change.
- A request has been made to reinstate the table showing the number of risks and actions that the Divisions/departments have and how many of these are overdue review and how many have overdue actions as it was felt that this provides an indicator of how well the Divisions are addressing and managing risk.
- Attention was drawn to importance of reviewing longstanding risks to acquire an indication as to whether the Trust's systems are being responsive enough and look towards taking the next step in respect to producing analytic trend data, identifying hotspots and areas of stagnation.

Following discussion, it was agreed to review the Trust's Risk Register Analysis Report, to ensure that the "Profile of Risks" table clearly shows the increase/decrease in risk of all risks; highlight which Divisions/Departments are driving and increase or decrease in risk; reinstate the table showing by Division/Department the number of risks, the number of risks overdue review and the number of actions overdue; highlighting longstanding risks and identify any other analyses that will assist in honing in on areas that are raising concern.

20/21/52.1 Action: JG/AB/CU

20/21/53 Care Delivery Board Update, including Corporate Risk Register

The Committee received a highlight report from the Chair of the Care Delivery Board, John Grinnell, following the meeting on the 5.11.20 along with the Corporate Risk Register.

The Chair of the Audit and Risk Committee felt that the amount of discussion that the Care Delivery Board devoted to risk was excellent as was the level of Exec attendance at the meeting. The update indicated that themes are being drawn out, interdependencies between risks are being recognised and the actions taking place to mitigate risks are substantial.

John Grinnell provided an overview of the inaugural risk-focussed Care Delivery Board meeting and advised of the three main themes within the risk management reports that framed discussions; access to services, staff availability and resources. In addition to the themes there were three key risk areas identified as requiring in-depth immediate discussions with the Operational Team and the Executive Team; major trauma, cardiac care, treatment and resources and accommodating children in mental health crisis. The following update was provided on these risks:

- *Major Trauma* – A paper was submitted to the Care Delivery Board to offer assurances on the risks within this theme. It was reported that there has been a series of medium-term actions implemented and assurance was offered in respect to the immediate mitigations that are in place in terms of managing trauma flow and ensuring the Trust meets standards. It was confirmed that further work is required to address this issue.
- *Cardiac Care, Treatment and Resources* - A network approach is being taken to address the Cardiac Improvement Programme. A group is in the process of being established in order to meet on a weekly basis to address the fragility of the services. The group will consist of a clinical team from Alder Hey and Royal Manchester Children's Hospital along with the Medical Directors of both Trusts; Nicki Murdock and Jane Valente.
- *Accommodating Children in Mental Health Crisis* - It was reported that root cause analyses have been conducted following two incidents on a general paediatric ward where it was felt that improvements could have been made in the care provided to these patients. There have been a lot of lessons learned in respect to training, education and awareness that the Trust is taking forward internally in the form of a robust action plan. Attention was also drawn to the funding that the Trust has received to support the Intensive Care Support Team in their work to help prevent this type of situation happening in the first place.

  Mitigations have been progressed in respect to the risk '*Help stop the deterioration of children's mental health and wellbeing in the community so that they don't require admission into the Emergency Department and onto the wards'*. It was reported that further actions are required to progress this area of work, but a number of discussions and challenges have taken place with real clinical depth to them.

Attention was drawn to the importance of the Care Delivery Board having a lens on the risks that are ranked at 12 and above as the organisation progresses its risk profile. It was also felt that the Trust's governance re-set is doing what it was designed to do. As the cycle progresses threads and themes will emerge from a risk element in respect to clinical quality, safety and people thus providing a better understanding to enable assurance to be drawn together at Audit and Risk Committee level. The Committee was advised that there is a general sense of support across the Divisions to the new approach to mitigate the organisation's risks.

The Chair felt that the information submitted to the Audit and Risk Committee was outstanding and noted that there is some reliance on external input to two of the key risks identified *(cardiac care, treatment and resources and accommodating children in mental health crisis)* and as a result of this will take longer to mitigate.

It was reported by <please insert name> that a review of the long-standing risks that have not been fully mitigated is going to be conducted to provide additional information in the Corporate Report as to why these risks are longstanding. Attention was drawn to the work that has commenced around the risk appetite statement and the new style Risk Management Strategy. It was felt that further work could take place to flag the internal and external reactive/proactive elements of the Trust's risks and link them with the risk appetite. It was pointed out that there will always be a cohort of risks that can't be fully

mitigated. These risks will link in with the organisation's tolerance and it was felt that the Trust is getting closer to being able to stratify these risks more clearly.

Fiona Marston believed that it would be beneficial for the Board to receive an overview of the recent progress that has been made in relation to risk to highlight the thread and joined up work that has ran throughout the reset as a result of the new governance approach, along with the positive outcomes. The Committee was advised that the Board will be provided with a six-month update on the governance reset, which was suggested could be done via a risk lens in addition to offering overall assurance.

Resolved:
The Audit and Risk Committee noted the update from the Care Delivery Board, the approved minutes from the meeting held on the 5.11.20 and the Corporate Risk Register.

20/21/54 Risk Management Strategy and Policy Framework

The Committee received the Risk Management Strategy and Policy Framework inclusive of the Risk Management Procedure for 2020, in line with the recommendation/deadline in the CQC Action Plan.

Following an internal supplementary action, a fundamental re-write of the document has taken place. It was confirmed that time will be set aside for consultation of the document to enable the respective people to review the changes that have been made and to feedback their comments. It was pointed out that work is also taking place on the risk appetite and will conclude in line with the approval of the amendments to the Risk Management Strategy in March 2021.

It was pointed out there are a number of minor amendments to be made to the document prior to re-circulation. Members of the Committee were asked to provide feedback on the document in preparation for January's Audit and Risk Committee meeting on the 21.1.21.

20/21/54.1 Action: All

Following discussion, it was proposed to:

- Submit the amended Risk Management Strategy to the Audit and Risk Committee on the 21.1.21.
- Submit the Risk Management Strategy to the Trust Board for feedback on the 25.2.21.
- Submit the final version of the Risk Management Strategy to the Trust Board on the 25.3.21 for ratification, following closure of the consultation period.

Resolved:
The Committee received and noted version 15 of the Risk Management Strategy and Policy Framework inclusive of the Risk Management Procedure for 2020.

20/21/55 Board Assurance Framework

The Audit and Risk Committee received an overview of the Board Assurance Framework (BAF) as at the 30th of October 2020. The following points were highlighted:

- The key focus of the BAF is ensuring that it aligns with the Trust's new governance approach for risk, and the agreed actions following a discussion with the Chairs of the Assurance Committees. It was pointed out that the document is submitted to the Assurance Committees in its entirety, but the front paper is still under development and will incorporate a monthly infection prevention and control update going forward along with an update on Organisational Excellence (OE) as this area of work develops.
- From an Audit and Risk Committee perspective the BAF provides relative information on the overall framework/control environment and highlights the improvement work that is taking place to make sure the document remains fit for purpose, addresses issues at the right level and ensures that connectivities are being made and articulated in respect to the strategic risks that the Assurance Committees have oversight of.
- The Committee was advised that there will be a number of adjustments made to the next iteration of the BAF due to emerging people issues, discussions around quality and the outcome of the Trust's safety day. It was also reported that the drafting of the risk appetite is underway and will be socialised across the Trust.
- The Chair provided clarity as to why each of the Assurance Committees have been allocated a BAF risk or risks. It was pointed out that the Audit and Risk Committee will have a holistic view of the BAF and in the event a concern/challenge is raised this will be deferred to the respective Committee for action. Gary Baines felt that the core corporate process is strong but felt that committee engagement is key going forward.
- The Chair raised a number of queries relating to the risks in the document:
  - *Risk 1.3: Keeping children, young people, families and staff safe* – It was pointed out that this risk was originally based on environmental factors but since September it seems to have evolved into an access risk and there is already a BAF risk relating to access. John Grinnell agreed to liaise with Adam Bateman to discuss this risk to ensure that there hasn't been an overlap from an access perspective.

20/21/55.1 **Action: JG**

  - *EU Exit:* It was queried as to whether the Trust Board requires an update on this risk taking into account the looming deadline. John Grinnell confirmed that work is taking place to review this risk.
  - *Digital Risk:* It was queried as to whether this risk should be removed from the BAF as it is now at target. If it remains as a risk on the BAF it was felt that the reference to the operational delivery of IT should be removed as this will be captured in the Corporate Risk Register. Erica Saunders and Jill Preece agreed to liaise with Kate Warriner to discuss the reframing of this risk.

20/21/55.2 **Action: ES/JP**

- Fiona Marston queried as to whether there was a more apt descriptor for describing the '*Game Changing Research and Innovation'* risk under the strategic pillar. It was pointed out that the risks relating to innovation are evolving and will develop over time. It was agreed to discuss this matter with Claire Liddy in readiness for the next iteration of the BAF.

20/21/55.3 Action: ES

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 30.10.20.

20/21/56 CQC Action Plan for 2020

The Audit and Risk Committee received the CQC Action Plan for 2020. The following points were highlighted:

- *Recommendation 8 (The Trust should review their internal risk identification methods to ensure that they identify and mitigate risks in a timely manner)* – The Trust's action to review and revise the Risk Management Strategy has been completed but there was a view that additional narrative should be included in the action plan to provide clarity in respect to the additional internal supplementary action that has been agreed.
- *Recommendation 43 (The Trust should ensure that staff minimise the risk of abduction or absconding and the security of personal property in the Neonatal Surgical Unit)* – Asset tags have been purchased and commissioned and are due to be implemented on the Neonatal Surgical Unit at Alder Hey. The Trust's system is also in the process of being aligned with that of the Liverpool Women's Hospital.

(It was agreed subsequent to the Audit & Risk Committee meeting that Recommendation 43 had been reported in error and instead should be reported to SQAC. JP agreed to make this reporting change for both SQAC and the Audit & Risk Committee.)

Resolved:
The Audit and Risk Committee received and noted the CQC Action Plan for 2020.

20/21/57 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 four reviews have been finalised since the previous meeting:

- Non-Clinical Claims which received a moderate opinion.
- Key Financial Controls which received a mixture of a high and substantial opinions.
- PFI Compliance which received a substantial opinion.
- Assurance Framework Opinion (stage 1) has been completed.

The Committee was advised that fieldwork has been completed and draft reports have been issued to the Trust for the Clinical Audit Processes review and the Data Quality review.

Attention was drawn to the work that is progressing in respect of National Safety Standards for Invasive Procedures (NATSIPPs) fieldwork, and it was pointed out that a discussion has taken place about the Terms of Reference for the Risk Management review due to a slight change to the focus of this work.

The Committee was provided with an overview of the outcome of the Non-Clinical Claims review that was conducted by MIAA. The review identified that the Trust recently hired Weightmans Solicitors on a six-month contract to assist in the management and administration of non-clinical claims, however, arrangements have yet to be made following this period. It was confirmed that the Trust has a framework in place for non-clinical claims including robust investigations and appropriate authorisation of claims, however, the Trust is not making timely liability decisions which has led to an increase in legal costs due to cases taking longer to progress. This was identified following testing as only one of the completed claims liability decisions was made within the correct timescales. MIAA has asked the Trust to review its monitoring of timescales for non-clinical claims.

It was also pointed out that the Health and Safety Committee did not meet between July 2019 and January 2020 but has met subsequently. The Health and Safety Committee reports to the Trust's People and Wellbeing Committee (PAWC) and there is no specific detail of the value and volume of non-clinical claims reported to the Trust Board. MIAA has requested that reporting on this area of work be submitted to PAWC and a review of the Claims Management Policy take place, as this was due for review in August 2020.

It was confirmed that a very detailed and comprehensive report was submitted to PAWC on the 17.11.20 by Weightmans Solicitors which has resulted in a number of actions that need to be progressed to make this area of work sustainable.

Attention was drawn to the Clinical Claims Report that was recently submitted to the Safety, Quality and Assurance Committee which mirrors non-clinical claims in terms of benchmarking and trend analysis against other paediatric trusts and peers. It was felt that it would be beneficial to look at these two areas jointly from a value for money lens in relation to what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, it was agreed that initially a discussion will take place between Erica Saunders and John Grinnell regarding this matter and then a meeting will be scheduled with the Chair to look at how this piece of work can be progressed.

20/21/57.1 Action: JG/ES/KB

The Chair felt that the work that was conducted on non-clinical claims was very good. It was pointed out that the timing of some audits has fallen into February, but attention was drawn to the responsiveness of staff to MIAA thus ensuring that there have been no delays in reports. Gary Baines thanked management for engaging with MIAA regardless of the pandemic and confirmed that the Trust is in a good position. The Chair asked for thanks to be fed back to all relevant staff members involved in audits for accommodating MIAA and responding quickly to their requests.

20/21/57.2 Action: KJ

The Chair referred to the Key Financial Controls review and pointed out that MIAA had identified 232 journals where it was indicated that the final approver was a NEP error. It was queried as to whether this issue has been resolved. It was reported that work is taking place with NEP to understand the issue and solve the problem.

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

20/21/58 Follow-up Audits

The Committee received an update on the status of the implementation of recommendations and action plans for outstanding recommendations.

It was reported that work has really progressed with all audit recommendations followed-up as of November 2020, pending the update relating to consultant job planning (see below). Kath Stott felt that this is a real testament to Rachel Lea, Ken Jones and staff members engaging really well with MIAA during the pandemic.

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

20/21/59 Update on Outstanding Actions from Consultant Job Planning Audit

The Audit and Risk Committee received an update on the outstanding actions from the Consultant Job Planning audit. A slide was submitted to the Committee which provided information on the following areas:

- Job Planning portal to be available in the New Year. The details of the provider will be confirmed in January 2021.
- Job Planning in the Divisions – Job planning has been taking place in paper format but as of January 2021 a formal process will be implemented via the use of the new portal.
- A Job Planning Support Group is in the process of being developed.
- Training and Education – Training sessions will commence with Service Managers, Clinical Speciality Directors, Clinical Directors and Divisional Directors once the portal is in place.
- Escalation will take place where there is no agreement.
- Attention was drawn to the recommendation that relates to the discussion of personal objectives in job plans. The Committee was advised that traditionally consultants discuss their personal objectives during an annual appraisal, but it was pointed out that job plans don't interlink with appraisals. It was felt that this matter could be rectified if personal objectives were addressed during a job planning discussion but this would need to be agreed as a Division and discussed with the Medical Director.

The Chair thanked Urmi Das for providing an overview of the forthcoming processes that are going to be implemented to address the recommendations of the audit. Following discussion it was agreed to provide an update once the new portal is in operation.

20/21/59.1 Action: UD
Urmi Das also agreed to meet with Kath Stott in order to update the Follow-up Audit Report in preparation for January's Audit and Risk Committee meeting.

20/21/59.2 Action: UD/KS

20/21/60 Update on Progress (E&Y)

The Committee was advised that it will receive a technical update from Ernst and Young during January's meeting along with the Audit Strategy Plan and fees for 2020/21.

The Chair queried as to whether Ernst and Young are anticipating any major changes in the audit approach for 2020/21. Hassan Rohimun agreed to share a report from FRC which provides an assessment of the approach used by Ernst and Young to conduct public sector audits. It was reported that the challenges for the audit industry relate to estimation and judgement. It was pointed out that Ernst and Young always engage, where relevant, with specialists to provide additional assurance from an estimation and judgement perspective and therefore have been assessed by the FRC as being in a good position.

20/21/61 Progress against actions from the Audit and Risk Committee Self-Assessment

The Committee received an update on the progress against actions from the Audit and Risk Committee Self-Assessment.

A discussion took place around the 2020/21 self-assessment process for Assurance Committees in light of the recent Committee reset. Attention was drawn to the immense change that has taken place in the Trust's Committee structure and whilst it was felt that April 2021 might be too soon for Committees to conduct self-assessments it was felt that there should be a single process implemented across the Committees for consistency using a different set of questions and a lens on the control environment.

MIAA were asked as to whether they could offer any advice on this matter as a result of working with an organisation/s who had had a similar re-structure. Gary Baines advised the Committee that the questions that will need to be answered at the end of the year will feature around how the Trust managed its governance processes throughout the pandemic whilst maintaining the daily business of the organisation.

Further questions were raised about the process that should be implemented to review the effectiveness of the Trust's Assurance Committees and it was agreed that a meeting should take place with MIAA to discuss this matter in greater depth to enable a recommendation to be submitted to the Audit and Risk Committee.

20/21/61.1 Action: JG/ES/JP/GB

The Chair referred to the report and drew attention to the action that relates to the Associate Director of Nursing and Governance role having more oversight to be able to provide a 'Risk Management Opinion' to the Committee on an annual basis. The Chair felt that further discussion ought to take place to agree as to whether this matter should be progressed and over what timeframe. It was pointed out that this action links in with the new Risk Management Strategy and the work that is taking place to embed risk across the Divisions. It was agreed to discuss this matter further in January 2021.

20/21/61.2 Action: JG/ES/CU/KB

20/21/62 M76 – Treasury Management Policy
Resolved
The Audit and Risk Committee approved version 1.4 of the refreshed Treasury Management Policy, pending the removal of the Operational Director of Finance as an authorised signatory due to a change in role.

20/21/62.1 Action: KJ

20/21/63 Development of a Robust Process for Gifts and Hospitality

The Committee was advised that the relatively new electronic system being used for declaring gifts and hospitality is starting to embed across the Trust and it was confirmed that there has been increase in declarations being made.

Discussions have taken place with the Deputy Director for Innovation, Emma Hughes, who has commenced to request a quarterly update from her team to ensure that all innovation focussed activity is being declared. Emma Hughes also refers to the guidance available when approval is required.

Concerns were raised in respect to the number of staff member across the Divisions who still need to submit a nil return via the system. The Chair highlighted the importance of the Divisions taking responsibility for these staff members and agreed that the Committee should monitor compliance over the next three months. It was agreed to submit a report on the 21.1.21 using data from the new system.

20/21/63.1 Action: ES

20/21/64 Losses and Special Payment

It was reported that the Trust has incurred twenty-four cases of losses and special payments with associated costs of £50,794 relating to the period of April 2020 to October 2020.

There were eight write-offs of bad debt relating to overpayment of salaries during the period of April 2020 to October 2020 totalling £15,435. These relate to a number of old cases dating as far back as 2016 which have previously been pursued via CCI Credit Management Limited, despite exploring a number of avenues many of these debtors have proved untraceable, as such the debt has now become uneconomic to chase any further.

Resolved:
The Audit and Risk Assurance Committee received and noted the contents of the Losses and Special Payments report from April 2020 to October 2020.

20/21/65 Waiver Activity Report
Resolved:
The Audit and Risk Committee received and noted the contents of the Waiver Activity Report for the period 1.4.20 to the 31.10.20.

20/21/66 Any Other Business
There was none to discuss.

20/21/67 Meeting Review

Risk

The Chair felt that the discussions on risk that have taken place during the Care Delivery Board have been excellent and pointed out that the relevant information and analysis is starting to be fed back to the Audit and Risk Committee.

Audit

The Chair felt that the audit element of the agenda is becoming established and more focussed as a result of the risk agenda. The Chair invited Committee members to advise of any changes that they would like to see in respect to forthcoming agenda items.

Date and Time of the Next Meeting: Thursday 21st of January 2021, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 23rd November 2020 at 10:00am, via Teams

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	Claire Dove	Non-Executive Director	(CD)
	John Grinnell	Director of Finance	(JG)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Sue Brown	Associate Development Director	(SB)
	Alison Chew	Associate Director Operational Finance	(AC)
	Raman Chhokar	Associate Chief Operating Officer, Medicine	(RC)
	Mark Flanagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Rachel Greer	Associate Chief Operating Officer, Community	(RGr)
	Dani Jones	Director of Strategy	(DJ)
	Rachel Lea	Acting Deputy Director of Finance	(RL)
	Claire Liddy	Director of Innovation	(CL)
	Andy McColl	Associate Chief Operating Officer, Surgery	(AM)
	Melissa Swindell	Director of HR & OD	(MS)
	Amanda Graham	Committee Administrator (*minutes*)	(AG)
Apologies:	Robin Clout	Interim Deputy Chief Digital Information Officer	(RC)
	Nicki Murdock	Medical Director	(NM)
	Ken Jones	Associate Finance Director Financial Control & Assurance	(KJ)
	Erica Saunders	Director of Corporate Affairs	(ES)

20/21/112 **Minutes from the meeting held on 14th October 2020.**
Resolved:
The minutes of the last meeting were approved as an accurate record subject to correction of an error in recording the health records saving figure of £50m on page 5, corrected to £50,000.
Action: IQ noted concerns around poor experience with Capita and suggested that a request is made for a contribution to costs incurred though write-offs; RL to work with MS to take forward.

20/21/113 **Matters Arising and Action log**
All in order.

20/21/114 **Declarations of Interest**
There were no declarations of interest.

20/21/115 **Finance Report**
Month 7
AC presented the Month 7 Finance Report. The NHS Financial Regime has now changed from M7-12 to reflect that there is a fixed block payment including fixed

allocations for COVID and restoration costs. A revised plan has been submitted to NHSI based on £5.7m deficit, which is being reported against for Month 7.

The in month positon is a deficit of £1.3m, £300k behind plan, due to a shortfall in non-clinical income and increased non pay costs within theatres & critical care related to patient acuity. COVID expenditure was equal to the payment received of £700k. Capital spend behind plan in month £200k.

Restoration activity targets have been set for October to March. In October the actual performance was below target for outpatient, elective and day-case activity.

A number of financial risks have now been resolved and the remaining risks in year are related to the forecast gap and have been raised with NHSI. The main risks going forward are in relation to cash and the potential impact any in year, and future operating deficits may have on the capital plan, further updates are to be received under the heading: Assurance on RABD key risk (Improving the Alder Hey £).

Resolved:
RABD received and noted the M7 Finance report.
Action: JG noted that a more detailed report on Divisional costs to be brought to future meeting.

20/21/116 **2020/21 Framework**

RL gave an overview of the 2020/21 Financial Framework including the latest forecast plan for 20/21 which has been resubmitted at £5.2m deficit. Two work-streams have bene activated under Managing the Alder Hey £ to drive cost reduction and increased productivity.

Awaiting guidance on 21/22 payment system however expect block funding to remain and changes to commissioning. RL outlined the implications of this for Alder Hey and noted that as the guidance is released, further updates will be provided to RABD.

JG noted the current situation re Complex Children's Tariff and that a paper is to be shared from the Children's Alliance on the outcome of the work to date.

Resolved:
RABD received an update against the 2020/21 Financial Framework.
Action: RL to bring item on 2021/22 to December RABD
Action: CL to bring item on the refreshed Business Development plan to January RABD

20/21/117 **Assurance on RABD Key Risks**

Productivity:
Each of the divisions provided an update on their current position and future plans in place.

CAMHS & Community
RG shared slides and highlighted the increase in outpatient activity since the last update, supported by the increase in digital sessions. It was noted that referral rates across the division are lower than 2019/20, however some services are seeing a significant increase..

Medicine

RC gave an overview of productivity for Medicine and noted that theatre start times are improving, with a T&F group having been set up for theatre productivity, Outpatient activity is increasing across both first and follow-up appointments, with progress against RTT targets.

IQ noted that an improvement is expected next month and asked for an update next month.

JG asked for clarity around activity metrics for the number of children treated per clinical session; RC agreed further data interrogation will be done to ensure accurate.

JG asked if digital consultations can be pulled out on analysis. RC will amend for next update.
Action: RC to update metrics for next update.

Surgery
AM shared slides illustrating the current productivity levels for Surgery and noted that start times are showing an improvement. The Day Case improvement group are now being supported by KPMG and the Brilliant Basics programme.

IQ requested a KPI on Consents ahead of time to be included in future updates; AM responded that there have been an expectation set to audit on that more regularly.

Action: AM to ensure KPI on Consents ahead of time is included in future report for Surgery

KW raised a question on decision making across divisions and reporting and recording and it was noted that Care Delivery Board is best placed to receive this.

SA asked re ownership for KPIs and support from across the clinical teams. AB noted this is a key factor and as theatres and outpatients are two of the top transformational projects, the approach is to ensure empowerment of the teams through the Brilliant Basics programme

ASD & ADHD Waits
RG gave an overview of the ASD / ADHD waiting times improvement project.
JG noted that through the positive outcomes achieved and recognised the division's hard work to date.

Cash
RL presented the cash paper outlining the background to the current cash position and the future plans including the committed cash spend in the 5 year capital programme.
The paper outlined the cash forecast over the next 5 years with a number of assumptions modelled. This will be updated as we continue to develop I&E plans for the next 5 years.

IQ noted that this was a very good paper and queried a line in the summary for Non-Cash items; RL will clarify.
IQ suggested maximising cash sources through reducing debtors and receipt of any further building sales.

Capital
AC gave an overview of the Capital plan, noting significant slippage of £10.4m, YTD due to the pandemic and relating to medical equipment; Estates and IT. It is expected that this slippage will be recovered during the rest of the year with a forecast slippage of £4m to the end of March.

Campus Development Update
RG gave an overview of the campus programme. Alder Centre now almost fully furnished with some occupation. Neonatal project is progressing with further work ongoing on the shell space occupation.

Handrail
RG gave an overview of the current position of the handrail report which is currently going through appropriate governance for approval. One identified action is to investigate the use of RFID (radio frequency identification). An initial estimate of costs to do all wards is approx. £150k subject to surveys and refining requirements.
Resolved:
RABD received and noted updates against the key risks.

20/21/118 **Digital Update**
KW gave an overview of the Digital update for November, including the winning of several national awards and a shortlisting for the HSJ awards for work around GDE and HIMSS.

Resolved:
RABD received and noted the Digital Report for November.

20/21/119 **Month 7 Corporate Report**
AB noted biggest operational challenge is waiting times; whilst some good progress is being made on some KPIs concern remains about the number of children waiting over 52w for treatment. Progress metrics have been agreed with the Divisions and enhanced plans and more efforts will be needed to meet these. Additional capacity is being made available to see these long-waiting patients.

Resolved:
RABD noted and received the M7 Corporate report.

20/21/120 **PFI Report**
Resolved:
RABD received and noted the PFI report. No queries were raised for response from Graeme Dixon.

20/21/121 **Proveca & Alder Hey Collaboration**
CL noted this report is to highlight a specific research arrangement with Proveca which may result in joint commercial opportunities and includes the due diligence
SA asked whether the commercial arrangements will be brought to RABD; CL noted that they will be brought to RABD in future.
SA asked for confirmation that looking at such deals sits within the terms of reference for RABD.
CD noted there needs to be assurance that there is no reputational risk and that relevant and appropriate frameworks should be applied.

Resolved:
RABD received and noted the Proveca update paper.

20/21/122 **Communications update**
RABD received the communications update presentation, giving an overview of how far Comms has progressed to its current position and future goals.
Resolved:
RABD received and noted the communications update.

20/21/123 **The Green Plan**
The proposed Green Plan paper was shared and MF gave an overview of its content. A Green Team steering group is being developed including clinicians to take forward the five-year Green Plan and keeping it on track aligned to the goals, with defined workstreams and regular updates to be brought to RABD.

A first draft Green travel plan has been drawn up with a decision to be made around who takes this forward operationally. Green procurement and overall Green financial arrangements are also being considered along with single use plastics etc across a broad range of workstreams to bring these into business as usual, on similar lines to the Modern Slavery contracts.

Benefits and measures and areas where progress can begin were outlined in the paper; MF noted that KPMG has previous expertise in this area specifically around cost-savings identification & measurement and grant opportunities.

IQ asked whether KPMG will be the independent reviewing expert for the overall plan; MF responded that KPMG already have a copy of the draft plan and have been asked to give initial views on whether the foundation work is robust.

IQ asked how this will become part of normal life for Alder Hey; MF noted that this will be part of the steering group's remit; there was a fully subscribed Green Summit due to take place in March which was cancelled and that one of the first indicators will be Green Travel Plan.

CD suggested having a Board-level Champion to give credibility with regular progress reporting to RABD.

JG noted the need for a version of the plan with key measurables & actions within for sharing; MF responded that expertise would have to be external with key internal operational experts to guide and refine the PID to make this part of normal business, as Green sits alongside everything that we do.

AB suggested bringing in an environmental impact assessment of everything that is material & strategic; future decisions should always be made with Green in mind.

CD will bring a presentation on the social framework and its measurement to Trust Board in January 2021; an invitation will be extended to senior Finance colleagues to various external presentations on procurement etc.

Resolved:

RABD received and noted the Green Plan report.

Action: IQ and JG to agree

- **Determine Board sponsor;**
- **Clarify reporting arrangements to Trust Board & RABD and associated schedules governance; and**
- **Discuss preparation of benefits realisation summary including costs**

Action: CD to bring social framework presentation to Trust Board in January 2021

20/21/124 **Board Assurance Framework**

JG gave a brief update noting that Brexit, workforce and possible wording refreshes around innovation & digital are to be subject to further work and review.

Resolved:

RABD received the BAF update.

20/21/125 **Any Other Business**

No other business was received.

20/21/126

Review of Meeting

Key points: Green agenda; tracking productivity in divisions.

Date and Time of Next Meeting: Monday 14th December 2020, 10:00, via Teams.

Alder Hey Children's NHS Foundation Trust

Safety Quality Assurance Committee
Confirmed Minutes of the last meeting held on Wednesday 18th November 2020
Via Microsoft Teams

Present:	Fiona Beveridge	(Chair) Non-Executive Director
	Nathan Askew	Chief Nursing Officer
	Adam Bateman	Chief Operating Officer
	Pauline Brown	Acting Chief Nurse
	Kerry Byrne	Non Executive Director
	Lisa Cooper	Director - Community & Mental Health Division
	Urmi Das	Interim Divisional Director for Medicine
	John Grinnell	Director of Finance/Deputy Chief Executive
	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	Deputy Director of Nursing
	Christopher Talbot	Safety Lead, Surgery Division

In attendance:

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

Agenda item:

20/21/56 & 20/21/64	Liz Edwards	Head of Clinical Audit & NICE guidance

20/21/52 Apologies:

Anita Marsland	Non Executive Director
Alfie Bass	Divisional Director, Division of Surgery
Dani Jones	Director of Strategy
Jacqui Pointon	Associate Chief Nurse/Safety Lead for Community Division
Dr. Nikki Thorbinson	Parent & Carer Governor
Kate Warriner	Chief Digital & Information Officer

FM welcomed all to the Safety & Quality Assurance Committee (SQAC). FM advised SQAC that she would be Chairing SQAC on behalf of AM, until such time that AM could resume Chairing the Committee.

20/21/52 Declarations of Interest

CQAC noted that there were no items to declare.

20/21/53 Minutes of the previous meeting held on 21st October 2020

Resolved: The minutes of the previous Safety & Quality Assurance Committee meeting held on 21st October 2020 were agreed as a correct record.

20/21/54 Matters Arising and Action Log

Action Log

19.20.161 – CQSG Key issues Report – 'meeting to be convened regarding key performance indicators'. NM advised that this action had previously been on hold, with the aim to discuss at Patient Safety Day which is scheduled to take place on 24th November 2020, with discussion to tale place regarding what indicators should be presented to SQAC from CQSG. NM advised that this item would be completed by the end of November 2020, with a further update at December 2020 SQAC meeting.

20.21.21 – Clinical Audit - 'Offline discussion to take place with LE, KB & AM in order to receive Clinical Audit Briefing'. KB confirmed that the Board & Committee Administrator was currently in the process of arranging a meeting to discuss this item further, the meeting would also include F Marston. NM requested whether she could be included in this meeting invite. KB confirmed that she would adivse KM to include NM.

Action: ES to update KM to include NM into the mtg invite, when diarising.

20.21.28 – 'Comparable benchmarking data regarding the - Was not brought rate', UD confirmed that she had been in discussion with other Paediatric Trusts namely Birmingham Children's whose Was not brought rate is 16%, with Alder Hey 'Was not brought rate – 13% and Bristol are at 10%. UD advised that colleagues from Birmingham had requested assistance from Alder Hey, in terms of how Alder Hey are managing the 'Was not brought rate'. UD advised that ongoing Discussion is taking place across the network.

20.21.40 - Positive Behavioural Support update – ES confirmed that discussions had taken place with regards to this action, and that there is an agreed plan to utilise funds across a number of cost centres. Training had commenced, and a meeting had taken place with the suppliers on 17th November 2020. LC thanked SQAC for ongoing support. SQAC noted that this action could be closed and removed from the action log.

20.21.42 – DIPC Exception Report – SQAC noted that NM would contact BL in order to receive an update from BL with regards to progress regarding offline discussions due to be held with BL and Divisional Directors. SQAC recognised that BL was new to post and currently had a number of ongoing priorities, and looked forward to receiving an update on progress at the next meeting. This item to remain on the action log to receive an update at the next SQAC meeting.

20.21.42 – 'Clinical Claims Report - MP liaising with NHS Resolution to investigate whether NHS Resolution are able to provide further information regarding benchmarking data'. PB advised that she would follow this up with MP in order to provide a position statement. ES advised that there is another report for non clincial claims which gets presented at People and Wellbeing and that there is a requirement for an overarching piece of work to be completed across both reports. ES stated that there is a requirement for a number of colleagues to review this further in order to compare data.

30.21.45 – BAF – PB advised that she had discussed this issue with Deputy Director of Nursing with regards to what AHP staff could be redeployed if required. Each of the divisions had been fully consulted and engaged and Divisions had advised regarding whether any AHP staff could be deployed. SQAC noted that the BAF Nurse Staffing action could be closed and removed from the action log.

20/21/55 **To agree top 5 risks**

NM stated that the top 5 risks shoud be Medication.
Rick should be included regarding Safety/Covid – and queried whether Covid should be split into two risks – relating to risk affecting patients and the risk affecting staff. NM referred to the risk affecting patients and advised that this would have a number of componenents relating i.e. risk to patients who are not presenting when they need to, a risk for those patients on waiting lists who need to be seen, either new patients or current patients, there would also be patients who are waiting for definitive procedures who are having to wait.
NM referred to staff risks, in terms of the potential of staff getting covid whilst at work, NM referred to a risk with regards to morale and fagigue of staff.
NM stated that there is also a risk regarding the vaccination programme and whether colleagues would take up the vaccine.

NM alluded to safety and quality risks, in terms of how colleagues are currently working and acknowledging any future changes.

NM referred to risk regarding Infection and Brexit, given that 75% of medication supplies are received from Europe. NM advised that the Government had indicated not to stock pile of medications, but for Trusts to expect longer lead times.

NM referred to change and fatigue, NM advised that colleagues had worked differently during panedemic, with some changes which had worked really well, with the Trust keen to continue with this and colleagues are working with KPMG, in order to introduce and embed a comprehensive quality improvement programme. NM stated that this would be a change for staff, NM advised that change can be tiring for staff, and some roles had been repurposed and would impact upon staff.

FB queried whether there is a clinical element, given that patients are seen remotely, and given that colleagues are working differently/protocol risk. NM advised that some staff had easily and quickly adopted to virtual working, whilst other staff had struggled, with further work to do in this area.

AB stated that previous discussion had taken place at the People and Wellbeing Committee on 17th November 2020, and that staffing issues had been discussed. AB stated it would be helpful to include information from Root Cause Analysis, Incident investigations, Never Events to include within risks i.e. situational awareness, never events, communication issues. FB stated that she envisaged that this would link into the infection risks. NM stated that there are some RCA's which had been undertaken during the pandemic, and whilst there was no evidence to support NM opinion, NM was of the opinion that fatigue of staff is a contributing factor, with staff making mistakes, although NM acknowledged that there is no factual evidence to support this. AB advised that he was referring to non Covid, and whether reference should be made within the top 5 risks to cultural issues or Never Events.

NA proposed medication errors should be included in the top 5 risks in terms of themes/ trends and risk of harm. FB questioned whether this could be widened to include clinical errors/incidents and not just medication errors, in order to include AB comments. NM stated that research regularly showed that 1 in 10 people in hospital would be subject to error, NM stated that this risk could be broadened, and could have mitigations within each division, i.e. human factors. NM confirmed that she would be happy with this approach.

ES suggested that these be kept broad, to enable to cover specifics raised, given focus on Never Events. ES referred to the People and Wellbeing Committee held on 17th November 2020 and stated that it was helpful to see the inter relationships regarding risks, and that she wouldn't foresee a problem in seeing risks in more than one place, particularly regarding workforce supply and staff fatigue.

FB referred to Mandatory training and mitigations.

JG requested that clinical errors/thematic review/never events and medication errors should be included.

JG stated that SQAC committee to date had not spent sufficient time discussing delays to clinical care and acces, given that this is a signficiant risk for the organisation in order for SQAC to assure themselves that clinical risk and management is being managed, JG advised that he would welcome further regular review of this risk going forward. JG confirmed that RABD are reviewing this risk regarding performance and operational delivery with regards to access to care. JG stated that it would be helpful for SQAC to have oversight regarding management of clinical risk and mitigating harm and access, JG stated that he would welcome regular review at SQAC. FB stated that this is included within covid patient patient risk, and that she envisaged that it would be included within covid and recovery, and that it would be helpful to ensure this has more emphasis, with the aim that in time Covid would drop off, and that the access issue remains prominent as a risk. JG stated that he would like to see those risks in the context of covid, as some risks are very much in the present e.g. the infection risks, whilst some risk have longevity, which would need to be framed appropriately. NA stated that it would be helpful if this wasn't completely in the frame of covid from access, as there are access issues which are being worked on, mental health targets, - patient access, whilst keeping this broad, would allow this to be addressed. CT was in agreement with JG and stated that access remains an issue, and that Covid had augmented the issue, CT advised that he would prefer to see this as a separate risk, and stated that this could be incorporated as appropriate.

KB referred to a discussion that had previously taken place with KB/JG/AB/ CU and divisional representatives about "Division BAFs". Whilst this has not been taken forward, the risks we are talking about would likely fit on Division BAFs.

KB queried whether an offline discussion about where risks are recorded is worthwhile as KB did not want to duplicate here risks which are already being tracked on existing risk registers and equally KB did not want risks being discussed at committees which are not included on risks registers. (This concern was subsequently answered later in this discussion, by reframing this discussion as "Top 5 Quality Priorities" rather than Top 5 risks.)

in order to further progress, in terms of finessing the 5 risks in order to review the risks across the organisation, but also across the divisions, and whether the risks are similar there is a need for the language to reflect this distinctly.

JG expressed caution regarding positioning and the intention, with caution required in terms of duplication of risks across functions. JG bourne from approach from RABD top 5 priorities in order to drive improvement. JG advised that committee's see this slightly differently from looking at this through pure risk lenses, with the need to build on some thematics. JG stated that it is important to be clear on what the intention. FB highlighted the importance regarding the people risk, as People & Wellbeing Committee would be reviewing this risk slightly different than that of SQAC. FB stated that she could see the same thematic risk, but noted that the risk may legitimately need to be dealt with differently with two different committees, and that the overlap of membership should assist with the clarity of purpose. JG emphasised the importance of all being clear on what the committee are trying to achieve, i.e. risk lense or to drive improvement. KB commented on the need for oversight across functions. ES advised that it is critical that all committee members are clear that this is about focus, and alignment following the committee reset. ES stated that regulators would be accepting of an approach that ensure this, as long as all can articulate what committee's are setting out to achieve. ES empahsied that all need to be clear what the risks are, and what is being reported month on month. NM stated that she could not think of a risk in any other committee that would not be a risk to patient safety and quality, and that any risks in any part of the organisation is a potential risk in terms of safety and quality.

NA stated that he wouldn't normally describe as risks, and queried whether these should be described as quality priorities which are tracked through quality improvement methodology, which would demonstrate improvement, NA advised this would be more helpful in order to ensure greater focus on improvement and mitigation, rather than articulating risk.

ES stated that the articulation and description could be discussed offline, and thanked NA for helpful comments.

Action: Offline discussion with colleagues to take place, SQAC to receive an update at the next SQAC meeting, further thought required regarding how influence agenda at the meeting.

Quality Improvement Progress Report

20/21/56 NICE Compliance Report/Confidential Enquiries Report

LE presented the NICE Compliance Report/Confidential Enquiries report, key issues as follows:-

- LE reported that the Clinical Audit team continue to work from home, with some audit activity suspended due to Covid 19 pandemic, this is the case for many audits within the Trust and many national and regional audit projects.
- The pandemic continued to generate additional audit activity, with 63 Covid related audits currently registered within the Clinical Audit Department.
- Between 1st July 2020 & 30th September 2020 53 clinical audits were registered, of these 20 (38%) were Covid 19 related. During this period 25 audits were completed.

- The Trust wide Clinical audit plan also incorporated audits undertaken to fulfil the Trust Quality contract, to date, this list had not been finalised, however the clinical audit team had been advised that this list is likely to remain the same as previous years, and this is reflected in the Trust clinical audit plan, as such the Trust Audit plan may be subject to amendment in Quarter 4.
- Local Audit plans and Audit registers – proposed local plans had been developed by Head of Clinical Audit and shared with Medical Division and Surgical Division, progress on delivering the plan is discussed at Divisional Integrated Governance meetings. Divisional Audit meeting had been established within Division for Community and Mental Health and Medical Division, it is anticipated that the Division of Surgical Care would establish a similar forum to ensure opportunity to discuss progress and planning of audit activity.
- The first clinical audit presention had been delivered using Teams live was broadcast on 14th October by Head of Occupational Therapy, who presented findings of audit of the demand for community occupational therapy.
- National Clinical Audit week is scheduled 23rd – 27th November 2020, which includes daily clinical audit presentations for staff held via Microsoft teams, using a combination of live presentations, providing a forum for question and answer sessions can be utilisied and recorded to share with those staff not able to join. The programme is due to be published on the Trust internet. A programme of monthly clinical audit presentations is planned to continue from December 2020. With Clinical audit presentation, reports, guidance and newsletter available on the clinical audit page on the intranet.
- MIAA review – MIAA undertook a review of the Clincial Audit function during September 2020, the draft report is planned to be returned to MIAA once comments by Associate Director of Nursing & Quality & Head of Clincial Audit had been finalised. The report indicated substantial assurance is evident, the report, specifically key findings, recommendations and an action plan is due to be presented to the Trust's Audit & Risk Committee & SQAC early in 2021.

NICE guidance, Quarter 2 2020-21 update:-

- 1 Clincial Guideline published during this quarter – NG182 Insect bites and stings: antimicrobial prescribing, this had been assigned to the Antimicrobial Lead within the Division of Surgery.
- Management of NICE guidance – the Divisions receive monthly updates and quarterly reports to the Integrated Governance meetings highlighting progress of each guideline. The NICE guidance co-ordinator provides a monthly update report to each Divison with regards to progress which is summarised in quarter report to Divisional Integrated Governance Committee meetings. SQAC noted Actions required
- Actions required included review of findings of MIAA report and associate action plan, development of local clinical audits plans for 2021/2022, review of resources within Clinical Audit team to delivery Clinical Audit programme, review process within the Divisions to respond to requirements of policy for dissemination and implelentation of national guidance policy – especially NICE guidance – especially NICE guidance. LE stated that she would like to propose

that when Clinical Audit meet with the Divisions that discussion/feedback regarding NICE is incorporated into Divisional discussions.

- LE advised that Clinical Audit are focussing on plans for 2021 and intend to review process when new guidelines are issued in order to further strenghthen clinical audit and look at how to enhance the clinical audit service provided.
- LE advised that there is a need to review resources within the Clinical Audit Team.
- SQAC received and noted the Trust Audit Plan 2020/21 Quarter 2.

FB congratulated LE and her team for provisional assurance from MIAA.
NA stated that this was a respectable paper, which clearly reflected the work achieved to date, NA stated that it was good to see that 25 audits had been completed, and advised that it would be helpful for a brief indication in future reports regarding the outcomes of those completed outcomes to be included in terms of assurance and compliance, with regards to the outcome of these audits. LE advised that each division receive a quarterly report, and that clinical audit list those actions that have been identified within the audits, however this is the only forum that this is fed back, with further work to do within the team in order to ensure that actions are completed and followed up, and whether there is a need to re audit. LE advised that she had previously discussed this issue with Associate Director Nursing & Governance in terms of improvements for the future, together with discussion regarding LE role. NA suggested it would be helpful to include compliant/completed/partly compliant or requires improvement, with outcome measures contained in future updates, in order for committee to obtain assurance. KB echoed NA comments in order to ensure that SQAC are fully sighted on the outcomes and themes, together with any findings of such significance that would warrant reporting to SQAC. FB welcomd this planned approach.

FB referred to Clinical Audit focus for 2021/22 and queried whether SQAC members all agreed to the planned focus on 2021/22. SQAC were in agreement. FB advised that Clinical Audit meetings with Divisions are critical for Clinical Audit and should continue, and should include NICE discussions.

FB sought clarity regarding the National Clinical Audit week 23rd - 27th November 2020 in terms of the daily presentation, and asked whether there is a planned communications drive, in order to widely publisice throughrough the Trust for those not able to join live. LE confirmed that the Comms team are due to issue comms to staff by close of play 18th November 2020.

FB referred to the desirability regarding a review of resources for the Clinical Audit Team and queried who would address this issue, and sought clarity whether this issue is something that should be completed within the next 12 month period. NA agreed that he is content to follow this up, and would welcome a review in Quarter 4, as part of the whole Quality and Safety agenda as a whole. NA confirmed that this would be reviewed in Quarter 4 and that the outputs would be shared with SQAC at the end of Quarter 4.

FB queried whether this is this right way to address the process regarding reviewing NICE guidelines, - NM advised that both NM and NA would support the team in order to work through this. NM stated that there is is a significant piece of work to commence, in order to concentrate available resources within the Trust, in order to provide the finest information, in order to help modify and improve services.

Action: NA to review resources within Clinical Audit Team and update to SQAC at the end of Quarter 4

20/21/57 Intensive Support Team - Update on Pilot

LC provided an update/overview on Instensive Support Team Update, which detailed an update on background, key priorities, progress on work to date, performance data & outcomes, and resources.
The national programme of work is 'Transforming Care' and focussed on improving health and care services so that more people can live in the community, with the right support and close to home.

Key priorities of work include, obtain support to ensure patients live a long and healthy lives, patients being treated with the same dignity and respect, having a home within their community, being able to develop and maintain relationships and getting the support they need to live a healthy, safe and fulfilling life.

- 32 referrals made to the team
- 17 cases accepted
- Of those cases not accepted 12 x MDT advice was given; 2 x declined by family; 1 x declined by IST (not met criteria). 11 cases continue with active involvement of IST. 6 cases care stepped down to Locality Specialist Mental Health Services

The pilot reports externally on a quarterly basis to the Cheshire & Merseyside TCP regarding activity, outcomes and progress. Internally the team reports on a monthly basis to the Community & Mental Health business meeting.

Following a successful bid to NHS England in 2019, Alder Hey was awarded funding to pilot an Intensive Support Team for children and young people across Liverpool and Sefton. The Intensive Support Team **(**IST) is a community based intensive positive behaviour support service for children and young people with a learning disability and/or autismwhose behaviours are described as 'challenging'. The team provides a multi-disciplinary approach to prevent inappropriate admissions to hospital and residential facilities and is a key part of Alder Hey's wider provision of mental health services and support to this often vulnerable cohort of children and young people.

None recurrent funding had been secured from NHS England via Cheshire & Merseyside TCP to support the initial pilot phase (2020/21). Subsequent funding had also been secured for an extension of the pilot during 2021/22. Funding allocated - 2020/21 - £147,832, - 2021/22 - £365,832.

The Director of Community & Mental Health Services is in ongoing discussions with the relevant CCGs regarding the allocation of recurrent funding and continuation of the team post 2022.

LC advised that she is hoping that a family of a complex patient would be presenting at Trust Board on 26th November 2020 and Trust Board whereby Trust Boad members would hear the patient story.

JG stated that this is a brilliant report, and queried the timeframe, LC confirmed this was January until end of October, JG stated that the numbers of patients did not look significant over the timeframe with an average of 4 patients per month,. LC stated that since the initial pilot that the funding had signifcicantly increased for the 2nd pilot, 2nd pilot to include additional occupational therapy, speech therapy

and additional psychological support. LC advised that based on the dynamic risk database that the Trust should only have a caseload of around 10-12 children at any one time – these are the really complex children, a number of referrals would be made, however a key remit of the team is to review all referrals, and the team would work with the referrer should the referral be inappropriate, LC advised that the numbers should be small, as the rest of the system should be supporting these children.. LC confirmed that further data would be collected. JG alluded to the different tiers with regards to interconnectiveness i.e. crisis care etc, and stated it would be helpful to see how interconnectivity. LC agreed to share strategy. LC stated that in the future it would not be an Intensive Support Team, it would be a function, once funding had been received, with the need for a larger vision. SQAC agreed it would be helpful to review this in the future when appropriate.

SQAC noted the significant improvements of this team and the impact on C&YP

SQAC received and noted the contents of the Intensive Support Team Pilot update.

FM thanked LC for update.

20/21/58 Division of Surgery Update

CT provided an update//overview on Safer Teams at Alder Hey Theatres (STAT), formally the HoT programme, essentially run by Imperial team, CT advised that clinical colleagues felt this should be branded by Alder Hey as the STAT team. Key issues as follows:-

- HoT Programme established in order to improve theatre safety, with the use of similatuion to show how human factors contribute, and how this impacts on theatres. CT confirmed that the Team had been assembled, programme content had been written, and simulation had been agreed, there are a number of sim cases. The team are currently in the process of procuring a mannequin, pilot team identified. CT highlighted the importance of inclusivity in order ensure full engagement, and roll out throughout the division. Lecture and teaching materials for human factors and sim progressed. Dates for pilot is set for 27th November 2020 – 6th January 2021.
- Coaching for future coaches had commenced on 13th November 2020 and branding is currently underway. CT advised that there is a need to secure future coaches for the 2nd phase of the programme.
- CT advised that progress had been made, following the pilot and implementation, plans early impolelentation of stat programme in Day Surgery is planned for February 2021.
- Undertake live'reinforcement' coaching every 12 months to teams who have undertaken the programme.
- Recruit and train additional faculty members in phase 2 as the programme develops for future sustainability in order to disseminate information regarding the programme.
- Meet and greet, newsletters, to explain content of programme and gain engagement from staff prior to roll out.

NA stated that this is a great programme and referred to sims resources and advised that there is additional money in the Trust and that Darren Shaw in L&D is looking to support such programmes. NA advised that he is ahappy to support sim element. NM welcomed the change in branding to STAT.

MS welcomed this programme and looked forward to replicating improvements and looked forward to receiving updates, and offered HR support should the team require any HR support.

- Consent – CT had discussed consent with AB regarding HC who had taken the lead regarding consent. CT advised that there had been a change to guidance published, with the need for review of consent guidance/review of policy. Division need to reflect on changes of new consent to ensure changes are incorporated into any audits, and how the division perform consent in the future. CT advised that the Division of Surgery would like to push for an educational programme. CT referred to the pressure ulcer day and stated that it would be helpful to have something similar regarding consent. CT referred to required funding, given that HC had been undertaken consent role for some time. CT queried whether the Trust had any funding for this consent role, in terms of whether this role should have PA's associated, in otrder to facilitate role.
  NM confirmed that she had undertaken a discussion with Divisional Director for Surgery and that HC needs ½ pa per week in terms of consent, and that clearly consent for nursing and AHP take consent on various issues, with nursing consent structured as they are educators. NM advised that medicine is not structured in this way. NM queried whether there was any capactiy within the quality team regarding educational component, in order to construct structure regarding consent. NM stated that there isn't a specific budget for this for mandated requirements. NM advised that following the planned patient safety day, that there maybe further information.

  CT confirmed that signficant work iss ttaking place on E consent, with all depatments within surgery division asked to populate E-consent and ddepartments have submitted information.

  CT stated that there should be a mandatory divisional audit on consent, feel should have a way of assuring new guidance is affecting how consent is made.

  FB stated that the updated was very clear, LC stated that it is mandatory audit in other organisations. LC advise C&YP forum had commleted significant work regarding consent, in order that they udnertstnad consent. LC stated it is a Trust wide issue. NM reiterated that the Tust does not have central monies to utilise.
  FB referred to group of specialist advisors that could be made.

  SQAC noted that further discussion would take place at Patient Safety day, with Executive team colleagues establishing the most appropriate way forward.

  FB queried whether an update is planend for the Board of Directors. ES advised that NM & NA would provide update at Board following patient safety day. ES stated that there is a planned CQC engagement meeting scheduled in December 2020 and this would be a good opportunity to share this update with CQC.

  FB thanked CT for update.
  SQAC looked forward to receiveing updates as work progresses.

20/21/59 Delivery of Outstanding Care
Safe
CQC Action Plan
ES presented the CQC Action Plan, key issued as follows:-
ES advised that she is extremely pleased with regards to the progress made within the CQC Action plan, and expressed particular thanks to the Surgery Division with

regards to progress made regarding the progress made in terms of Consent . ES advised that she envisaged further continued improvements for the November CQC Action Plan update.

SQAC received and noted the CQC Action Plan, and noted the completed actions. SQAC noted that the Action plan is currently on track for continued improvement. FB thanked ES for update**.**

20/21/60 **DIPC Exception Report**

B Larru presented the DIPC exception report which provided a brief summary and overview of the position to date, key issues detailed below:-

BL referred to a cumulative number of bacteraemia's and advised that the most significant finding was an increase in Gram positive bacteraemia due to MSSA which had increased since last year (7 cases to date). Grand negative CLABSI - (14 cases to date.)

BL advised that since the beginning of the pandemic the Trust had seen an Increase in the number of C.difficile cases (3 cases to date), however BL did not have the data to interrogate all cases further. LB had participated in RCA which identified hat a patient had received more prolonged antibiotics than they should have received.

BL referred to MRSA RCA and stated that on review of the RCA it was very notable that colleagues had not been following guidance, on how to bath, and decontaminate patients.

- Flu Compliance – 83.04% compliance.
- BL reported that there had been a change in the Infection Prevention and Control Leadership Team during Quarter 2 and policies and processes are being reviewed and revised, and would be shared with the Committee as they are updated.
- BL stated that she has a close relationship with teams, working together in order to share expertise, with the team learning to work differently.

Quarter 2 DIPC report

BL presented the Infection Prevention Services Report Quarter 2 2020-21 which provided an overview on the following items, hospital acquired bacteraemia for Q2 compared to Q2 2019/20, PPE update, Trust Guidelines, COVID testing, environmental cleanliness, patient treatment, fit testing and previous false positive # COVID 19 outbreak.

- In comparison to last year largest Hand hygiene compliance – 96.7%, for the quarter with 3466 opportunities.
- IPC member from Community Division continues to work on IPC work plan for 2020/21 which includes 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.
- BL advised that the construction of negative pressures cubicles for the PICU was due to start in September 2020, but had been postponed until March 2021 because of bed capacity and winter pressures.
- BL confirmed that there is a strong plan to reach 100% for staff testing and is well embedded within the Trust.

JG referred to C Diff and questioned whether the IPC team have a plan to

address. BL advised that the IPC team are working with the Business Intelligence Team in order to ascertain numbers of children who may have received an infection. JG stated that it is helpful to hear planned approach and it is good to see how colleagues develop what information is shared with SQAC. BL stated that given that she is relatively new to post, that she needs time to interrogate the data from BI team, in order to interrogate information and compare/review data. BL highlighted that she required quality clinical data.

FB advised that she looked forward to receiving an enhanced detailed report in due course.

FB thanked BL for informative update.
SQAC received and noted the DIPC Exception report.

Well Led

20/21/61 Board Assurance Framework

ES presented the Board Assurance Framework, key issues as follows:-
ES advised it was disappointing to see that the cover sheet unfortunately had been omitted within the meeting pack. ES referred to top 5 priorities and welcomed the opportunity to work with NA in terms of the first risk which has a focus on people, issues regarding processes.

ES confirmed that access received thorough review within numerous places.

KB agreed committees would undertake deep dives and queried whether NA & AB could provide deep dives on Risks 1.1 and 1.2 at future SQAC Committee meetings.
SQAC noted that deep dives for Risks 1.1 and 1.2 would be scheduled as appropriate at future meetings.

SQAC received and noted the BAF update.
FM thanked ES for update.

20/21/62 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 October 2020.:-

Safe

- Division had 143 incidents reported which is an increase since September 2020.
- Zero incidents recorded of moderate, severe, or fatal harm
- Zero never events
- Zero pressure ulcers
- Challenges for the division remained regarding coded medication incidents which related to lost prescriptions, with signficiant work taken place to date with regards to electronic prescribing, with the division working with colleagues who are piloting the impact on Royal Mail , in terms of lost prescriptions. This is recorded on the Risk Register.
- ANTT training compliance in OPD, there is an improvement plan which the Division would be regularly monitoring.
- Continued lack of tissue viability support to the division, LC stated that there is a meeting arranged with NA to address this ssue.

Caring

- 28 Excellent reports, 6 compliments

- 3 formal complaints received in the Division
- 32 PALS
  - 1 Joint complaint with medical colleagues regarding tics and touretts, and one regarding community paediatrics waitings times for ADHD and ASD.
  - FFT reporting had signficiantly improved, with over 95% of C&YP Recommending Outpatients, and just under 95% had recommend community services.
  - FFT comments following attend anywhere, significantly improved the number of children who are feeding back.

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
- Cleanliness score of 97.9%
- Sepsis – good progress had been made within Inpatients, 100% compliance with some really sick children, high acuity, children really well managed. Challenge remained with regards to sepsis in ED – 74% in October, running on this % over the last few months, the Division are viewing this in depth, delay in venus access, significant sick babies presenting, more children are requiring investigations under the age of 3 months, CW stated it is important to perform invesstigations in order to ensure patient received correct treatment plan/correct antibiotics are provided. CW advised apporpirate investigations can take some time for appropriate discussion with microbilogists. Weekly meetings take place with Governance Leads, Sepsis team which are extremely useful in order to address issues and promptly act on any issues raised.
- ED working group had been set up which ensure staff involved, with ED reviewing data which had been raised at a previous performance meeting.
- CW advised that the division have challenges, however CW provided assurance regarding improvements.
  NM stated that in terms of compliance it would be helpful for different terminology to be used to describe this. NM stated that for those complex children who have particular complex care needs, that these patients should be proactively reviewed in order to ensure there is a protocol for these individual complex patients. NM advised that it is imperative that Junior Doctors are involved in these weekly meetings.
  NM stated that in terms oft antibiotics within 60 minutes, 90 minutes and after 90 minutes, -if concentration on those children within 60 minutes, the Trust should get biggest improvement. CW advised that the data would be shared at future SQAC, following a revision to the dashboard in order to rearticulate the target. SQAC noted that there is a requirement for revision to dashboard required to articulate these changes.

Caring

- 7 Complaints and 25 PALS responses.

Effective

- ED performance continued to meet the national standard – 96.8% With effect from 17th November 20202 NHS 111 was live and ED is very responsive to this.

Responsive

- RTT compliance remains challenging at 68%, UD advised that she is hoping that the Division would see an increase in December to 92%, this is an improvement since September.
- The Was not brought rate remains a challenge at 13.7%
- There continue to be no patients waiting over 52 weeks for treatment.
- Continued recovery plan of diagnostic targets, 98.8%
- Challenges remained regarding outpatient imaging reporting times, Associate Chief of Operations is reviewing this position.

Well Led

- Expenditure within the Division remains £264K overspent due to pressures and pay, there is a focussed effort to reduce expenditure
- Medical Appraisals are at 96%
- Mandatory training remains static at 89.9%, with colleague from HR reviewing this further. Mandatory training could be related that admin staff required to undertake face to face training, which is not required. HR are currently reviewing this. CW referred to mandatory training that could not take place face to face, the Division are looking at a plan to improve this The Division are reviewing Paediatric Life Support training, in order to further enhance and improve this.

JG referred to the RTT performance and trajectory and commended the Division of Medicine for current RTT performance position.

SQAC received and noted the Division of Medicine update

Surgery Division

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

Safe

- Zero Never Events
- Clinical near miss increasing
- Clinical minor, non permanent increasing
- Zero clinical incidents resulting in severe, moderate or permanent harm
- Zero grade 3 pressure ulcers, with the division undertaking significant work in this area
- 2 medication errors resulting in harm
- 1 HAI (Pseudomonas)
- Highlights, increased incident reporting, Cleanliness score of 98% and Improvement Sepsis treatment of antibiotics within 60 minutes to 86%
- Challenges for the Division related to medication errors resulting in harm, flu vaccination rate is low (64%) and Sepsis breaches in neonates.

Caring

- 9 new formal complaints received**,** themes alleged failure in care, waiting times for appointments.
- PALs – 29, themes alleged failure in medical care, waiting times and appointment delay (OPD).
- Highlights included the division proactively managing formal complaints, however the division envisage further new complaints, given the capacity constraints and complaints regarding waiting times and access to routine care,

with ongoing issues regarding outpatients, in terms of clinical assessments, and noting reduced footfall.

Effective

- Readmissions to PICU within 48 hours (achieved)
- Outpatients remain stable – 2572, 3140, 2548
- Theatre utilisation – 89.9%
- Increase in children cancelled on day of elective surgery (non clinical reasons) -Below pre covid/ Swab testing and staffing issues.

Highlights

- No patients waiting over 28 days for new theatre date if cancelled on the day
- Hightest number of CCAD cases since March 2020
- Reduction in OPD cancellations by Hospital weeks

Challenges

- Was not brought rate 10.1%
- Increased number of referrals
- Day surgery and OPD activity is lower than same time last year
- Lack of flexilbity regarding cancellation/bringing patients in at short notice for theatre (impact on utilisation)

Responsive

- Maintenance of lower % of patients with open pathways over 18 weeks - 46%
- Concern regarding 149 patients with outstanding treatment waiting over 52 weeks
- 100% patients who know planned date of discharge,
- Increase in patients involved in learning (98.8%)

Highlights

- Increased operating capacity – day case working group and weekend DC lists with increased activity
- Diagnostic testing completed within 6 weeks (100%)

Challenges

- Challenges regarding referral to treatment time. Further increase in capacity required to meet pre Covid activity levels and recovery plans difficulty (OPD virtual/phsycial capacity)

Well led

- Privacy and dignity policy completed
- Mandatory training remains constant at 86%
- 66% of PDRs completed
- 3.2 all Covid related absence – short term sickness increase (2.09%)
- Safer staff increased rota fill rate 93.6% (September 2020)
- 93 Theatre PDR completed
- Challenges regarding low engagement in staff 32% signficiant challenges

Highlights

- Patient Information and policies (current performance 94%)
- 93% theatre PDR completed

Challenges

- Low engagement in staf survey (32%)
- Clinical gudelines oversight – document management system to be introduced

FB thanked CT for update, and recognised the challenges within the Division.

LC stated that it would be helpful for regroup in order to clarify what information needs to be shared at future SQAC meetings and that it would be helpful for offline discussion. FB confirmed that she had previously had a discussion with NM & NA and that FB would have an offline discussion with ES to address this timing issue in terms of information received from BI Team.

FB expressed thanks to all of the Divisions for comprehensive reports provided.

20/21/63 ***CQSG Key issues report***

NM presented CQSG Key issues report, key issues as follows:-

- NM advised that both NM & NA have plans to further enhance the CQSG meetings in the future, with discussion planned at Patient Safety day to discuss with clinical colleagues, in order to share ideas and future plans with colleagues
- CQSG received Drugs & Therapeutics Report which showed an increase in the number of drugs for approval. NM had spoken to C Liddy and K Warriner given that a significant amount of individual drug approval requests are made which are urgent, and that colleagues could not wait for a monthly meeting, in order to seek approval. NM had requested the introduction of an electronic process, in order to obtain approval, whilst ensuring appropriate electronic system to record the request for drug approval, or research approval, this was ratified at CDEG, in order to ensure robust recording.
- Radiation protection – had been presented to People & Wellbeing Committee with regards to mandatory training regarding wearing badge.

- Accessible Information Assurance Report, with regards to using interpreters, colleagues are working with the CCG in order to identify how improvements could be made.

FB thanked NM for update.

20/21/64 **Quarter 2 Complaints Report**

LE presented Quarter 2 Complaints Report, key issues as follows:-

- 34 formal complaints received which is an increase to previous year.
- Covid had impacted on the complaints function and had significantly impacted on face to face meetings.
- Team had reviewed how MP's complaints are managed.
- Largest number of complaints noted within the Medicine Division, relating to cessation of service for patients with ticks and Tourette's syndrome. With information online, and an online petition.
- LE advised that the aim is to acknowledge complaints within 3 working days, 82% had been acknowledged, aim is to respond to complaints within 25 working days – 52% had been responded within this timeframe. 23 responses to complaints in Quarter 2. 35 days – 34% responded to within timeframe. LE stated that the reasons for the delays related to complex cases, cross divisional information gathering, in order to ensure a good quality response is provided.
- From the 23 complaints 9 were upheld, 2 were not upheld 12 were partially upheld, LE does not have any data in terms of why they were partially upheld.
- Increase in Quarter 1 – pandemic/lockdown increase compared to last year by 64.
- PALS by Division and themes are consistent.

- LC stated that she had previously requested that compliments be included in the report, and noted compliments had still not been included.
  FB referred to MP's enquires/complaints and queried how the risk would be managed and whether the MP complaints would be double counted. PB advised that the process in place within PALS would ensure that MP complaints would not be double counted.
  FB alluded to the Ticks and Tourette's issue and sought clarification of whether there was any potential for further complaints to be received. CW confirmed that she did envisage that further complaints would be received in the future and that a high level RCA had taken place, team undertake biweekly regular update meetings with CCG and colleagues and the Division are in communication with parent forum. CW advised that this is challenging for the division and that significant work is taking place within the community and with the CCG. CW stated that NA is supporting the Division in terms of managing this situation.

  FB referred to complements and whether they should be included within the report. NM advised that there is a need to review terminology.
  NA advised that it was helpful to see the Complaints report, NA referred to the response rate and advised that this significantly need to be improved upon. NA advised that he would be working with colleagues in order to improve response rates. NA stated that there is opportunity in the future to enhance the report, with further work to do. KB welcomed and echoed NA comments. KB welcomed an enhanced report in order to provide SQAC with assurance. SQAC noted that complaints regulations . LC reemphasised the importance of ensuring compliments are recorded.

- There were no referrals to the Health Service Ombudsman in Quarter 2.
  LE advised that she can't report on any update on any complaints with those currently with Health Services Ombudsman and that these cases would be explored in next quarter.

  NM referred to previous complaints reports, and the importance of maintaining focus in the right way in order to ensure complaints are addressed as appropriate.

  SQAC looked forward to reviewing enhanced Complaints report for the next quarter. SQAC agreed it would be helpful to incorporate audit review within a separate report to ensure more in depth understanding of the policy.

20/21/65 **Any other business**

NM thanked FB for Chairing SQAC in the absence of AM.
NA requested whether committee could receive a forward view of future agenda items, and requested whether a forward view could be included on future SQAC agendas, in order to provide divisional colleagues, transparency. ES advised that the detail is included on the SQAC Workplan and that she would discuss this offline with NA.

Action: NA & ES to discuss offline

20/21/66 **Review of meeting**

FB stated that this had been a thorough discussion with good discussion in terms of 5 quality priorities. Good discussion took place regarding audit and NICE guidelines and ensuring that the right governance is in place. Informative update

from Surgery Division regarding STAT programme and associated actions required regarding consent . FB stated that it is important that consent is progressed.

FB shared that the Informative updated from IPC and understanding highlighted solid engagement.

Informative discussion regards Complaints, which had identified a need for a deep dive as part of the reporting cycle.

20/21/67 Date and Time of Next meeting

16th December 2020 at at 9.30 via teams